

REPORTS OF THE BOARD OF TRUSTEES

The following reports were presented by Sandra Adamson Fryhofer, MD, Chair:

1. OPPOSITION TO REQUIREMENTS FOR GENDER-BASED TREATMENTS FOR ATHLETES (RESOLUTION 19-A-19)

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

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 19-A-19
REMAINDER OF REPORT FILED
*See Policy TBD***

Resolution 19-A-19, “Opposition to Requirements for Gender-Based Treatment for Athletes,” sponsored by the Medical Student Section, was referred to the Board of Trustees. Resolution 19-A-19 asked:

1. That our American Medical Association (AMA) oppose any regulations requiring mandatory medical treatment or surgery for athletes with Differences of Sex Development (DSD) to be allowed to compete in alignment with their identity; and
2. That our AMA oppose the creation of distinct hormonal guidelines to determine gender classification for athletic competitions.

BACKGROUND

Resolution 19 reacts to guidelines issued in 2018 by the International Association of Athletics Federations (IAAF)—now World Athletics—updating eligibility criteria for athletes with differences of sex development (DSD) who wish to compete as women in certain international track and field events. Under these guidelines, to be eligible to compete in the 400m, hurdles races, 800m, 1500m, one-mile races and combined events over the same distances, women with DSD who have serum testosterone levels above 5 nmol/L and who are androgen sensitive must:

- be legally recognized as female or intersex
- reduce their circulating serum testosterone levels to below 5 nmol/L for a continuous period of 6 months, and
- maintain their serum testosterone level below 5 nmol/L continuously for as long as they wish to remain eligible to compete (regardless of whether they are in competition) [1].

Female athletes with DSD who choose not to reduce their serum testosterone levels will be eligible to compete in all events that are not international competitions and in events in international competitions other than those specifically prohibited [1].

In a separate report, World Athletics outlines eligibility criteria for transgender athletes competing in international competitions. They specify that

- to be eligible to participate in the female category of competition, a transgender female athlete must provide a written and signed declaration that her gender identity is female;
- she must demonstrate to the satisfaction of an expert panel that the concentration of testosterone in her serum has been less than 5 nmol/L continuously for a period of at least 12 months; and
- she must keep her serum testosterone concentration below 5 nmol/L for so long as she wishes to maintain her eligibility to compete in the female category [2].

They further specify that “no athlete will be forced to undergo any medical assessment and/or treatment” and that neither “legal recognition of the athlete’s gender identity” nor “surgical anatomical changes” are required to compete [2].

These guidelines represent the most recent in a series of efforts by the international athletic community to ensure fairness in women's competitions that began with "gender verification" policies in the 1960s. In 1968, following the extraordinary successes of Tamara and Irina Press in the 1960 and 1964 Olympics, who were suspected of being male, female athletes were required to prove their sex to be eligible to compete as women in international events [3]. Over time, procedures to determine sex evolved from having female athletes parade naked before a panel of judges, through gynecological examination of external genitalia, to the use of sex chromatin tests, and ultimately DNA-based testing [3]. In 2000, the International Olympic Committee (IOC) and IAAF discontinued routine gender verification in favor of "suspicion-based testing," reserving the right to test if officials or competitors raised questions about a female athlete's sex.

In 2011, in the wake of controversy over South African runner Caster Semenya, the IOC's Medical Commission recommended hormone-based testing, that is, that individuals recognized in law as female be eligible to compete in women's competitions so long as their serum testosterone levels were "below the male range" or if they had an androgen resistance and derived no competitive advantage from testosterone levels in the male range [3]. The IAAF adopted hormonal testing and implemented new policy that routinely tested all female athletes and required those who tested outside the normal range to undergo treatment to normalize their androgen levels to be eligible to compete.

In March 2019 the United Nations Human Rights Council adopted Resolution 40/5, "Elimination of discrimination against women and girls in sport," noting concern that the IAAF/World Athletics eligibility criteria

are not compatible with international human rights norms and standards, including the rights of women with differences of sex development, and concerned at the absence of legitimate and justifiable evidence for the regulations to the extent that they may not be reasonable and objective, and that there is no clear relationship of proportionality between the aim of the regulations and the proposed measures and their impact [4].

The resolution further expressed concern that

discriminatory regulations, rules and practices that may require women and girl athletes with differences of sex development, androgen sensitivity and levels of testosterone to medically reduce their blood testosterone levels contravene international human rights norms and standards ... [4]

In 2021 the IOC amended its stance and issued a new "Framework on Fairness, Inclusion and Non-Discrimination on the Basis of Gender Identity and Sex Variations" that eliminated specific instructions on eligibility to compete [5]. Rather, the framework sought to offer general guidance to sports governing bodies:

to promote a safe and welcoming environment for everyone, consistent with the principles enshrined in the Olympic Charter; it "acknowledges the central role that eligibility criteria play in ensuring fairness, particularly in high-level organized sport in the women's category" [5].

With the framework, the IOC recognized "that it is not in a position to issue regulations that define eligibility for every sport" and explicitly left it "to each sport and its governing body to determine how an athlete may be at disproportionate advantage to their peers" [5].

Also in 2021, the authors of a 2017 study on which World Athletics relied heavily in developing its eligibility criteria published a correction in response to ongoing critique from independent statisticians. The correction acknowledged that "there is no confirmatory evidence for causality in the observed relationships reported" [6]. The authors further noted that the initial research was "exploratory and not intend[ed] to prove a causal influence and that some statements in the original publication could have been misleading" [6].

World Athletics has not modified its criteria [6], however, and controversy regarding participation by female athletes with DSD continues.

The related controversy concerning participation of transgender athletes in all types of sports has escalated in recent years. Since 2020, a number of state legislatures have introduced proposals to prohibit transgender girls from competing in girls' high school (and in some cases college) sports. In March 2020, Idaho was the first state to impose a ban on transgender women and girls' participation in school sports. In 2021, Alabama, Arkansas, Florida, Mississippi, Montana, Tennessee, and West Virginia passed similar bans, and South Dakota's governor issued two

Executive Orders which implemented a similar prohibition. At the same time the Connecticut court case *Soule et al v. CT Association of Schools et al* was in process. In this case the Alliance Defending Freedom sought to ban two Black, transgender girls from competing in high school track and field [7].

The Idaho ban was blocked by a federal court in August 2020. The AMA, along with the American Academy of Pediatrics and other health care organizations, submitted an amicus brief with the Ninth Circuit Court of Appeals noting that the law undermines the accepted approach for treating gender dysphoria. The brief stated that prohibiting transgender females from participating in school-sponsored sports in keeping with their gender identity interferes with the treatment of gender dysphoria by preventing transgender females from living openly in accordance with their true gender [8].

The AMA, together with five other healthcare organizations, also submitted an amicus brief in *Soule et al v. CT Association of Schools et al*. In it, they emphasize that untreated gender dysphoria can cause debilitating distress, depression, impairment of function, self-mutilation, other self-injurious behaviors, and suicide. They also note that transgender individuals are subject to discrimination in multiple areas of their lives, and this both exacerbates negative health outcomes and reinforces the stigma associated with being transgender. Being subject to stigmatization is psychologically harmful and so creates additional negative mental health consequences [9].

Soule et al was dismissed at the state level and (as of August 2022) an appeal in the 2nd Circuit Court remains undecided. As of May 2022, eighteen states have enacted laws or issued rules that either ban or limit the participation of transgender athletes in public school sports [10]. As a result, in some states regulations are more restrictive at lower levels of competition and in recreational programs than they are at higher levels.

For instance, the IOC guidelines amended in 2021 reflect an inclusive and non-discriminatory position with respect to transgender athletes, consistent with their guidelines for athletes with DSDs. They state that

- eligibility criteria should be established and implemented fairly and in a manner that does not systematically exclude athletes from competition based upon their gender identity, physical appearance and/or sex variations;
- no athlete should be subject to targeted testing because of, or aimed at determining, their sex, gender identity and/or sex variations;
- athletes should not be pressured to undergo medically unnecessary procedures or treatment to meet eligibility criteria; and
- criteria to determine eligibility should not include gynecological examinations or other invasive physical examinations aimed at determining an athlete's gender or sex [5].

FAIRNESS IN SPORT

Regulations intended to promote fairness in sport by restricting the participation of individuals whose genetic characteristics are deemed to give them unfair advantage over competitors raise a series of questions about what the goals of sport are, what counts as an “unfair” advantage, and what should be done to “level the playing field.”

Biological Advantage

Policy restricting competition by female athletes who have serum testosterone levels above a designated “normal” range rests on (at least) two problematic assumptions. The first of those assumptions is that there is a straightforward relationship between testosterone and athletic performance that unequivocally gives these athletes significant advantage over female competitors whose bodies do not produce “excess” endogenous testosterone. The second is that serum testosterone levels can meaningfully be measured, and that prescribed levels can be safely and effectively maintained. The specific contribution of testosterone to overall athletic performance continues to be a subject of debate. Critics of the research on which the IAAF based its regulations on endogenous testosterone have argued that a key study concluding that women with the highest testosterone levels significantly and consistently outperformed other female competitors rests on flawed data [11]. Concerns have also been raised about the rigor of its statistical analysis [12]. The main author, moreover, was the director for the IAAF Science and Health Department, raising questions about possible conflict of interest [13]. More importantly, demonstrating a correlation between testosterone and athletic performance in female athletes falls short of establishing the unfairness of such advantage [13].

However, even if the effect of testosterone on athletic performance was conclusively established, single point-in-time tests for overall level of serum testosterone cannot provide conclusive evidence that the individual has or will benefit. It is known that women with androgen insensitivity disorder physiologically cannot gain benefit from excess endogenous testosterone. Multiple factors affect serum concentrations of testosterone, including time of day; age- and gender-corrected normal ranges using a standard assay have not been established; and there is no universally recognized standard for calibrating testosterone [14].

Further, “the relevance of free testosterone vs [sic] the fraction actually available to tissues (the “bio-testosterone”) is not well understood” [15]. Nor do the IAAF regulations take into account the existing lack of consensus about “how to use medications safely to lower testosterone levels when used off-label, the side effects of the medications, [or] the difficulties of maintaining the testosterone levels below the levels requested by IAAF owing to natural fluctuations” [13].

Leveling the Playing Field

Assuming, for purposes of analysis, that testosterone does confer a significant competitive advantage in sport, knowing that does not in itself determine what steps should be taken to “level the playing field.” The latter decision is a normative matter, not an empirical one.

To be defensible, rules and practices intended to ensure that no individual athlete enjoys an unfair advantage over competitors requires that rules treat all relevantly similar advantage-conferring attributes in a like manner. Testosterone testing for female athletes who have been singled out on the basis of their appearance or performance for all practical purposes subjects these individuals to genetic testing not imposed on their competitors.

Fairness would require that sports organizations test for *any* “performance enhancing genes that predispose [individual athletes] to be athletically superior” [16]. In the present state of knowledge, this is no more realistic an approach than are current testosterone assays. The influence of genetic factors on athletic performance is multifactorial and sport specific [17]. Organizations would further have to regulate all such advantage-conferring attributes consistently.

One way to categorize fair versus unfair advantages is by conceptualizing advantages as stable (fair) or dynamic (unfair) [18]. Fair advantages are those the athlete largely cannot affect, (such as chronological age, height, genetics, etc.). Unfair advantages are those the athlete can affect (such as speed, strength, endurance, etc.). On this account, genetic differences in testosterone would be stable advantages that could be subject to leveling or more fine-grained classification.

Thinking specifically about leveling the playing field with respect to inequalities in testosterone levels, three approaches present themselves [13]. First, sports organizations could require athletes to lower testosterone levels that exceed a defined threshold to below a predetermined level. Second, organizations could create separate categories for competition based on the level of biological variations, allowing all athletes with serum testosterone within a certain range to compete against one another, regardless of sex or gender identification [13]. Or, third, they could create categories based on modifying the external conditions of competition instead of intervening in athletes’ bodies. Handicapped horse racing offers a model [13].

THE ROLE OF PHYSICIANS

World Athletics eligibility criteria take the first of these approaches: intervening in the bodies of transgender athletes and athletes with DSDs. In doing so, they virtually require the participation of physicians helping athletes achieve and maintain the stipulated levels of serum testosterone. To the extent that medical interventions to lower testosterone may not be *clinically* indicated, is physician participation appropriate? Overall, existing policies of the American Medical Association and the World Medical Association (WMA) argue against physicians cooperating in the implementation of these regulations.

Existing AMA policy in H-470.978, “[Blood Doping](#),” and H-470.976, “[Abuse of Anabolic Steroids](#),” prohibit physician participation in blood doping or prescribing anabolic steroids. H-470.994, “[Non-Therapeutic Use of Pharmacological Agents by Athletes](#),” opposes the use of interventions to enhance athletic performance but is silent with respect to physicians’ specific responsibilities.

Principle VIII of the AMA *Principles of Medical Ethics* states that “A physician shall, while caring for a patient, regard responsibility to the patient as paramount.” Opinion 1.2.5, “Sports Medicine,” in the AMA *Code of Medical Ethics* limits its focus to physicians present during athletic events. It directs those who “serve in a medical capacity at athletic, sporting, or other physically demanding events should protect the health and safety of participants.” This is particularly relevant to minors who wish to participate in sports in line with their gender identity, since CEJA Report 3-I-18 “Pediatric Decision-making” specifies that the best interests of a minor should be “understood broadly” and treatment decisions should be made in light of “likely impact on the child’s psychosocial wellbeing” [19]. Opinion 5.5, “Medically Ineffective Interventions,” which specifically addresses the use of life-sustaining interventions in contexts of terminal illness, provides that physicians “should only recommend and provide interventions that are medically appropriate.” It also notes that patients should not receive specific interventions simply because they request them.

Further, Opinion 8.5, “Disparities in Health Care,” states that “differences in treatment that are not directly related to individual patients’ clinical needs or preferences constitute inappropriate variations in health care.” This can be construed as ruling out unnecessary testing or alteration of treatment related to gender identity when these are required by third parties for participation in sports. In Opinion 1.1.2, “Prospective Patients,” physicians are required to refrain from discrimination on the basis of gender and gender identity, which in accordance with principles of justice, should extend to declining to participate in (and so refusing to legitimize) discriminatory practices that violate patients’ human rights.

In a press release in April 2019, the World Medical Association demanded that the IAAF “immediately withdraw” its new eligibility regulations for classifying female athletes and urged physicians to “take no part” in implementing them. In October 2021 WMA updated “Declaration on Principles of Health Care in Sports Medicine” to oppose World Athletics eligibility regulations and condemn “medical treatment solely to alter athletic performance,” as “unethical.”

These provide strong arguments that, as professionals committed to promoting first and foremost the well-being of their patients, it is not appropriate for physicians to provide medical interventions required to fulfill the World Athletics regulations mandating specific testosterone levels for either athletes with DSDs or transgender athletes. These arguments also suggest it is inappropriate for a physician to cooperate with any public school or recreational team that requires medical testing and/or physician confirmation that an athlete is a particular gender in order for them to participate.

RECOMMENDATION

In view of these considerations, your AMA recommends that the following recommendations be adopted in lieu of Resolution 19-A-19 and the remainder of this report be filed:

1. That our American Medical Association (AMA) oppose mandatory testing, medical treatment or surgery for transgender athletes and athletes with Differences of Sex Development (DSD), and affirm that these athletes be permitted to compete in alignment with their identity.
2. That our AMA oppose the use of specific hormonal guidelines to determine gender classification for athletic competitions.
3. That our AMA oppose satisfying third-party requirements to certify or confirm an athlete’s gender through physician participation.

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2. FURTHER ACTION TO RESPOND TO THE GUN VIOLENCE PUBLIC HEALTH CRISIS (RESOLUTION 246-A-22)

Reference committee hearing: see report of Reference Committee F.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 246-A-22
REMAINDER OF REPORT FILED
See Policy TBD**

At the 2022 Annual Meeting, the House of Delegates (HOD) referred Resolution 246, "Further Action to Respond to the Gun Violence Public Health Crisis," to the Board of Trustees (Board) for a report back to the HOD at 2022 Interim Meeting. Resolution 246, introduced by the Medical Student Section, asked that our American Medical Association (AMA) convene a task force for the purposes of: "working with advocacy groups and other relevant stakeholders to advocate for federal, state, and local efforts to end the gun violence public health crisis; identifying and supporting evidence-based community interventions to prevent gun injury, trauma, and death; monitoring federal, state, and local legislation, regulation, and litigation relating to gun violence; and reporting annually to the HOD on the AMA's efforts to reduce gun violence." The reference committee heard mixed testimony on whether a task force was necessary to develop actionable recommendations for our AMA to be a leader in responding to the firearm violence crisis; similar

testimony was offered during the HOD floor debate. This report therefore addresses recent AMA activities on preventing firearm violence and makes a recommendation about creating a task force.

BACKGROUND

The AMA declared firearm violence a public health crisis at the 2016 Annual Meeting, which convened in the aftermath of the mass shooting at the Pulse nightclub in Orlando where 49 people were killed. Immediately before the 2022 Annual Meeting, two mass shootings occurred within 10 days at an elementary school in Uvalde, Texas and a grocery store in Buffalo, New York. In the AMA's press statement after the Uvalde shooting, then AMA President Gerald Harmon, MD, stated, "The shooting yesterday at an elementary school is horrific and sadly—and unacceptably—all too familiar in the United States. A week after Buffalo, 10 years after Sandy Hook, 23 years after Columbine; the places and cities change, but the story is the same—too-easy access to firearms, inaction on wildly popular, common-sense safety measures like background checks, and countless lives lost or changed forever." Dr. Harmon further stated, "More and more it is clear no place is safe—malls, schools, movie theaters, places of worship, and grocery stores have all been targeted.... We call on lawmakers, leaders, and advocates to say enough is enough. No more Americans should die of firearm violence. No more people should lose loved ones."

In remarks at the 2022 Annual Meeting, Dr. Harmon declared that "Gun violence is a plague on our nation. It is a public health crisis, and much of it is preventable." Also at the Annual Meeting, then AMA Board Chair Bobby Mukkamala, MD, addressed the HOD to reaffirm that the Board is fully committed to continuing to work on preventing firearm violence as a top AMA advocacy priority. With over 45,000 firearm-related deaths in 2020 and a continuing string of mass shootings, the Board recognizes this public health crisis needs heightened efforts and new strategies. According to the Gun Violence Archive—an independent, non-profit data collection and research group that provides free online public access to accurate information about gun-related violence in the U.S.—there have been 393 mass shootings in 2022 (as of August 4, 2022) and a total of 26,300 deaths from firearm violence from all causes. Recent data from the Centers for Disease Control and Prevention (CDC) indicate that firearm deaths are increasing, and disparities are widening, with young people, males, and Black people experiencing the highest firearm homicide rates. These statistics are clearly unacceptable, especially since firearm injuries and deaths are preventable.

RECENT AMA ADVOCACY ACTIVITIES

During the 117th Congress, our AMA has advocated for evidence-based, commonsense legislative proposals to address firearm violence. The AMA expressed support for H.R. 8, the "Bipartisan Background Checks Act of 2021," (Thompson, D-CA/Upton, R-MI), which would expand the existing background check system to cover all firearm sales, including those at gun shows, over the internet and through classified ads, while providing reasonable exceptions for law enforcement and family and friend transfers. This bill was passed by the U.S. House of Representatives on March 11, 2021, but has not been considered by the U.S. Senate. The AMA also supported H.R. 7910, the "Protecting Our Kids Act," (Nadler, D-NY), an omnibus package of eight previously introduced bills focused on preventing firearm violence. This bill was passed by the House of Representatives on June 22, 2022, but also was not considered by the Senate.

However, Congress succeeded in passing the first major firearm legislation in over 30 years with S. 2938, the "Bipartisan Safer Communities Act" (Murphy, D-CT/Cornyn, R-TX), which the AMA supported. President Biden signed this bill into law on June 25, 2022, and AMA Board Chair Sandra Fryhofer, MD, attended the signing ceremony. Key provisions of the bill include:

- Providing grants for states to establish or strengthen extreme risk protection orders;
- Adding convicted domestic violence abusers in dating relationships to the National Instant Criminal Background Check System (NICS);
- Requiring the NICS to contact authorities to see whether an individual under the age of 21 has a "disqualifying" juvenile record for buying a firearm;
- Making it a federal crime to buy a firearm on behalf of an individual who is prohibited from doing so; and
- Including new spending for school security and mental health treatment.

In the AMA's statement following the Act's enactment into law, AMA President Jack Resneck, Jr., MD, noted that this law will save lives, and stated "The measures in this law—funding for red flag programs, closing the so-called 'boyfriend loophole,' and expanding background checks on people between the ages of 18 and 21 seeking to buy a

gun—will keep weapons out of the hands of people wishing to do harm. This law isn't a panacea, and more work remains to prevent firearm violence, but it is an important, critical step in the right direction.” Our AMA is now focused on advocating to ensure that the new funding authorized in the new law is actually appropriated, advocating for states to establish or strengthen extreme risk protection orders, and ensuring that the other provisions are properly and quickly implemented.

The AMA is also working to ensure that Congress appropriates increased funding for research to prevent firearm violence. The AMA is working with medical specialty societies, including the American Academy of Pediatrics (AAP), to support \$60 million in funding for the CDC and the National Institutes of Health (NIH) to conduct public health research on firearm morbidity and mortality prevention. This would double the amount of funding provided last year. Our efforts have been successful so far: the House 2023 Labor-HHS Appropriations bill that passed out of the Appropriations Committee on June 30 includes the \$60 million for the NIH and CDC firearm injury and prevention programs funding. The Senate Appropriations Committee released the Chairman's mark of all 2023 appropriations bills on July 28; the summary document listed the same \$60 million for firearm injury and mortality prevention research at NIH and CDC. Our AMA will continue to monitor appropriations developments and advocate to ensure that this funding is approved by Congress.

In addition, our AMA is advocating our policy through the courts. Most recently, the U.S. Supreme Court in *New York State Rifle & Pistol Association Inc., et al. v. Bruen* struck down a New York law limiting the concealed carrying of firearms in public to those who demonstrated proper cause for needing to do so—such as documented threats of physical violence against them in a 6-3 ruling. The Litigation Center of the American Medical Association and State Medical Societies, the Medical Society of the State of New York, American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry had filed an amicus brief urging the Supreme Court to uphold a lower-court decision and arguing that the law's requirements do not violate the Second Amendment. The amicus brief from the AMA and others argued that New York has the right to “enforce its reasonable licensing requirements for individuals who wish to carry concealed handguns in public spaces, including our streets, highways, stores, shopping malls, movie theaters, Little League games, hospitals, subway cars, concert halls, football stadiums, outdoor festivals, bars, restaurants, basketball courts, parks, political rallies, houses of worship, and other crowded venues filled with children and adults alike.” The brief also noted that more than 8,800 New Yorkers died of firearm-related injuries between 2010 and 2019, and that firearm violence “is a grave public health crisis that must be addressed by measures such as New York's concealed carry law.” The AMA noted its deep disappointment with the Court's “harmful and disturbing decision” to rule against the law, which it described as an “appropriate and constitutional response to the scourge of firearm violence” in New York communities.

In addition, our AMA will work to implement the new policies approved by the HOD at the recent 2022 Annual Meeting. With the rising availability of homemade “ghost guns,” the AMA called on state legislatures and Congress to subject these weapons to the same regulations and licensing requirements as traditional firearms (Policy H-145.967, “Regulation of Homemade Firearms”). New policy was also adopted that our AMA support legislation requiring that packaging for any firearm ammunition produced in, sold in, or exported from the United States carry a boxed warning. At a minimum, the warning should be text-based statistics and/or graphic warning labels related to the risks, harms, and mortality associated with firearm ownership and use. It also should include an explicit recommendation that ammunition be stored securely and separately from firearms (Policy H-145.968, “Support for Warning Labels on Firearm Ammunition Packaging”).

Another policy adopted is focused on ensuring that active-shooter and live-crisis drills consider the mental health of children (Policy D-145.993, “Addressing Adverse Effects of Active-Shooter and Live-Crisis Drills on Children's Health”). With school shootings continuing at a troubling pace and few regulations in place to address the country's firearm crisis, some schools prepare faculty and children to respond. While well-intentioned, there are concerns that the style of drill may have unintended harmful effects on children's mental health. To address these concerns, the policy adopted encourages active-shooter and live-crisis drills to be conducted in an evidence-based and trauma-informed way that takes children's physical and mental wellness into account, considers prior experiences that might affect children's response to a simulation, avoids creating additional traumatic experiences for children, and provides support for students who may be adversely affected. Our AMA will work with relevant stakeholders to raise awareness of ways to conduct active-shooter or live-crisis drills that are safe for children and developmentally appropriate. The AMA will also advocate for research into the impact of live-crisis exercises and drills on the physical and mental health and well-being of children, including the goals, efficacy, and potential unintended consequences of crisis-preparedness activities involving children.

COLLABORATIONS

Our AMA is a partner organization of AFFIRM at The Aspen Institute, which is a non-profit dedicated to ending the American firearm injury epidemic using a health-based approach. AFFIRM combines health expertise with the knowledge and traditions of responsible firearm stewardship to achieve consensus recommendations. AFFIRM is committed to reducing the rate of firearm injuries and deaths. AFFIRM also builds partnerships with non-medical organizations that are equally committed to preventing firearm injury, including groups committed to firearm safety and shooting sports.

The AMA has joined the American College of Physicians (ACP), American Academy of Family Physicians, AAP, American College of Surgeons (ACS), American Psychiatric Association (APA), and American Public Health Association in calling for policies to help stem firearm-related injuries and deaths in the United States. The organizations endorsed the article, *Firearm-Related Injury and Death in the United States: [A Call to Action From the Nation's Leading Physician and Public Health Professional Organizations](#)*, published online in *Annals of Internal Medicine* on August 7, 2019.

Our AMA is actively participating in monthly meetings convened by the AAP on advocacy related to doubling last year's appropriations funding for research on preventing firearm violence. The AMA also participated in a 2019 meeting on firearm violence organized by ACS and will be actively participating in a follow-up Medical Summit on Firearm Injury Prevention being sponsored by ACS in collaboration with the ACP, the American College of Emergency Physicians, and the Council of Medical Specialty Societies. The objectives of the 2022 summit are to use a consensus-based, non-partisan approach to selecting recommendations for executive action and/or legislation at the federal, state, and municipal levels that would decrease firearm-related injuries and identify elements of the most effective programs that can be implemented by physician practices/clinics/hospitals/health systems in partnership with their communities to effectively lower the risk of violence, with an emphasis on marginalized communities that are disproportionately impacted by violence.

The AMA is also scheduling meetings with representatives of law enforcement and education organizations to see where consensus might be reached on possible solutions to reducing firearm violence and preventing firearm injuries and deaths. Our AMA is also planning federation calls to follow-up on the Medical Summit on Firearm Injury Prevention and plans to convene an informal advisory group of physicians to brainstorm additional ideas on how to prevent and reduce injuries and deaths from firearm violence.

EDUCATION

In 2017, the AMA and the American Bar Association held a joint conference in Chicago, "Preventing Gun Violence: Moving from Crisis to Action." This conference led the Council on Science and Public Health to initiate a report on "The Physician's Role in Firearm Safety," which was adopted by the House of Delegates at the 2018 Annual Meeting. At that meeting, the Council also co-sponsored an educational session with the AMA's Advocacy Resource Center focused on "Preventing Gun Violence: What Physicians Can do Now." The session focused on describing the trends in morbidity and mortality associated with firearm violence in the U.S., identifying evidenced-based strategies available to reduce firearm morbidity and mortality, and defining the physician's unique role in promoting firearm safety and preventing firearm violence. Featured speakers included Marian "Emmy" Betz, MD, MPH, MPH, University of Colorado School of Medicine; Garen Wintemute, MD, MPH, University of California-Davis School of Medicine; and Megan Ranney, MD, MPH, Warren Alpert Medical School, Brown University. Dr. Betz, Dr. Wintemute and Dr. Ranney then collaborated with the AMA to develop an enduring CME module, "The Physician's Role in Promoting Firearm Safety," which was published on the AMA Ed Hub in December of 2018.

The AMA also recognizes the need for state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including when and how to ask sensitive questions about firearm ownership, access and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties. To inform this work the AMA conducted research to: (1) understand physician's barriers and emotions related to firearm safety discussion with patients; (2) co-create with physicians and partners on relevant tools or methods to help improve firearm safety; and (3) recommend a path forward for the AMA to aid physicians in having firearm safety conversations. Six interviews were conducted with subject matter experts working in the field of firearm safety and violence prevention and four two-hour co-creation groups were held exploring current barriers to firearm safety

conversations, physicians' emotions, and functional and emotional design needs. The four co-creation groups were convened by specialty (pediatrics, primary care (adult), psychiatry, and emergency physicians). Each group included four physicians.

The findings of this research have informed the development of a resource to help physicians effectively screen and counsel patients at risk of firearm related injury and mortality. The resource is an online tool containing guidance on when and how to ask sensitive questions about firearm ownership, access, and use, as well as state-specific legal information about discrete legal topics related to firearms, such as laws governing physician speech about firearms, physicians' obligations to disclose confidential patient information, safe storage and child access prevention laws, and laws governing the possession and transfer of firearms. The tool is expected to be launched by the end of 2022.

EXISTING AMA POLICY

In addition to the newly adopted policies noted above, the AMA has developed and adopted over [30 policy recommendations](#) over the past two decades to reduce firearm trauma, injury, and death. These include:

- [A waiting period for firearm availability, and Background checks for all firearm purchasers](#), Policy H-145.996
- [Firearm safety and research and enhancing access to mental health care](#), Policy H-145.975
- [Gun safety education and regulation of interstate traffic of guns](#), Policy H-145.997
- [Distribution of firearm safety materials in the clinical setting](#), Policy D-145.996
- [Limit and control the possession and storage of weapons on school property](#), Policy H-145.983
- [Firearm safety counseling with patients](#), Policy H-145.976
- [Trigger locks and gun cabinets to improve firearm safety](#), Policy H-145.978
- [Data on firearm deaths and injuries](#), Policy H-145.984
- [Prevention of unintentional shooting deaths among children](#), Policy H-145.979
- [Ban on handguns and automatic repeating weapons](#), Policy H-145.985
- [Prevention of firearm accidents in children](#), Policy H-145.990
- [Waiting period before gun purchase](#), Policy H-145.992
- [Restriction of assault weapons](#), Policy H-145.993
- [Mandated penalties for crimes committed with firearms](#), Policy H-145.999
- [Public health policy approach for preventing violence in America](#), Policy H-515.971

DISCUSSION

The Board believes that the above policies and additional policies that have been adopted by the HOD provide abundant opportunity to advocate at the federal, state, and local levels and with other stakeholders for evidence-based policy solutions to respond to the current public health crisis of firearm violence. The challenge in achieving legislative success, especially at the federal level, is not the lack of sufficient or adequate AMA policy but rather the political realities in the current Congress, especially advancing specific legislation through the U.S. Senate. Congress regards the passage and enactment of the Bipartisan Safer Communities Act as the high bar on what firearm related laws can be achieved at the federal level in the current political environment. Therefore, while seeking opportunities at the federal level to further advance comprehensive legislation, including expanding background checks to all firearm purchasers or restricting assault weapons and large capacity magazines, the AMA will continue to advocate for timely implementation and adequate funding of the recently enacted Bipartisan Safer Communities Act, with a particular focus at the state level in expanding Extreme Risk Protection Order (ERPO) laws.

The Board acknowledges the impassioned testimony expressed during reference committee and on the floor of the HOD about the need to create an AMA task force to develop actionable recommendations for the AMA to be a leader in responding to the gun violence crisis. As summarized in this report, however, our AMA is already engaged in the advocacy, litigation, and coalition activities similarly called for in Resolution 246 and in accord with existing AMA policy. The Board concludes, therefore, that a task force, as called for in Resolution 246, is not necessary for the AMA to remain a leader and strong advocate for state and federal legislation and regulations to reduce firearm violence. Furthermore, the Board remains committed to seeking new solutions (through advocacy, litigation, education, and coalition activities) to reduce firearm violence, and can accomplish this in a more responsive and nimble manner than through a new task force. Accordingly, the Board recommends that Resolution 246 not be adopted. However, in order to keep the Federation of Medicine and the HOD up-to-date on developments in this space, the AMA will make readily

available on the AMA website the comprehensive summary of AMA policies, activities, and progress regarding the public health crisis of firearm violence.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 246 and that the remainder of the report be filed:

1. Our AMA will make readily accessible on the AMA website the comprehensive summary of AMA policies, plans, current activities, and progress regarding the public health crisis of firearm violence.
2. Our AMA will establish a task force to focus on gun violence prevention including gun-involved suicide.
3. Our AMA will support and consider providing grants to evidence-based firearm violence interruption programs in communities, schools, hospitals, and clinics.
4. Our AMA will collaborate with interested state and specialty societies to increase engagement in litigation related to firearm safety.
5. Our AMA will report annually to the House of Delegates on our AMA's efforts relating to legislation, regulation, and litigation at the federal, state, and local levels to prevent gun violence.

3. DELEGATE APPORTIONMENT AND PENDING MEMBERS

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

HOUSE ACTION: REFERRED

At June's Annual Meeting, Board of Trustees Report 20 was considered, with the following recommendations referred for report at this meeting (to avoid confusion with the original recommendations, letters are used here to designate the recommendations):

- A. That delegate apportionment for 2023 for constituent societies be based on official 2022 year-end AMA membership data as recorded by the AMA.
- B. That delegate apportionment for 2024 be based on then current bylaws.
- C. That the Council on Constitution and Bylaws prepare bylaws amendments to implement these recommendations, with the report to be considered no later than the November 2022 meeting of the House of Delegates.
- D. That Policy G-600.016, "Data Used to Apportion Delegates," be rescinded.

The following recommendation from the same report was referred for decision.

- E. That pending members no longer be considered in apportioning delegates in the House of Delegates.

The recommendations labelled A-D above hinged on Recommendation E, which would have ceased counting pending members for apportionment purposes. By and large Recommendations A-D could be considered to have been subordinate to or contingent on Recommendation E.

PENDING MEMBERS DEFINED

Essential to dealing with the matter of pending members is the definition. Board Report 1-I-18 defined pending members as individuals who are not current members at the time they pay their dues for the following calendar year. Two elements are required: the person is not a current member at the time of dues payment and the person joins for the following calendar year. The report had been prepared in response to a proposal to count these pending members for delegate apportionment. To prevent gaming the system, by for example joining only every other year, the House determined that a pending member would be counted for apportionment purposes the following year if and only if they had again paid their dues early (i.e., before year end).

FOLLOW ON ACTION

As noted, Recommendation E (originally the first of six recommendations in the Board's report) was referred for decision. Acting in September, the Board adopted this recommendation, meaning pending members will not be counted for apportionment purposes. As a practical matter, once someone becomes a pending member, the individual must be tracked across time in perpetuity solely for apportionment. Say an individual becomes a pending member in Year 0, meaning they will be an actual member in Year 1. To be counted for apportionment purposes in Year 2, the pending member must have paid their dues for Year 2 in Year 1. That will be true for successive years without end (pay for Year 3 in Year 2, for Year 4 in Year 3, and so on). Note that a current member (who has never been counted as a pending member) who always pays dues "early" is not a pending member.

If that pending member's dues payment is delayed to January 1 (or later) of Year 2, they will not have been counted in apportioning Year 2 delegates but will be counted at the end of Year 2 for Year 3 as a regular member, NOT as a pending member. At that point, the individual is a regular member unless their membership lapses and they cycle back into the pending member category. In other words, the timing of one's dues payment and one's membership status at the time of that payment affect how and whether one is counted for apportionment purposes. These elements cannot be captured by AMA's membership accounting system across a potential 40- or 50-year career in medicine. To track the information would require an estimated quarter million dollar change to the membership accounting system.

Your Board acknowledges the arguments for counting pending members but believes counting them not only unnecessarily complicates the apportionment process but that it devalues other benefits of membership and active members themselves:

- The notion that pending members gain representation only by being counted for apportionment purposes belies the fact that delegates represent the needs of not only members but patients, their sponsoring societies, and the profession, including nonmembers.
- Suggestions that being counted toward representation in the House of Delegates is attractive are speculative at best. Physicians consistently report valuing the advocacy that emerges from House of Delegates policy, not the House of Delegates per se.
- Pending members are in fact NOT members. Individuals who join late in the year wishing to be counted—a premise that is largely unsupported—could easily join for the current year by paying half-year dues.
- Some have argued that not counting pending members is tantamount to treating them as second-class members. As just noted, they are not members, at least not initially, but decisions about apportionment need not be linked to more concrete member benefits, which are a separate business decision that can and should be addressed as a membership matter.
- Finally, no evidence has emerged to suggest that the offer to count pending members for apportionment purposes has led to membership gains. Virtually all the pending members in the initial implementation had joined prior to the implementation of the experiment. Few states gained delegates, meaning few have benefitted if at all.

While the makeup of the House is the province of the House, your Board believes that the longstanding policy of counting actual members for apportionment has served our members well. Counting pending members can be considered to diminish or discount actual members' value as much as it can be seen to enhance representation.

POLICY ADOPTED AT A-22

The following policy was adopted at June's Annual Meeting and is the subject of Report 1 from the Council on Constitution and Bylaws at this meeting. The policy was adopted in lieu of a proposal to extend the delegate freeze into 2023. If implemented—bylaws amendments are required—in 2023 constituent societies will be apportioned delegates using the following formula, whereby each society will get the greatest of the three calculated numbers:

- The number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members;
- The number of delegates apportioned for 2022 so long as that figure is not greater than 2 more than the number apportioned at the rate of 1 per 1000, or fraction thereof, AMA members; or
- For societies that would lose more than five delegates from their 2022 apportionment, the number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members plus 5.

Although implementation depends on action to be taken at this Interim Meeting, your Board would emphasize that this plan, which originated with the Board's report, was based on counting actual members and was intended not to continue counting pending members. In addition, the Board's action on the item referred for decision means pending members will not be counted for apportionment purposes.

REFERRED ITEMS

Turning to the four referred items, each will be dealt with in turn. Recommendation A (as labelled herein) called for constituent society apportionment in 2023 to be based on "official 2022 year-end membership data" and simply flowed from the recommendation that preceded it to not count pending members. That latter recommendation, labelled "E" in this report, has been adopted by Board action. Existing bylaws or possible amendments at this meeting will suffice. No action is therefore required on the referred recommendation.

Recommendation B calling for delegate apportionment in 2024 to be based on then current bylaws is unnecessary. Current bylaws are by definition controlling. Moreover, the language does not affect the ability of the House to amend bylaws, so again, no action is required.

The recommendation in Board of Trustees Report 20-A-22 calling for the Council on Constitution and Bylaws to prepare a report essentially flagged the Council that bylaws amendments might be necessary. It is more a style for AMA reports than a necessity, as the Council has the authority to generate and offer reports on its own. The recommendation requires no action.

The fourth referred recommendation, labelled D, was simply a housekeeping matter, meant to cull an unneeded policy from the compendium, which contains 3955 separate policy statements. Policy G-600.016, "Data Used to Apportion Delegates," reads as follows:

1. Our AMA shall issue an annual, mid-year report on or around June 30 to inform each state medical society and each national medical specialty society that is in the process of its 5-year review of its current AMA membership count.
2. "Pending members" (defined as individuals who at the time they apply for membership are not current in their dues and who pay dues for the following calendar year) will be added to the number of active AMA members in the December 31 count for the purposes of AMA delegate allocations to state medical societies for the following year and this total will be used to determine the number of national medical specialty delegates to maintain parity.
3. Our AMA will track "pending members" from a given year who are counted towards delegate allocation for the following year and these members will not be counted again for delegate allocation unless they renew their membership before the end of the following year.
4. Our AMA Board of Trustees will issue a report to the House of Delegates at the 2022 Annual Meeting on the impact of Policy G-600.016 and recommendations regarding continuation of this policy.

Paragraphs two and three of the policy are not relevant if pending members are no longer counted. Paragraph four was fulfilled by Board of Trustees Report 20-A-22, even though all but one of the recommendations it contained were referred. While a case might be made for retaining paragraph one, our AMA's Federation Relations and Membership units are in regular communication with societies in the House, and any society can easily request its current data at any time. For specialty societies not undergoing their five-year review, the report has no value, and little need for a mandated report is apparent. Consequently, the policy is recommended for rescission.

RECOMMENDATION

Your Board is cognizant of the fact that some members of the House believe that counting pending members is beneficial to membership and acknowledges the right of the House to determine its makeup. Nevertheless, your Board has concluded that counting pending members for apportionment lacks merit for the reasons outlined above. Also worth noting is that the House will act on Council on Constitution and Bylaws Report 1, which will determine the path taken and may also affect action on this report.

Your Board of Trustees recommends that Policy G-600.016 be rescinded and the remainder of the report filed.

4. PRESERVING ACCESS TO REPRODUCTIVE HEALTH SERVICES

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

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED**

See Policies H-5.990, H-5.993, and D-5.999

INTRODUCTION

At the 2022 American Medical Association (AMA) Annual Meeting (2022 Annual Meeting), our AMA House of Delegates adopted Policy D-5.999, “Preserving Access to Reproductive Health Services,” which states:

That our AMA:

1. Recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right;
2. Opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion;
3. Will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion;
4. Supports shared decision-making between patients and their physicians regarding reproductive healthcare;
5. Opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients;
6. Opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services;
7. Will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services;
8. Will review the AMA policy compendium and recommend policies which should be amended or rescinded to reflect these core values, with report back at I-22.

This Board report, therefore, addresses paragraph 8 of the policy, reviews AMA policy related to reproductive health, discusses policies for amendment or rescission, and provides recommendations.

AMA POLICY

Our AMA has many policies addressing access to abortion and other reproductive health care services. These policies, including those adopted or amended during the 2022 Annual Meeting, are as follows:

Policy D-5.999, “Preserving Access to Reproductive Health Services”

Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will review the

AMA policy compendium and recommend policies which should be amended or rescinded to reflect these core values, with report back at I-22. (Res. 028, A-22)

Policy H-5.995, “Abortion”

Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of this state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice. (Sub. Res. 43, A-73; Reaffirmed: I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: CMS Rep. 1, I-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed: CEJA Rep. 01, A-20)

Policy H-5.993, “Right to Privacy in Termination of Pregnancy”

The AMA reaffirms existing policy that (1) abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances good medical practice requires only that the physician or other professional withdraw from the case so long as the withdrawal is consistent with good medical practice. The AMA further supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities. (Res. 49, I-89; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: CCB/CLRPD Rep. 2, A-14)

Policy H-5.983, “Pregnancy Termination”

The AMA adopted the position that pregnancy termination be performed only by appropriately trained physicians (MD or DO). (Res. 520, A-95; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)

Policy H-5.990, “Policy on Abortion”

The issue of support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures. (Res. 158, A-90; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Res. 1, A-09; Reaffirmed: CEJA Rep. 03, A-19)

Policy H-5.988, “Accurate Reporting on AMA Abortion Policy”

Our AMA HOD cautions members of the Board of Trustees, Councils, employees and members of the House of Delegates to precisely state current AMA policy on abortion and related issues in an effort to minimize public misperception of AMA policy and urges that our AMA continue efforts to refute misstatements and misquotes by the media with reference to AMA abortion policy. (Sub. Res. 21, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11; Reaffirmed: CEJA Rep. 1, A-21)

Policy H-5.989, “Freedom of Communication Between Physicians and Patients”

It is the policy of the AMA: (1) to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient;

(2) working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship;

(3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications; and

(4) to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients. (Sub. Res. 213, A-91; Reaffirmed: Sub. Res. 232, I-91; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res. 203 and 707, A-98; Reaffirmed: Res. 703, A-00; Reaffirmed in lieu of Res. 823, I-07; Reaffirmation I-09; Reaffirmation: I-12; Reaffirmed in lieu of Res. 5, I-13)

Policy H-100.948, “Supporting Access to Mifepristone (Mifeprex)”

Our AMA will support mifepristone availability for reproductive health indications, including via telemedicine, telehealth, and at retail pharmacies and continue efforts urging the Food and Drug Administration to lift the Risk Evaluation and Mitigation Strategy on mifepristone. (Res. 504, A-18; Modified: Res. 27, A-22)

Policy H-140.835, “Political Interference in the Patient-Physician Relationship”

Our AMA opposes any policies that interfere with the patient-physician relationship by giving probate, inheritance, a social security number, or other legal rights to an undelivered pregnancy, or imposing legislative barriers to medical decision-making by changes in tax codes or in definitions of beneficiaries. (Alt. Res. 7, I-17)

Policy H-5.998, “Public Funding of Abortion Services”

The AMA reaffirms its opposition to legislative proposals that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population. (Sub. Res. 89, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: BOT Rep. 12, A-05; Reaffirmed: CMS Rep. 1, A-15)

Policy H-425.969, “Support for Access to Preventive and Reproductive Health Services”

Our AMA supports access to preventive and reproductive health services for all patients and opposes legislative and regulatory actions that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population. (Sub. Res. 224, I-15 Reaffirmation: I-17)

Policy H-185.937, “Reproductive Parity”

Our AMA supports legislation and policies that require any health insurance products offering maternity services to include all choices in the management of reproductive medical care. (Res. 4, I-13)

Policy H-295.923, “Medical Training and Termination of Pregnancy”

1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.
2. Our AMA supports the availability of abortion education and exposure to procedures for termination of pregnancy, including medication abortions, for medical students and resident/fellow physicians and opposes efforts to interfere with or restrict the availability of this education and training.
3. Our AMA encourages the Accreditation Council for Graduate Medical Education to consistently enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists’ recommendations. (Res. 315, I-94; Reaffirmed: CME Rep. 2, A-04; Modified: CME Rep. 2, A-14; Modified: CME Rep. 1, A-15; Appended: Res. 957, I-17; Modified: Res. 309, I-21)

Policy H-5.980, “Oppose the Criminalization of Self-Induced Abortion”

Our AMA: (1) opposes the criminalization of self-managed abortion and the criminalization of patients who access abortions as it increases patients’ medical risks and deters patients from seeking medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-managed abortion and the criminalization of patients who access abortions; and (3) will oppose efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients and requirements that physicians function as agents of law enforcement—gathering evidence for prosecution rather than as a provider of treatment. (Res. 7, A-18; Modified: Res. 27, A-22)

Policy H-420.954, “Truth and Transparency in Pregnancy Counseling Centers”

- (1) It is AMA’s position that any entity that represents itself as offering health-related services should uphold the standards of truthfulness, transparency, and confidentiality that govern health care professionals.
- (2) Our AMA urges the development of effective oversight for entities offering pregnancy related health services and counseling.
- (3) Our AMA advocates that any entity offering crisis pregnancy services
 - a. truthfully describes the services they offer or for which they refer—including prenatal care, family planning, termination, or adoption services—in communications on site and in their advertising, and before any services are provided to an individual patient; and
 - b. be transparent with respect to their funding and sponsorship relationships.

- (4) Our AMA advocates that any entity licensed to provide medical or health services to pregnant women
- a. ensure that care is provided by appropriately qualified, licensed personnel; and
 - b. abides by federal health information privacy laws.
- (5) Our AMA urges that public funding only support programs that provide complete, non-directive, medically accurate, health information to support patients informed, voluntary decisions. (Res. 7, I-11; Reaffirmed: CEJA Rep. 1, A-21; Modified: BOT Rep. 14, A-22)

Policy H-5.982, “Late-Term Pregnancy Termination Techniques”

(1) The term 'partial birth abortion' is not a medical term. The AMA will use the term “intact dilatation and extraction” (or intact D&X) to refer to a specific procedure comprised of the following elements: deliberate dilatation of the cervix, usually over a sequence of days; instrumental or manual conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of the fetus to effect vaginal delivery of a dead but otherwise intact fetus. This procedure is distinct from dilatation and evacuation (D&E) procedures more commonly used to induce abortion after the first trimester. Because 'partial birth abortion' is not a medical term it will not be used by the AMA.

(2) According to the scientific literature, there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D&X. The AMA recommends that the procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgment, acting within standards of good medical practice and in the best interest of the patient.

(3) The viability of the fetus and the time when viability is achieved may vary with each pregnancy. In the second trimester when viability may be in question, it is the physician who should determine the viability of a specific fetus, using the latest available diagnostic technology.

(4) In recognition of the constitutional principles regarding the right to an abortion articulated by the Supreme Court in *Roe v. Wade*, and in keeping with the science and values of medicine, the AMA recommends that abortions not be performed in the third trimester except in cases of serious fetal anomalies incompatible with life. Although third-trimester abortions can be performed to preserve the life or health of the mother, they are, in fact, generally not necessary for those purposes. Except in extraordinary circumstances, maternal health factors which demand termination of the pregnancy can be accommodated without sacrifice of the fetus, and the near certainty of the independent viability of the fetus argues for ending the pregnancy by appropriate delivery. (BOT Rep. 26, A-97; Modified and Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17)

Policy H-5.997, “Violence Against Medical Facilities and Health Care Practitioners and Their Families”

The AMA supports the right of access to medical care and opposes (1) violence and all acts of intimidation directed against physicians and other health care providers and their families and (2) violence directed against medical facilities, including abortion clinics and family planning centers, as an infringement of the individual's right of access to the services of such centers. (Res. 82, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Res. 422, A-95; Reaffirmation I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19)

DISCUSSION

In its review of the policy compendium, the Board identified some duplicative policies. Policy H-5.993, “Right to Privacy in Termination of Pregnancy” and Policy H-5.995, “Abortion,” each contain nearly identical language affirming: (1) that abortion is a medical procedure that should be performed in conformance with standards of good medical practice and the laws of the state; (2) that no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles; and (3) that a physician or other professional who wishes to withdraw from a case must do so in conformance with good medical practice. Additionally, Policy H-5.983, “Pregnancy Termination,” Policy H-5.993, “Right to Privacy in Termination of Pregnancy,” and Policy H-5.995, “Abortion,” each state that abortions should be performed only by physicians. Accordingly, the AMA Board of Trustees (the Board) recommends that these policies (Policy H-5.993, “Pregnancy Termination,” Policy H-5.995, “Abortion,” and Policy H-5.983, “Pregnancy Termination”) be consolidated into one policy, Policy H-5.993, “Right to Privacy in Termination of Pregnancy,” and that the remaining two policies be rescinded.

The Board also identified some policies that require updating or amendment for clarification purposes. Specifically, Policy H-5.993, “Right to Privacy in Termination of Pregnancy,” states that physicians may withdraw from cases they view as violative of good medical judgment or personally held moral principles so long as withdrawal is consistent

with good medical practice. The Board recommends that this policy also state that withdrawal due to personally held moral principles must be consistent with ethical obligations. *AMA Code of Medical Ethics* Opinion 1.1.7, “Physician Exercise of Conscience,” states, among other things, that “physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer.”

Policy H-5.993, “Right to Privacy in Termination of Pregnancy,” also states that the AMA supports the position that “the early termination of pregnancy is a medical matter between the patient and the physician [...]” The Board notes that inclusion of the word “early” has created some confusion. Since Policy H-5.982, “Late-Term Pregnancy Termination Techniques,” already addresses determinations of fetal viability and indications for abortion late in pregnancy, the Board recommends deletion of the word “early.”

Policy H-5.993, “Right to Privacy in Termination of Pregnancy,” also states that an abortion should only be performed by a physician. This policy was adopted when most abortions were surgical; however, by 2020, an estimated 54% of abortions were induced with prescription medication. The Board recommends this policy be amended to state that abortion is “the practice of medicine and requires the personal performance or supervision by an appropriately licensed physician.” The amendment will enable the AMA to advocate for broad, equitable access to abortion care in accordance with Policy D-5.999, “Preserving Access to Reproductive Health Services,” by building capacity within the physician-led healthcare teams that provide abortion care, while also advocating for continued physician supervision of non-physicians who prescribe medication for abortions.

Policy H-5.993, “Right to Privacy in Termination of Pregnancy,” also states that abortion “is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities.” The Board recommends replacing “availability of appropriate facilities” with “ability to perform the procedure safely.” Because over half of abortions are now induced with prescription medication, they do not necessarily require care in a facility. Conditioning AMA support of abortion care on “availability of appropriate facilities” may be used by some as justification for placing medically unnecessary facility requirements on abortion providers. By amending the policy to emphasize safety generally, the policy is less likely to be misconstrued.

In addition, Policy H-5.990, “Policy on Abortion,” states that support of or opposition to abortion is a matter for members to decide individually. Since newly adopted policy at the 2022 Annual Meeting, Policy D-5.999, “Preserving Access to Reproductive Health Services,” supports access to abortion as an organizational policy matter, the Board recommends that Policy H-5.990, “Policy on Abortion,” be amended to clarify that the AMA believes members’ *personal* views on abortion should be decided individually.

Additionally, Policy H-5.982, “Late-Term Pregnancy Termination Techniques,” states that the determination of the viability of a fetus during the second trimester is to be made by a physician. Newly adopted policy at the 2022 Annual Meeting, Policy D-5.999, “Preserving Access to Reproductive Health Services,” is broader. Specifically, this new policy protects clinical determinations and assessments regardless of the stage of pregnancy. The Board, therefore, recommends that Policy H-5.982, “Late-Term Pregnancy Termination Techniques,” be amended to remove the reference to viability in the second trimester. Policy H-5.982 also includes a recognition of the constitutional principles articulated by the Supreme Court in *Roe v. Wade*. In light of the Supreme Court’s decision in *Dobbs v. Jackson Women’s Health Organization*, the Board recommends that Policy H-5.982 be further amended to reflect this legal activity.

Finally, with the completion of this report, the Board recommends that Policy D-5.999, “Preserving Access to Reproductive Health Services,” be amended to remove the directive to review AMA policy, recommend policies for amendment or rescission and report back at the 2022 Interim Meeting.

In addition to review of policy required by the new policy, the Board notes that Resolution 621-A-22, Establishing a Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted, instructs our AMA to convene a task force to respond to restrictions on and criminalization of abortion and other evidence-based care. Importantly, at the time of the writing of this report (August 2022), the AMA is in the process of developing the task force, with the task force expected to be formed by the time of the AMA 2022 Interim Meeting in November. It is critical to further note that activity—in both AMA Advocacy and AMA Office of General Counsel—to protect the patient-physician relationship is robust and ongoing. The following is a summary of relevant activity as of early August 2022 when this report was drafted.

Since the U.S. Supreme Court decision in *Dobbs v. Jackson Women's Health Organization* which overturned *Roe v. Wade* and *Planned Parenthood v. Casey*, the AMA has been pursuing multiple strategies, at the state level, to address the broad spectrum of issues now facing physicians and patients. Shortly after the decision was issued, the AMA convened state medical associations to understand state-by-state dynamics and the concerns of physicians. The AMA has since held multiple meetings with state medical associations and national medical specialty societies to understand the challenges facing physicians and plan a coordinated strategy to protect access to care. The AMA Advocacy Resource Center is working closely with the Federation to protect patients and physicians from legislative intrusions into and criminalization of the practice of medicine. In many states, it is not clear how broadly abortion restrictions will be interpreted, and confusion remains about how restrictions impact medically necessary pregnancy terminations, prescribing of certain medications for reasons unrelated to pregnancy, and the provision of other types of care. The AMA is working with the Federation and other stakeholders to seek clarification from policymakers, as well as collecting information, producing resources, and conducting legislative analyses to help states navigate this new regulatory scheme.

One way AMA Advocacy staff is collecting much-needed clinical information for states across the country is by engaging expert physician members of the Board, Council on Legislation, and Council on Medical Service. AMA Advocacy staff is also engaging attorneys in the American Society of Medical Association Counsel to identify answers to legal questions raised in states across the country as legislation and regulation is contemplated and introduced. The AMA Center for Health Equity is collaborating with the AMA Advocacy team, as well, working to identify impact on historically marginalized and minoritized communities and strategies related to health equity. Finally, at the 2022 AMA State Advocacy Roundtable, the AMA hosted an interactive discussion among Federation staff about the implications of the *Dobbs* decision and because of that discussion is working to create resources for the Federation. This activity is ongoing.

At the federal level, the AMA immediately called for greater digital privacy for patients out of concern that minimal oversight of data use by digital apps could place women in jeopardy in states seeking to enforce abortion restrictions. The AMA joined the American College of Obstetricians and Gynecologists (ACOG) in calling for the U.S. Food and Drug Administration to remove or modify the Risk Evaluation and Mitigation Strategies (REMS) and Elements to Assure Safe Use (ETASU) requirements for mifepristone. The Biden Administration also reminded hospitals and health care providers of their obligation to comply with the provisions of the Emergency Medical Treatment and Labor Act (EMTALA) that preempt any state laws that restrict access to stabilizing medical treatment, including abortion procedures and other treatments that may result in the termination of a pregnancy, and reminded pharmacies of their obligations related to prescription medications for reproductive health under federal civil rights laws.

Finally, in the courts, the AMA has joined ACOG and the Society for Maternal-Fetal Medicine in amicus briefs around the country seeking to protect access to reproductive care and combat intrusion on the physician-patient relationship. As of early August, amicus briefs have been filed in Georgia, Kentucky, Ohio, South Carolina, Utah, and West Virginia. Additional filings are expected in coming months. These briefs have supported challenges to a range of harmful laws, including bans from the 1800s, trigger laws intended to ban all abortion following the reversal of *Roe v. Wade*, and criminal penalties that potentially include felony charges for physicians. In addition, the AMA has worked to support federal guidance and litigation around access to care in the courts through its amicus efforts. The AMA will continue to work with the Federation and external stakeholders in the courts and at the state and federal levels to protect the physician-patient relationship and access to reproductive care.

RECOMMENDATIONS

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

1. That Policy H-5.993, "Right to Privacy in Termination of Pregnancy" be amended by addition and deletion as follows:
 1. The AMA reaffirms existing policy that (a) abortion is a human right and the practice of medicine ~~a medical procedure~~ and should be performed ~~only by a duly licensed physician~~ in conformance with standards of good medical practice ~~and the laws of the state~~; and (b) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances, ~~good medical practice requires only that the~~ a physician or other professional may withdraw

from the case so long as the withdrawal is consistent with good medical practice and ethical guidance on the exercise of conscience.

2. The AMA further supports the position that ~~the early~~ termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the ability to perform the procedure safely ~~availability of appropriate facilities.~~
2. That Policies H-5.995, "Abortion," and Policy H-5.983, "Pregnancy Termination," be rescinded.
3. That Policy H-5.990, "Policy on Abortion," be amended by addition as follows:

The issue of personal support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures.

4. That Policy D-5.999, "Preserving Access to Reproductive Health Services," be amended by deletion as follows:

Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; ~~and (8) will review the AMA policy compendium and recommend policies which should be amended or rescinded to reflect these core values, with report back at the 2022 Interim Meeting.~~

5. TOWARDS DIVERSITY AND INCLUSION: A GLOBAL NON-DISCRIMINATION POLICY STATEMENT AND BENCHMARK FOR OUR AMA (RESOLUTION 602-N-20)

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

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 602-N-20 REMAINDER OF REPORT FILED

See Policies H-65.965, H-65.988, H-65.950, G-630.040, and TBD

BACKGROUND

At the November 2020 House of Delegates (HOD) meeting, the [House of Delegates referred](#) Resolution 602, "Towards Diversity and Inclusion: A Global Non-discrimination Policy Statement and Benchmark for our AMA." [Resolution 602](#), introduced by the Women Physicians Section asked that our American Medical Association (AMA):

Adopt an overarching non-discrimination policy on the basis of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any other reason unrelated to character, competence, ethics, professional status or professional activities that applies to members, employees and patients.

Demonstrate its commitment to complying with laws, rules or regulations against discrimination on the basis of protected characteristics.

Reaffirm Policy H-65.988, “Organizations Which Discriminate,” and Policy G-630.040, “Principles on Corporate Relationships,” in its overarching non-discrimination policy.
Reaffirm Policy G-600.067, “References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment.”

Study the feasibility and need for a comprehensive business conduct standards policy to be fully integrated with the conflict of interest policy, and report back to the AMA House of Delegates within 18 months.

Provide an update on its comprehensive diversity and inclusion strategy to the AMA House of Delegates within 24 months.

Resolution 602 calls upon our AMA to adopt an overarching non-discrimination policy; reaffirm current AMA policy; study the feasibility and need for a comprehensive business conduct standards policy to be fully integrated with the conflict of interest policy; and provide an update on our AMA’s comprehensive diversity and inclusion strategy.

The reference committee received testimony supportive of the intent of Resolution 602 but noted there were several amendments proffered to broaden inclusiveness, as well as to strengthen the language contained in existing AMA policy. Still others advocated for referral of this item due to the complexity of the requests and the need to develop an integrated response.

The reference committee supported referral of this item to allow our AMA House of Delegates to receive a report back that codifies policies and activities and optimizes the language contained in an overarching non-discrimination policy.

This report: 1) describes our AMA’s commitment to human rights and health equity that would support an overarching non-discrimination policy and 2) summarizes our AMA’s existing non-discrimination policies passed by the House of Delegates.

DISCUSSION

The federal landscape related to discrimination is constantly evolving, so any overarching policy will need to be flexible in its wording and regularly updated.

The HOD’s policy statements on health topics serve as a cornerstone of our AMA, making clear what our AMA stands for as an organization, providing information and guidance to physicians and others about health care issues.

AMA’s commitment to human rights and health equity

Our AMA Policy H-65.965, “Support of Human Rights and Freedom,” provides a clear statement of our AMA’s commitment to supporting and maintaining respect for human rights. It reads as follows:

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual’s sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age; (3) opposes any discrimination based on an individual’s sex, sexual orientation, gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA’s policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

The policy provides a key foundation in fostering equity and inclusion both within the organization and externally.

Additionally, our AMA has [made a commitment](#) to “actively work to dismantle racist and discriminatory policies and practices across all of health care.” Furthermore, “our AMA recognizes that racism in its systemic, structural, institutional, and interpersonal forms as a serious threat to public health, the advancement of health equity, and a

barrier to appropriate medical care” and “supports the development of policy to combat racism and its effects” (Policy H-65.952, “Racism as a Public Health Threat”).

By establishing the AMA Center for Health Equity, our AMA has demonstrated its intention and commitment to [embed health equity into the DNA of the organization](#) and its work. As part of the “Plan for Continued Progress Toward Health Equity” (Policy D-180.981) our AMA has made the pursuit of diversity, equity, and inclusion a key strategy to operationalize health equity. This pursuit includes a commitment to anti-racism/anti-discrimination/anti-harassment policies. Our AMA has continued to expand on our diversity and inclusion strategy as outlined in Board Report 10-A-22 about 2021 progress on the AMA’s Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity.

Existing AMA HOD non-discrimination policies

A policy scan of our AMA’s HOD non-discrimination policies identified 88 non-discrimination policies. This summary only includes policies currently published in our AMA’s PolicyFinder. Policies that were rescinded are not included. The policies are grouped below based on the nature of the protections covered by the policies. The number of policies matched to each grouping is listed below (Please see Appendix A for details):

- Non-discrimination policies – AMA (3)
- Non-discrimination policies – Constitution and Bylaws (3)
- Non-discrimination policies listed under AMA governance (3)
- General non-discrimination policies that protect all individuals (11)
- Non-discrimination policies that apply to specific populations (17)
- Non-discrimination policies that protect physicians and/or their practices (23)
- Non-discrimination policies that protect international medical graduates (IMGs) (4)
- Non-discrimination policies that protect residents (5)
- Non-discrimination policies that protect medical students (4)
- Non-discrimination policies that protect patients (14)
- Non-discrimination related to terrorism (1)

Within HOD policies, H-65.965, “Support of Human Rights and Freedom,” modified in 2022, provides the most comprehensive list of protected groups. Policy G-600.067, “References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment,” mentioned in the original resolution, was rescinded and replaced [via Board Report 5-N-21](#) by Policy H-65.950 stating that our AMA recommends preferred terminology for protected personal characteristics to be used in AMA policies and position statements. Board Report 5-N-21 provides a summary of categories or characteristics cited by AMA policy and a sampling from other organizations.

Policy H-65.951, “Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions,” provides guidelines for effective non-discrimination policy for healthcare, including implementation considerations.

Eight other HOD policies provide a similar list of protections, 17 policies target discrimination of very specific groups (e.g., victims of domestic violence), and seven policies used the word “discrimination” in the title of the policy but not within the body of the policy statement.

Policy H-140.837, “Policy on Conduct at AMA Meetings,” sets forth our AMA’s policy of zero tolerance for any type of harassing conduct by physicians and others attending AMA functions or meetings and defines prohibited behaviors. The policy also provides multiple reporting options available to both the targets of any harassment and witnesses to prohibited conduct, including an option to register complaints confidentially to an external vendor online or via a toll-free hotline.

Multiple HOD policies seek to influence the non-discrimination policies and/or activities of other organizations. In some (but not all) instances, the policies are membership related. Non-discrimination policies related to membership include: G-600.020, “Admission of Specialty Organizations to our AMA House,” and G-600.014, “Guidelines for Admission of Constituent Associations to our AMA House of Delegates.” Policies unrelated to membership include: D-255.995, “Discrimination Against IMGs in Classified Advertising,” and H-295.955, “Teacher-Learner Relationship in Medical Education.”

Policy H-65.988, “Organizations Which Discriminate,” also listed as a relevant AMA policy in Resolution 602, provides the organization with guidance encouraging, but not mandating, that meetings or other gatherings be held in organizational facilities that do not discriminate on the basis of race, religion, or gender and encourages its constituent societies to adopt a similar policy.

RECOMMENDATIONS

Based on a review of internal policies, the Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 602-N-20, and the remainder of this report be filed.

- That our AMA reaffirm its commitment to complying with all applicable laws, rules or regulations against discrimination on the basis of protected characteristics, including Title VII of the Civil Rights Act, The Age Discrimination in Employment Act, and the Americans with Disabilities Act, among other federal, state and local laws.
- That our AMA reaffirm Policy H-65.965, “Support of Human Rights and Freedom,” as an overarching non-discrimination policy for the Association.
- That our AMA reaffirm Policy H-65.988, “Organizations Which Discriminate,” Policy G-630.040, “Principles on Corporate Relationships,” and Policy H-65.950, “Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment.”
- That our AMA provide updates on its comprehensive diversity and inclusion strategy as part of the annual Board report to the AMA House of Delegates on health equity.

APPENDIX - AMA Non-Discrimination Policies

Note: This summary only includes policies currently published in our AMA’s PolicyFinder. Policies that were rescinded are not included.

Non-discrimination policies – AMA (3)

- [Policy on Conduct at AMA Meetings and Events H-140.837](#)
- [Non-discrimination Policy H-65.983](#)
- [Organizations Which Discriminate H-65.988](#)

Non-discrimination policies – Constitution and Bylaws (3)

- [Discrimination. B-1.4](#)
- [Resident and Fellow Section. B-7.1.4 Other Representatives to the Business Meeting](#)
- [Medical Student Section. B-7.3.3.4 National Medical Student Organizations.](#)

Non-discrimination policies listed under governance (3)

- [Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment H-65.950](#)
- [Admission of Specialty Organizations to our AMA House G-600.020](#)
- [Guidelines for Admission of Constituent Associations to our AMA House of Delegates G-600.014](#)

General non-discrimination policies that could potentially apply to/benefit all individuals: (11)

- [Support of Human Rights and Freedom H-65.965](#)
- [Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984](#)
- [Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions H-65.951](#)
- [Code of Medical Ethics 7.3.7 Safeguards in the Use of DNA Databanks](#)
- [Issues in Employee Drug Testing H-95.984](#)
- [Code of Medical Ethics 4.1.3 Third-Party Access to Genetic Information](#)
- [Code of Medical Ethics 11.1.1 Defining Basic Health Care](#)
- [Individual Health Insurance H-165.920](#)
- [Code of Medical Ethics 9.5.3 Accreditation](#)
- [Discriminatory Policies that Create Inequities in Health Care H-65.963](#)
- [Code of Medical Ethics 4.2.6 Cloning for Reproduction](#)

Non-discrimination policies that apply to specific populations (17)

- [Federal Drug Policy in the United States H-95.981](#)
- [Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations H-65.976](#)
- [Insurance Discrimination Against Victims of Domestic Violence H-185.976](#)
- [Racial and Ethnic Disparities in Health Care H-350.974](#)

- [Reducing Inequities and Improving Access to Insurance for Maternal Health Care H-185.917](#)
- [Retirement and Hiring Practices H-25.996](#)
- [Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations D-65.996](#)
- [Health Care Disparities in Same-Sex Partner Households H-65.973](#)
- [Code of Medical Ethics 4.2.1 Assisted Reproductive Technology](#)
- [Code of Medical Ethics 4.2.3 Therapeutic Donor Insemination](#)
- [Removing Financial Barriers to Living Organ Donation H-370.965](#)
- [Organ Transplant Equity for Persons with Disabilities D-370.980](#)
- [Ensuring the Best In-School Care for Children with Diabetes H-60.932](#)
- [Improving Screening and Treatment Guidelines for Intimate Partner Violence \(IPV\) Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals \(LGBTQ\) D-515.980](#)
- [Juvenile Justice System Reform H-60.919](#)
- [Opposition to Discriminatory Treatment of Haitian Asylum Seekers H-350.951](#)
- [Parental Leave H-405.954](#)

Non-discrimination policies that protect physicians and/or their practices (23)

- [Advocacy for Physicians with Disabilities D-90.991](#)
- [Principles for Advancing Gender Equity in Medicine H-65.961](#)
- [Code of Medical Ethics 9.5.5 Gender Discrimination in Medicine](#)
- [Women in Organized Medicine H-525.998](#)
- [Volume Discrimination Against Physicians H-180.963](#)
- [Notification to Patients of Charge Amounts Prior to Service as Per Omnibus Reconciliation Act of 1986 H-390.962](#)
- [Discrimination of Women Physicians in Hospital Locker Facilities H-525.981](#)
- [Discrimination Against Physicians by Health Care Plans H-285.985](#)
- [Amend the Patient Protection and Affordable Care Act \(PPACA\) H-165.833](#)
- [Redefining AMA's Position on ACA and Healthcare Reform D-165.938](#)
- [Averting a Collision Course Between New Federal Law and Existing State Scope of Practice Laws H-35.968](#)
- [Protection of Medical Staff Members' Personal Proprietary Financial Information H-225.955](#)
- [PRO Readmission Review H-340.989](#)
- [Medical Specialty Board Certification Standards H-275.926](#)
- [Intrusion by Hospitals into the Private Practice of Medicine H-240.979](#)
- [Equal Payment for Services H-385.945](#)
- [Hospitals Limited to Participating Physicians H-390.971](#)
- [Code of Medical Ethics 5.7 Physician-Assisted Suicide](#)
- [AMA Principles for Physician Employment H-225.950](#)
- [Limitation of Physicians' Fees H-380.997](#)
- [Patient Protection and Clinical Privileges H-230.989](#)
- [Discrimination Against Physicians in Treatment with Medication for Opioid Use Disorders \(MOUD\) H-95.913](#)
- [Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism H-65.949](#)

Non-discrimination policies that protect IMGs (4)

- [Unfair Discrimination Against International Medical Graduates H-255.978](#)
- [AMA Principles on International Medical Graduates H-255.988](#)
- [Abolish Discrimination in Licensure of IMGs H-255.966](#)
- [Discrimination Against IMGs in Classified Advertising D-255.995](#)

Non-discrimination policies that protect residents (5)

- [Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919](#)
- [Eliminating Religious Discrimination from Residency Programs H-310.923](#)
- [Gender-Based Questioning in Residency Interviews H-310.976](#)
- [Discrimination Against Resident Candidates Based on Graduate Medical Education Medicare Funding H-305.971](#)
- [Non-discrimination Toward Residency Applicants H-295.969](#)

Non-discrimination policies that protect medical students (4)

- [Equal Fees for Osteopathic and Allopathic Medical Students H-295.876](#)
- [Underrepresented Student Access to US Medical Schools H-350.960](#)
- [Teacher-Learner Relationship In Medical Education H-295.955](#)
- [Principles of and Actions to Address Primary Care Workforce H-200.949](#)

Non-discrimination policies that protect patients (14)

- [Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act D-185.981](#)
- [Genetic Discrimination and the Genetic Information Non-discrimination Act H-65.969](#)

- [Consumer Genetic Testing and Privacy D-315.970](#)
- [Discrimination and Criminalization Based on HIV Seropositivity H-20.914](#)
- [Patient Privacy and Confidentiality H-315.983](#)
- [Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act H-185.925](#)
- [Fifty Percent Copayment Requirement for Codes 290-310 Mental Disorders H-345.986](#)
- [Non-discrimination in Health Care Benefits H-185.986](#)
- [Gender Rating and Discrimination Based on Prior Cesarean Section H-180.950](#)
- [Discrimination Against Patients by Medical Students H-295.865](#)
- [Discriminatory Payment Policies D-70.969](#)
- [The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987](#)
- [Code of Medical Ethics 1.1.7 Physician Exercise of Conscience](#)
- [Assistants at Surgery H-385.969](#)

Non-discrimination related to terrorism (1)

- [Non-discrimination in Responding to Terrorism H-65.978](#)

6. INFORMAL INTER-MEMBER MENTORING

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the November 2021 Special Meeting of the House of Delegates (HOD), Policy D-635.980, “Informal Inter-Member Mentoring,” was adopted.

To implement the policy, our AMA has convened a Mentorship Steering Committee consisting of representatives from each of the AMA sections (see appendix). Given the sections’ role as the place for members to become more actively involved in the AMA and their focus on leadership development, the sections are a natural home for this initiative. As the work of the Steering Committee and organization continues, we will continue to be broadly inclusive of the diversity of experiences and needs across our membership.

The Mentorship Steering Committee has been charged with identifying mentorship opportunities and best practices within individual sections and more broadly across the organization. The Committee has discussed the importance of creating informal, organic opportunities for mentors and mentees to identify one another and connect, as opposed to establishing more formal programs with assigned mentors/mentees.

Discussions about the most appropriate format for such interaction continue and will guide management in its exploration of scalable mechanisms to achieve the aim of the policy. Your Board will provide a progress report at the 2023 Annual Meeting.

7. TRANSPARENCY OF RESOLUTION FISCAL NOTES (RESOLUTION 608-A-22)

Reference committee hearing: see report of Reference Committee F.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 608-A-22
REMAINDER OF REPORT FILED**
See Policy TBD

Resolution 608 from the 2022 Annual Meeting, “Transparency of Resolution Fiscal Notes,” was introduced by Resident and Fellow Section and referred. The resolution proposed amendments to Policy G-600.061, “Guidelines for Drafting a Resolution or Report,” as follows:

RESOLVED, That our American Medical Association amend current Policy G-600.061, “Guidelines for Drafting a Resolution or Report,” by addition and deletion to read as follows:

(d) A fiscal note setting forth the estimated resource implications (expense increase, expense reduction, or change in revenue) of ~~the any proposed policy, program, study or directive to take~~ action shall be generated and published by AMA staff in consultation with the sponsor, prior to its acceptance as business of the AMA House of Delegates. Estimated changes in expenses will include direct outlays by the AMA as well as the value of the time of AMA's elected leaders and staff. A succinct description of the assumptions used to estimate the resource implications must be included in the AMA House of Delegates Handbook to justify each fiscal note. ~~When the resolution or report is estimated to have a resource implication of \$50,000 or more, the AMA shall publish and distribute a document explaining the major financial components or cost centers (such as travel, consulting fees, meeting costs, or mailing). No resolution or report that proposes policies, programs, studies or actions that require financial support by the AMA shall be considered without a fiscal note that meets the criteria set forth in this policy.~~

In its report, the reference committee, stated:

Your Reference Committee heard mixed testimony on Resolution 608. Testimony noted that standardizing the fiscal note process will be beneficial for both the resolution author and the House of Delegates. It was stated that a process for developing fiscal notes was previously established through current AMA policy. Additionally, a concern was raised the proposed process could hinder the timely generation of fiscal notes for emergency resolutions. Due to issues raised during testimony, your Reference Committee believes that an exploration of all concerns related to fiscal note development is merited and recommends referral.

The resolution was not discussed in the House, as the reference committee recommendation was adopted on the consent calendar. The full text of the policy in its current form is below in Appendix A. Appendix B provides the text of Resolution 608.

BACKGROUND

Fiscal notes have been attached to items of business, particularly resolutions for decades. In 1999, (then) Policy H-545.935, "Expanded Fiscal Notes on Resolutions," stated:

Fiscal notes estimated to be more than \$5,000 shall specify whether it is a "loss of revenue," "additional operating expense," or "savings to the AMA." The AMA publishes and distributes a document containing explanations and/or assumptions for fiscal notes on each resolution estimated to have a fiscal impact of \$50,000 or more, containing greater detail and supporting documentation, including major components or cost centers (such as travel, consulting fees, meeting costs, mailing).

At the 1999 Annual Meeting, Council on Long Range Planning and Development (CLRPD) Report 4 altered the policy somewhat and incorporated it into (then new) Policy H-545.933, "Guidelines for Drafting a Resolution," with the new language as follows:

A fiscal note setting forth the estimated cost of the proposed policy, program, or action shall be generated by AMA staff in consultation with the sponsor. Fiscal notes estimated to be more than \$5,000 shall specify whether it is a "loss of revenue," "additional operating expense," or "savings to the AMA." When the resolution is estimated to have a fiscal impact of \$50,000 or more, the AMA shall publish and distribute a document explaining the major financial components or cost centers (such as travel, consulting fees, meeting costs, or mailing). No resolution requiring finances shall be considered without attachment of such fiscal note.

The same report created (then) Policy H-545.934, "Guidelines for Drafting a Report," under which "all reports to the HOD for action shall include a fiscal note and a designation whether or not it is within the current budget."

At the 2003 Annual Meeting, CLRPD Report 6-A-03 made the two guideline drafting policies parallel, calling for a fiscal note for any "proposed policy, program, or action" whether in a resolution or report. Similarly, the requirement to publish and distribute a document on the financial components was extended to reports, and consideration of either a resolution or action report without the requisite fiscal note was to be precluded. The fiscal note focus was changed from cost to "resource implications (expense increase, expense reduction, or change in revenue)."

Except for consolidating the two policies into a single policy, other changes to the policy since 2003 did not address the portion on fiscal notes. The policy as it appears in the Appendix has been in place since 2018.

CURRENT PRACTICE WITH FISCAL NOTES

Fiscal notes are based on a gross estimate of the AMA staff time that would be required to implement the resolution or report as written along with other cost centers such as survey expenses and consultant fees or foregone revenue. A fiscal note is printed on every resolution and action report (i.e., informational reports are excluded), provided the information is available when the document is officially released in the handbook, addendum, or tote.¹ Fiscal notes can only rarely be calculated precisely, so current practice characterizes the fiscal note for most items within one of three ranges:

- Minimal – less than \$1,000
- Modest – between \$1,000 - \$5,000
- Moderate – between \$5,000 - \$10,000

Items for which the fiscal note exceeds \$10,000 are addressed in the “Summary of Fiscal Notes [meeting]” document, which is included in the initial handbook and is updated and included in the tote distributed for the second opening.

In fact, the fiscal notes for all items of business having a fiscal note appear in the “Summary of Fiscal Notes,” including those items that did not directly incorporate the figure when initially released. For those items where the note exceeds \$10,000, additional information is included for most, with exceptions largely from section-sponsored resolutions transmitted for immediate consideration by the House of Delegates and for which only a gross figure is available, but otherwise, a breakdown of the fiscal note is provided using broad categories (e.g., consultant fees). For example, the document included the following fiscal notes in June:

- Res 242, Public Awareness and Advocacy Campaign to Reform the Medicare Physician Payment System: Est btwn \$1M - \$25M to conduct a public awareness camp (incl. paid ads, social and earned media, patient and phys grassroots) to prevent/mitigate further Medicare payment cuts and lay the groundwork to pass fed legislation. Incl prof. fees and promotion
- Res 615, Anti-Harassment Training: Est cost approx. \$60K-\$65K to create 3 targeted eLearning modules. Incl end to end content design & devel costs to start from scratch, subj matter expert honorariums and staff time

The summary document provides this additional information for all items for which the fiscal note exceeds \$10,000, not only those greater than \$50,000 as called for by existing Policy G-600.061. Also worth noting is that the resolution sponsor is contacted when the fiscal note exceeds \$5,000. That sometimes leads to a change in the resolution.

Limitations in the Current Fiscal Note Process

As noted generating reliable estimates of the “estimated resource implications (expense increase, expense reduction, or change in revenue),” to use the language of the current policy, of an item of business, particularly resolutions, is difficult. Resolutions are most frequently submitted on or near deadlines, meaning time for processing—and preparing a fiscal note is only one facet of that process—must be accomplished relatively quickly and like any estimate, cannot be calculated with precision. Fiscal notes for reports are generally more reliable than those for resolutions because more time is available for their development, but even so, they should be considered qualified estimates rather than definitive.²

Moreover, few resolutions specify parameters sufficiently to yield reliably precise figures. While estimates of foregone revenue and changes in member benefits are readily calculated simply because accurate figures can be used (e.g., the number of members and the revenue or cost per member are available), even those figures are subject to estimates of the number of members who will take advantage of the proposal. Resolutions calling for our AMA to study an issue

¹ The tote contains items of business submitted after the on time deadline for a meeting. Historically, this has been the “Sunday tote,” but for A-22 was the “Saturday tote,” and for the Special Meetings was a “Friday tote.”

² The Report of the Speakers’ Special Advisory Committee from the 2009 Annual Meeting included a chart, characterized how business is processed for a meeting. The chart would not be substantially different today.

are particularly prone to interpretation. Does “study” simply mean that a report be prepared, or does it require more extensive effort, such as fielding a survey or soliciting members’ experiences?

Finally, it should be borne in mind that the fiscal note is prepared based on the item of business as written. Changes by the reference committee and amendments in the House can significantly alter the item, potentially decreasing confidence and increasing error in the fiscal note. Routine informational reports to the House that are attributable to existing policy (e.g., the annual tobacco report, the annual demographic report, the update on the ACA at every HOD meeting) incur costs that are not captured by fiscal notes at all, even though their genesis is found in resolutions adopted by the House. The expense related to reports that stem from referred resolutions is similarly not captured in a fiscal note. Based on observations over multiple House meetings, it seems that “small” fiscal notes—small by whatever definition—concern few people, while “large” fiscal notes—probably defined as in excess of \$500,000—however accurate, seemingly cause concern that the dollars are used as a barrier against doing the work, rather than acceptance that the work can be and often times is costly.

Lost in the discussion of fiscal notes is the fact that every item of business incurs various expenses. Those expenses begin with the sponsoring organization and extend to our AMA for processing, distribution, and implementation, even if implementation is little more than recording the statement in PolicyFinder. Similarly, items of business indirectly add to expenses for members of the House who leave their practices to attend House of Delegates meetings. To be clear, these observations are not criticisms, only an acknowledgement that fiscal notes do not cover all associated costs, such as various regulatory schemes or insurance practices impose costs on physicians even if unintended and unacknowledged.

RESOLUTION 608-A-22

The declared intent underlying Resolution 608-A-22 is found in the whereas clause that states, “Providing the rationale behind the fiscal note to the House of Delegates would promote understanding, transparency, standardization and enable the House to utilize the AMA’s resources more judiciously.” (The full text of the resolution, including the whereas clauses, is found in Appendix B.) The fiscal note for the resolution was just over \$5800 annually, or moderate using the standard terminology, assuming the submission of 280 resolutions per year.

The resolution proposes changes to three elements of the existing policy regarding fiscal notes, although the need for each change is not explicitly stated:

- Removes proposed “policies and programs” from the requirement for a fiscal note while inserting “study or directive to take” before the word “action.”
- Requires that the fiscal note be generated and published “prior to acceptance as business.”
- Calls for including a succinct justification for each fiscal note to be included in the handbook.

The rationale for the first change is unclear. If the intent is simply to propose alternative language for the existing policy, the change serves no real purpose. If the intent is to use the “directive to take action” terminology to cover any resolution calling for any sort of activity, the distinction with and inclusion of “study” is unnecessary. Given that the authors distinguish between “study” and “directive to take action,” it would be inconsistent to remove the word “program” from the policy.

More problematic is the removal of the word “policy,” which is inconsistent with the author’s suggestion that the change will “enable the House to utilize the AMA’s resources more judiciously,” as it ignores the fact that every resolution incurs some cost, even if minimal. And it should be reiterated that processing, distribution, and other meeting-related costs are not captured by fiscal notes. In addition, even purely philosophical statements of policy may carry costs associated with implementation and advocacy. For example, recent policies emphasizing the role of physicians on the health care team have led to considerable activity.

Finally, the “policy, program, or action” language was developed by the Council on Long Range Planning and Development after careful consideration and presentation of its 1999 report mentioned above. Your Board cannot support the proposed change to this part of the policy.

The second proposed change calls for preparing and publishing the fiscal note before accepting the item as business. Again the intent is unclear. Whenever possible, as noted above, fiscal notes are appended to the resolution before it is

distributed in the handbook, addendum, or tote, and the summary of fiscal notes document appears in the handbook and in updated form in the tote. Thus it would seem that this is already accomplished.

The policy already calls for the fiscal note to be developed in consultation with the authors, but given the usual timing of resolution submissions and the multiple processing steps, the Speakers have determined that this consultation is required only for those resolutions for which the fiscal note exceeds \$5000. To consult with the sponsor for every resolution would be problematic. First, it would likely add significantly to the processing time for resolutions. Most resolutions are submitted by medical society staff, but the person sending the resolutions to the House Office is not necessarily the best contact for the resolution. Connecting with the proper individual may take time, and it is not uncommon that the most knowledgeable party is the physician who initially generated the idea that then came through the society. Relatedly, section-sponsored resolutions, particularly those sent for immediate consideration by the House, may require governing council input if questions arise about the fiscal note, a potentially time-consuming process. Second, such consultations seem largely unnecessary for resolutions that have minimal costs. The value added for the time invested is virtually nil, as fiscal notes under \$5,000 essentially represent staff time, meaning there is little to explicate. Finally, resolutions are technically not accepted as business until the House acts (usually as part of the second opening) by which time fiscal notes have been prepared and published for all items of business, with only a handful of exceptions. If the authors have in mind that the fiscal note should be made available before the resolution can be included in the handbook, they have effectively created an impossible task or need to suggest a workable mechanism that will allow timely publication of meeting materials.

Not seeing how this change benefits the House and not seeing how this proposal could be implemented without disrupting or delaying HOD meeting preparations, your Board does not support this change.

The last change proposed would include a “succinct description of the assumptions used to estimate the resource implications” of each resolution in the handbook. As noted, most resolutions with a fiscal note under \$5,000 reflect costs associated with staff time, and the same is true for fiscal notes up to \$10,000. Including assumptions on staff costs would involve adding the hours and salary rates for AMA employees that would be an inappropriate public disclosure of compensation in many cases. Insofar as fiscal notes over \$5000 are discussed with the sponsor and the summary of fiscal notes document includes elements of the costs associated with resolutions having fiscal notes in excess of \$10,000, your Board believes this change is unnecessary.

RECOMMENDATION

Your Board of Trustees recommends that Resolution 608 not be adopted and the remainder of the report be filed.

APPENDIX A - PolicyG-600.061, “Guidelines for Drafting a Resolution or Report”

Resolutions or reports with recommendations to the AMA House of Delegates shall meet the following guidelines:

1. When proposing new AMA policy or modification of existing policy, the resolution or report should meet the following criteria:
 - (a) The proposed policy should be stated as a broad guiding principle that sets forth the general philosophy of the Association on specific issues of concern to the medical profession;
 - (b) The proposed policy should be clearly identified at the end of the resolution or report;
 - (c) Recommendations for new or modified policy should include existing policy related to the subject as an appendix provided by the sponsor and supplemented as necessary by AMA staff. If a modification of existing policy is being proposed, the resolution or report should set out the pertinent text of the existing policy, citing the policy number from the AMA policy database, and clearly identify the proposed modification. Modifications should be indicated by underlining proposed new text and lining through any proposed text deletions. If adoption of the new or modified policy would render obsolete or supersede one or more existing policies, those existing policies as set out in the AMA policy database should be identified and recommended for rescission. Reminders of this requirement should be sent to all organizations represented in the House prior to the resolution submission deadline;
 - (d) A fiscal note setting forth the estimated resource implications (expense increase, expense reduction, or change in revenue) of the proposed policy, program, or action shall be generated by AMA staff in consultation with the sponsor. Estimated changes in expenses will include direct outlays by the AMA as well as the value of the time of AMA's elected leaders and staff. A succinct description of the assumptions used to estimate the resource implications must be included in each

fiscal note. When the resolution or report is estimated to have a resource implication of \$50,000 or more, the AMA shall publish and distribute a document explaining the major financial components or cost centers (such as travel, consulting fees, meeting costs, or mailing). No resolution or report that proposes policies, programs, or actions that require financial support by the AMA shall be considered without a fiscal note that meets the criteria set forth in this policy.

2. When proposing to reaffirm existing policy, the resolution or report should contain a clear restatement of existing policy, citing the policy number from the AMA policy database.
3. When proposing to establish a directive, the resolution or report should include all elements required for establishing new policy as well as a clear statement of existing policy, citing the policy number from the AMA policy database, underlying the directive.
4. Reports responding to a referred resolution should include the resolves of that resolution in its original form or as last amended prior to the referral. Such reports should include a recommendation specific to the referred resolution. When a report is written in response to a directive, the report should sunset the directive calling for the report.
5. The House's action is limited to recommendations, conclusions, and policy statements at the end of report. While the supporting text of reports is filed and does not become policy, the House may correct factual errors in AMA reports, reword portions of a report that are objectionable, and rewrite 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. The supporting texts of reports are filed.
6. All resolutions and reports should be written to include both "MD and DO," unless specifically applicable to one or the other.
7. Reports or resolutions should include, whenever possible or applicable, appropriate reference citations to facilitate independent review by delegates prior to policy development.
8. Each resolution resolve clause or report recommendation must be followed by a phrase, in parentheses, that indicates the nature and purpose of the resolve. These phrases are the following:
 - (a) New HOD Policy;
 - (b) Modify Current HOD Policy;
 - (c) Consolidate Existing HOD Policy;
 - (d) Modify Bylaws;
 - (e) Rescind HOD Policy;
 - (f) Reaffirm HOD Policy; or
 - (g) Directive to Take Action.
9. Our AMA's Board of Trustees, AMA councils, House of Delegates reference committees, and sponsors of resolutions will try, whenever possible, to make adjustments, additions, or elaborations of AMA policy positions by recommending modifications to existing AMA policy statements rather than creating new policy.

Policy Timeline: CLRPD Rep. 4, A-99; Modified by BOT Rep. 15, A-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CLRPD Rep. 2, A-02; Modified: CLRPD Rep. 6, A-03; Reaffirmed: BOT Rep. 19, A-04; Appended: Res. 606, A-05; Appended: Res. 611, A-07; Modified: CCB/CLRPD Rep. 1, A-12; Modified: Speakers Rep., A-18

APPENDIX B – Resolution 608-A-22

Whereas, AMA resolutions include a fiscal note to share the projected cost of the resolution resolved clauses, if adopted; and

Whereas, The fiscal note is often categorized minimal, modest or moderate or sometimes, more specifically states an estimated cost in dollars; and

Whereas, Little justification or detail is provided to explain fiscal notes; and

Whereas, Providing the rationale behind the fiscal note to the House of Delegates would promote understanding, transparency, standardization and enable the House to utilize the AMA's resources more judiciously; therefore be it

RESOLVED, That our American Medical Association amend current policy G-600.061, "Guidelines for Drafting a Resolution or Report," by addition and deletion to read as follows:

(d) A fiscal note setting forth the estimated resource implications (expense increase, expense reduction, or change in revenue) of ~~the any proposed policy, program, study or directive to take action~~ shall be generated and published by AMA staff in consultation

with the sponsor, prior to its acceptance as business of the AMA House of Delegates. Estimated changes in expenses will include direct outlays by the AMA as well as the value of the time of AMA's elected leaders and staff. A succinct description of the assumptions used to estimate the resource implications must be included in the AMA House of Delegates Handbook to justify each fiscal note. ~~When the resolution or report is estimated to have a resource implication of \$50,000 or more, the AMA shall publish and distribute a document explaining the major financial components or cost centers (such as travel, consulting fees, meeting costs, or mailing). No resolution or report that proposes policies, programs, studies or actions that require financial support by the AMA shall be considered without a fiscal note that meets the criteria set forth in this policy.~~

8. THE RESOLUTION COMMITTEE AS A STANDING COMMITTEE OF THE HOUSE (RESOLUTION 605-N-21 AND RESOLUTION 619-A-22)

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: RECOMMENDATIONS NOT ADOPTED REMAINDER OF REPORT FILED

At the November 2021 Special Meeting of the House of Delegates (HOD) Texas introduced the following resolution (605-N-21), which was referred:

RESOLVED, That the Bylaws of the American Medical Association be amended to provide that the Resolution Committee be responsible for reviewing resolutions submitted for consideration at all meetings of the American Medical Association House of Delegates and determining compliance of the resolutions with the purpose of any such meeting; and be it further

RESOLVED, That the membership of the Resolution Committee reflect the diversity of the House of Delegates; and be it further

RESOLVED, That the Resolution Committee rules be written to produce impartial results and appropriate changes be made to the AMA Bylaws as necessary to empower the committee.

The reference committee had recommended referral and characterized the testimony in the hearing as follows:

Your Reference Committee heard robust, yet widely divided testimony on formalizing the Resolution Review Committee as a standing House of Delegates committee. Testimony reflected that the Resolution Review Committee was implemented as a temporary solution to address an unprecedented situation.

Opposition to formalizing the Resolution Review Committee entailed concerns, such as inconsistencies with evaluating resolutions, limiting discussion on ideas and emergent issues, ineffective extraction process, lack of inclusivity in policy deliberations, and exclusion of the minority voice in the parliamentary process.

Testimony favoring formalization of the resolution review process cited issues regarding members of our AMA House of Delegates not having sufficient time to review a growing volume of business and the need to triage priority items of business.

The resolution was then debated in the House and referred, and much of that debate could be characterized like the testimony in the reference committee.

At the 2022 Annual Meeting, Texas, South Carolina, Florida, Mississippi, New Jersey, and Pennsylvania introduced Resolution 619-A-22, which reads:

RESOLVED, That the Resolutions Committee be formed as a standing committee of the house, the purpose of which is to review and prioritize all submitted resolutions to be acted upon at the annual and interim meetings of the AMA House of Delegates; and be it further

RESOLVED, That the membership of the Resolutions Committee be composed of one Medical Student Section (MSS) member, one Resident and Fellow Section (RFS) member, and one Young Physicians Section (YPS) member, all appointed by the speakers through nominations of the MSS, RFS, and YPS respectively; six regional

members appointed by the speakers through nominations from the regional caucuses; six specialty members appointed by the speakers through nominations from the specialty caucuses; three section members appointed by the speakers through nominations from sections other than the MSS, RFS, and YPS; and one past president appointed by the speakers; and be it further

RESOLVED, That the members of the Resolutions Committee serve staggered two-year terms except for the past president and the MSS and RFS members, who shall serve a one-year term; and be it further

RESOLVED, That members of the Resolutions Committee cannot serve more than four years consecutively; and be it further

RESOLVED, That if a Resolutions Committee member is unable or unwilling to complete his or her term, the speakers will replace that member with someone from a similar member group in consultation with that group the next year, and the new member will complete the unfulfilled term; and be it further

RESOLVED, That each member of the Resolutions Committee confidentially rank resolutions using a 0-to-5 scale (0 – not a priority to 5 – top priority) based on scope (the number of physicians affected), urgency (the urgency of the resolution and the impact of not acting), appropriateness (whether AMA is the appropriate organization to lead on the issue), efficacy (whether an AMA stance would have a positive impact), history (whether the resolution has been submitted previously and not accepted), and existing policy (whether an AMA policy already effectively covers the issue). Resolutions would not have to meet all of these parameters nor would these parameters have to be considered equally; and be it further

RESOLVED, That the composite (or average) score of all members of the Resolutions Committee be used to numerically rank the proposed resolutions. No resolution with a composite average score of less than 2 would be recommended for consideration. The Resolutions Committee would further determine the cutoff score above which resolutions would be considered by the house based on the available time for reference committee and house discussion, and the list of resolutions ranked available for consideration would be titled “Resolutions Recommended to be Heard by the HOD”; and be it further

RESOLVED, That the Resolutions Committee also make recommendations on all resolutions submitted recommending reaffirmation of established AMA policy and create a list titled “Resolutions Recommended for Reaffirmation,” with both lists presented to the house for acceptance; and be it further

RESOLVED, That the membership of the Resolutions Committee be published on the AMA website with a notice that the appointed members should not be contacted, lobbied, or coerced; any such activity must be reported to the AMA Grievance Committee for investigation; and should the alleged violations be valid, disciplinary action of the offending person will follow; and be it further

RESOLVED, That the bylaws be amended to add the Resolution Committee as a standing Committee with the defined charge, composition, and functions as defined above for all AMA HOD meetings effective Interim 2022.

Reference committee testimony on June’s resolution echoed the comments that had been heard at the preceding November meeting and acknowledged the referral of the matter at that meeting. This resolution too was referred.

At the outset your Board would note that a decision regarding a resolution committee rightly rests with the House. Your Board is not empowered to establish House procedures, so this report is intended to determine the will of the House in this matter.

BACKGROUND

The House has never restricted the subject matter of resolutions. No subject is foreclosed at any HOD meeting, and aside from a few late resolutions, nearly all resolutions have been accepted over the years. The Annual Meeting has no defined focus. The Interim Meeting, however, is to focus on advocacy-related matters, and when that decision was made, a resolution committee was implemented to ensure that focus. The special meetings of 2020 and 2021 employed resolutions committees to limit the business to urgent or priority issues. Thus the limitations that have been imposed were based not on the subject matter but on the focus (i.e., advocacy) or need for action (i.e., urgency and priority).

Resolution Committee – Interim Meetings

A committee tasked with the review of resolutions did not originate with the special meetings. It was just over twenty years ago that the House of Delegates determined that the Interim Meeting should be focused on advocacy matters, and while June's annual meetings would consider any business properly submitted, November's meetings should consider only resolutions that address advocacy and legislation. Matters concerning ethics were later added as an appropriate topic in November. It should be noted that the Interim Meetings are a full day shorter than our Annual Meetings further supporting a need for a narrow focus of business to be considered.

To ensure the focus on advocacy, AMA bylaws were amended, and bylaw 2.12.1.1, "Business of Interim Meeting," reads:

The business of an Interim Meeting shall be focused on advocacy and legislation. Resolutions pertaining to ethics, and opinions and reports of the Council on Ethical and Judicial Affairs, may also be considered at an Interim Meeting. Other business requiring action prior to the following Annual Meeting may also be considered at an Interim Meeting. In addition, any other business may be considered at an Interim Meeting by majority vote of delegates present and voting.

Determining what business is appropriate for consideration at an Interim Meeting is the province of the Resolution Committee. That section of the bylaws reads:

2.13.3 Resolution Committee. The Resolution Committee is responsible for reviewing resolutions submitted for consideration at an Interim Meeting and determining compliance of the resolutions with the purpose of the Interim Meeting.

The Resolution Committee for the Interim Meeting is appointed by the Speaker with broad representation from the House including members from all sections and councils. Our Bylaws restrict the committee to a maximum of 31 delegates. The committee does not meet, rather each member of the committee independently reviews the resolutions and sends their recommendations to the Office of House of Delegates Affairs, which tallies the individual votes. A "resolution shall be accepted for consideration at an Interim Meeting upon majority vote of committee members voting." Items recommended against consideration by the committee are subject to appeal to the House, which can accept the resolution by majority vote as noted above. Your Board is not aware of any objections to the way in which the Interim Meeting Resolution Committee has operated, including the fact that its members have traditionally not been identified.

Resolutions Committees – Special Meetings, 2020 & 2021

Health and safety concerns as well as government-imposed restrictions stemming from the SARS-CoV-19 pandemic disallowed holding in-person meetings of the House of Delegates for the 2020 and 2021 calendar years.¹ Under AMA bylaws, your Board of Trustees can and did call for special meetings of the House of Delegates, with four such meetings in those two years.

The bylaws for special meetings state that notice of the meeting "shall specify the time and place of meeting and the purpose for which it is called, and the House of Delegates shall consider no business except that for which the meeting is called" (§2.12.2). Your Board declared that the purposes of the special meetings included leadership transitions (for the June meetings) and the consideration of urgent or priority business of the Association. Determining what proposals met the defined purposes of the meetings was thought best left to the House, following the model of the Resolution Committee associated with the Interim Meeting. That course was adopted for the November 2020, June 2021, and November 2021 special meetings. The June 2020 special meeting was much more circumscribed, with only a handful of items required by the bylaws considered in a meeting that required only about three hours.

¹ Other meetings, including the State Advocacy Summit, National Advocacy Conference, and various RUC and CPT meetings, were also cancelled or moved to a virtual format. Your Board of Trustees did not meet in person between March 2020 and July 2021, until all had been vaccinated against COVID. Masks and other precautions were standard for the initial face-to-face meetings.

To be clear, the special meetings that were held in June 2021 and November 2020 and 2021 were not annual or interim meetings and were convened under different bylaws. Following the pattern of the Resolution Committee for the Interim Meeting, the Speakers appointed members for the similarly named committees associated with each special meeting to address through their individual assessments the priority or urgency of all resolutions.² Volunteers were solicited from across the House, including the sections, regional caucuses, councils, and Specialty and Service Society. The November 2020 committee included 10 delegates; both 2021 meetings included 31 delegates, with representation from all membership segments. (Though not technically applicable to the special meetings, the special meetings resolutions committees adhered to the bylaws-imposed limit of 31 members that applies to an Interim Meeting Resolution Committee.)

In addition to determining what proposals met the urgency or priority threshold, mechanisms had to be developed to allow debate and voting in accord with Illinois corporate law, AMA bylaws, and the House's procedures. Although the available tools were relatively easy to use, AMA's procedures such as limiting election votes to delegates, substituting alternate delegates for their delegates (and vice versa), and allowing any member to testify in a reference committee presented special challenges related to use and familiarity with new technology. Consequently, concerns arose about the ability of the House to address the usual volume of business in a virtual format, which led to the need to pare the business to a reasonable level. The model of the Interim Meeting Resolution Committee provided the best available solution. A similar mechanism is used by the British Medical Association and was used by some state and specialty societies during the pandemic.

Aside from a different focus for the special meetings, namely urgency or priority as noted in the call to each meeting, the special meeting resolutions committees functioned like the Interim Meeting Resolution Committee, with each member making independent judgments about every resolution. Each resolution was rated on a five-point scale from "a top priority" to "not a priority at this time," using a priority matrix that had been developed by a subcommittee of the initial committee.³ The initial priority matrix was modified slightly and approved by the subsequent committees. The average score for each resolution was calculated, and every resolution that was collectively rated as at least a medium priority (a "3" on the five-point scale) along with a handful that scored slightly below medium priority was recommended for acceptance, with the remaining items recommended against acceptance. Recommendations were based on each item's rating—at least medium priority, although a few items rated slightly less than medium priority were proposed for acceptance. It was thought better to err on the side of inclusion. The committee's recommendations were presented to the House as a consent calendar from which any delegate could extract an item, with the House determining whether to consider that item by a majority vote.

The votes by the House were taken without oral debate, which is not ordinary practice in the House. This was intended to avoid debate about what would be debated, but the delegate requesting extraction could prepare a written statement on why the item should be considered, with that statement provided to the House in various ways: as part of the committee's written report, appearing on screen before and during the vote, and at the November 2021 meeting appearing on screen while read aloud by the Speaker before the vote. In no case across the three meetings was a committee recommendation overturned, which has led some to call foul and argue that the process was unfair and dismissive of the minority view. Complying with AMA bylaws, which meant considering only the business for which the meetings had been called, was the reason for using resolutions committees across the special meetings.

VIEWS ON A RESOLUTION COMMITTEE

The divergent views expressed about the referred resolutions derive from different perspectives. Those favoring the resolutions want to focus the work of the House of Delegates on matters that our AMA can effectively address and that are deemed important and relevant to the largest number of physicians. They favor in-depth discussion and debate about fewer issues over limited debate about a multitude of business items.

Those opposed to the resolutions are generally more concerned about ensuring that all resolutions are considered, with those concerns characterized in terms of fairness, member engagement and process transparency.

² In a similar fashion, the councils and Board limited their report submissions to those deemed most urgent or the greatest priority.

³ Members of the Interim Meeting Resolution Committee are typically presented with a binary choice for each resolution: it is or is not advocacy, but the special meetings' purpose being urgency or priority augured for a finer gradation.

PROCESS FOUNDATION AND OUTCOMES OF THE SPECIAL RESOLUTIONS COMMITTEE

AMA-sponsored meetings, including the House of Delegates meetings, are conducted according to the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure*, albeit with slight modifications such as the distinction between referral for report and referral for decision. Noted therein is that “the purpose of parliamentary procedure is to facilitate the orderly transaction of business and to promote cooperation and harmony” (p 7). Shortly thereafter is stated that “The majority vote decides. The ultimate authority of an organization is, as a general matter, vested in a majority of its members” (p 8).

Your Board believes that the resolutions committees employed for the special meetings were implemented in good faith to allow the House to exercise its legislative and policymaking authority cooperatively using tools and a format that are inherently less efficient than our AMA’s traditional in-person meetings while staying true to our parliamentary processes and House practices.

A fundamental aspect of the deliberative process is that a legislative body has the right to determine its agenda. A full debate, discussion and vote on every proposal is not guaranteed. Indeed, House procedures provide two motions that preclude full consideration of specific items: the motion to object to consideration and the motion to table. Other House procedures, the reaffirmation calendar (initiated in 1991) and the Interim Meeting Resolution Committee, effectively operate to the same end. Insofar as these mechanisms generally become operable on the basis of a majority (or even supermajority) vote—extractions from the reaffirmation calendar being an exception—they fully comport with parliamentary procedure and, by inference, represent the majority’s view.

That none of the items extracted from the resolution committee reports was successfully added to the agenda of one of the special meetings does not mean the process was ineffective or unfair. At the November 2021 meeting, 165 resolutions were submitted. From that pool, the resolutions committee had recommended that 39 be accepted, as those were of at least medium priority or nearly so. Of those recommended against acceptance, 98 were not extracted, and among the 28 extracted items, three-fifths (i.e., 60%) or more of those voting supported the committee’s recommendation against consideration for 23 items, and the smallest margin was a four-point difference (52% to 48%).

OPERATION OF THE HOUSE OF DELEGATES

Commentary from both supporters and opponents of the resolutions committee noted the need for efficiency in the House of Delegates, although no concrete changes for improving efficiency were heard beyond the perceived pros or cons of a resolution committee. Efficiency in House of Delegates meetings has long been sought, and multiple changes have been implemented by various Speakers toward this goal. The previously mentioned reaffirmation calendar is one, and another is treating reference committee reports as a consent calendar from which items are extracted for debate in the House, which dates from the mid-1990s. The Interim Meeting Resolution Committee was instituted not as an efficiency measure but as a mechanism to allow the House to ensure the meeting is focused on advocacy.

The table below shows the number of resolutions submitted to each meeting since 2007, not including memorial resolutions and without regard to whether each resolution was considered. The four meetings in 2020 and 2021 were of course the special meetings conducted online.

Resolutions Submitted to House of Delegates Meetings, 2007-2022

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020*	2021*	2022
June	246	233	220	195	183	212	176	197	194	182	193	200	233	0	148	265
Nov.	97	112	93	109	119	82	93	117	98	103	101	107	99	100	165	-

* These were the special meetings.

The number of items of business is inarguably correlated with the time required for reference committee hearings and likely related to the duration of business sessions and debate in the House as well.⁴ Few would question the assertion that items considered late in a reference committee or on the last day at the House of Delegates meeting typically get a less thorough hearing than items considered earlier. Reference committees frequently rush through the last few items

⁴ Consider that the Interim Meeting is a full day shorter than the Annual Meeting and typically has only about half the number of items of business, which are handled in two fewer reference committees.

on their agendas, and delegates' comments and testimony are not uncommonly constricted—forced into 60 second time slots—on the last day of the meeting. Prioritizing the business to be considered would be better than the somewhat random consignment of items to late in the agenda, whereby they receive foreshortened consideration.

CONCLUSION

In many ways a resolution committee would parallel efforts to focus the activities of our AMA across strategic arcs. Whether a resolution committee is viewed as a means to focus deliberations on priority issues or a cudgel to limit business, particularly business that is perceived to come from minority viewpoints or to propose possibly unpopular policies, is clearly a subjective evaluation. Also true is that the effect of a resolution committee on the proceedings of a House of Delegates meetings is unknown.

Your Board believes a process that would allow the House of Delegates to focus on key concerns of patients and our profession may merit a test. That decision, however, rests solely with the House. Your Board is not empowered to set out House procedures, and this report should be considered a vehicle to determine whether the House of Delegates wishes to implement a trial of a standing resolution committee for future meetings. Should the House favor a test, your Board will come back with a detailed proposal at the June 2023 House of Delegates Meeting (June 10-14, 2023) recommending both the parameters for a resolution committee and the necessary bylaws changes.

The idea that a resolution committee would recommend which resolutions should be considered strikes some as an affront to the democratic nature of the House of Delegates. Others view it as a means to focus the work of the House on matters of greatest importance to the profession. Virtually any issue can be presented to the House for consideration, and the House has the right to choose which items should be considered or whether any limits should be imposed.

The nature of the virtual format of the special meetings limited the volume of business that could be considered. The limit was imposed, however, not primarily based on volume but on the collective evaluation of a proposal's urgency or priority. In fact, the special meetings were called by the Board to only handle urgent and priority business. For in-person meetings, the House has previously decided to focus the Interim Meeting on advocacy matters and not to restrict the business considered at the Annual Meeting.

A decision whether to change the procedures of the House by implementing a resolution committee for all House of Delegates meetings appropriately rests with the House of Delegates, not your Board of Trustees. This report is intended to be a vehicle to determine the will of the House.

RECOMMENDATION

Your Board of Trustees offers the following recommendation to be adopted in lieu of Resolutions 605-N-21 and 619-A-22 and the remainder of the report filed.

That the Board of Trustees prepare a report for consideration at the 2023 Annual Meeting recommending a trial of a resolution committee, including the make-up and operation of the committee and create measures of fairness and effectiveness of the trial.

9. EMPLOYED PHYSICIANS

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED

INTRODUCTION

At the November 2021 Special Meeting of the House of Delegates (HOD), Resolution 615, "Employed Physicians," was introduced by the Oklahoma, Alabama, District of Columbia, Georgia, Mississippi, New Jersey, North Carolina, South Carolina, and Tennessee delegations and referred for report. In brief, Resolution 615 asks the AMA to:

1. dedicate full-time staff to address employed physician issues, which would include providing legal assistance to physicians on contractual matters;

2. increase the representation of “employed physicians” (a term that would need to be defined) in the HOD by allocating additional representation to the Organized Medical Staff Section; and
3. increase representation of employed physicians in AMA leadership by adding OMSS representatives (who would be employed physicians) to the Board of Trustees and to each AMA council and committee.

Testimony on Resolution 615 reflected concern with the proposed representation scheme. Nevertheless, it was clear that the HOD seeks, in the words of the reference committee, “a workable plan for supporting employed physicians.” This report examines how the voice of employed physicians might best be heard within the organization. See Appendix A for full text of Resolution 615-N-21.

BACKGROUND

The AMA supports the needs of physicians in all modes of practice, including employed physicians. Moreover, the AMA has long recognized that employed physicians as a category have unique needs that can and should be met by the AMA. In particular, AMA Policy G-615.105, “Employed Physicians and the AMA,” states that the AMA will:

- “strive to become the lead association for physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities;”
- “provide...assistance, such as information and advice, but not legal opinions or representation, as appropriate, to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other entities...” and
- “work through the Organized Medical Staff Section and other sections and special groups as appropriate to represent and address the unique needs of physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities.”

The AMA’s work on behalf of employed physicians has included the creation of model employment contracts, offering of multiple education opportunities on employment matters, development of the seminal “[AMA Principles for Physician Employment](#)” (AMA Policy H-225.950), and legislative, regulatory, and judicial advocacy on employment concerns such as non-compete agreements, due process rights, and so forth.

Defining “employed physician”

There is at present no universally acknowledged definition of what constitutes an employed physician relative to one that is not employed. While employed physicians could be understood to be physicians who are paid for their services by another party, the simple act of receiving a paycheck is not necessarily determinative of a physician’s employment status.

For the purposes of this report, we propose the following working definition of what it means to be an employed physician:

An employed physician is any non-resident, non-fellow physician who maintains a contractual relationship to provide medical services with an entity from which the physician receives a W-2 to report their income and in which the physician does not have a controlling interest, either individually or as part of a collective.

Trends in physician practice ownership and employment

For many years, physicians have been moving away from private practice and toward employment by health care entities. The AMA’s Physician Benchmark Survey found in 2020 that for the first time fewer than half (49.1 percent) of physicians surveyed reported that they worked in physician-owned private practice (as opposed to self-identifying as employees or contractors), which was down from 2018 when 54 percent of physicians surveyed worked in physician-owned practices.¹ As of May 2022, there are just under 1.1 million active primary care and specialist physicians working in the US,² implying that roughly 537,000 physicians are employed.

The benchmark survey showed that the trend toward employment varied widely across specialties. Surgical subspecialties and radiology held the lowest percentages of employed physicians, both under 40 percent. At the other extreme, family medicine, pediatrics, internal medicine subspecialties, general surgery and emergency medicine physicians all reported that greater than 50 percent of physicians were employed, with family medicine and pediatrics having the lowest rates of practice ownership.

The COVID-19 pandemic potentially confounds the study of trends in physician employment during the last two years. During the pandemic, physician overhead costs increased while payments failed to keep pace,³ which likely accelerated the trend toward physician employment and practice acquisition by health care entities. Indeed, a 2021 study examining growth trends in physician practice ownership and employment between January 1, 2019, and January 1, 2021, found that more than 48,000 physicians left independent practice to become employees of a health care entity during that time, a 12 percent increase in the number of employed physicians. At the same time, hospitals and other health care entities acquired 20,900 physician practices, a 25 percent increase in corporate-owned practices.⁴

DISCUSSION

As the number of employed physicians continues to grow relative to the number who are in private practice, our AMA will continue to represent and otherwise meet the needs of employed physicians, as it does the needs of physicians in all practice settings. Resolution 615 proposes two key areas for AMA action, which we evaluate here before offering an alternative approach to ensure the voice of employed physicians continues to be heard within our organization.

Dedicated staffing to address employed physician issues

Resolution 615 asks the AMA to dedicate full-time staff to address issues of concern to employed physicians, with the authors going so far as to suggest in their Statement of Priority that AMA ought to establish a new stand-alone business unit (“office of the employed physicians”). We agree that employment relationships create unique challenges for physicians who choose this mode of practice and further, that AMA ought to be aware of these challenges and seek to address them. However, we do not believe that establishing a staffing entity dedicated to employed physicians is the correct approach.

The needs of employed physicians are addressed across the existing staffing entities of the AMA. For example, AMA section staff, advocacy staff, and legal counsel form a center of expertise around physician-hospital relations, including contracting and medical staff bylaws protections for employed physicians. Similarly, in tackling physician burnout, the Professional Satisfaction and Practice Sustainability unit (“PS2”) considers how systemic deficiencies in healthcare organizations drive burnout among employed physicians. This pattern is borne out across the AMA, leading us to conclude that the needs of employed physicians would be better served by encouraging the various components of our organization to continue to consider the specific needs of physicians in all practice settings, including employed physicians, as they go about their work.

Relatedly, Resolution 615 asks the AMA to provide a greater level of service to employed physicians in contracting matters—specifically, to provide legal opinions. AMA Policy G-615.105, which the resolution seeks to amend to achieve its goal, states explicitly that the AMA will not provide legal opinions or representation:

As a benefit of membership our AMA will provide, through the Sections and Special Groups, assistance, such as information and advice, but not legal opinions or representation, as appropriate, to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.

While it is appropriate for our AMA to provide some level of guidance to physicians in contractual matters (e.g., AMA’s model annotated employment contracts for group practice employment and hospital employment, both of which are currently undergoing updates), AMA itself is not positioned to provide legal opinions or representation for individual physicians across U.S. states and territories, each with its own nuances of employment law. AMA has previously explored partnering with a third party to provide such services to physicians at a discounted rate but ultimately found such an arrangement to be cost prohibitive.

Expanded representation of employed physicians across AMA governance

Resolution 615 asks the AMA to expand the representation of employed physicians across AMA governance, including in the House of Delegates, on the Board of Trustees, and on all AMA councils and committees. This expansion would be accomplished by granting OMSS proportional representation in the HOD and set-aside seats on the Board and councils/committees.

The resolution purports to base this proposed structure on the proportional representation granted to medical students and residents/fellows in the HOD (i.e., regional and sectional delegates, respectively), and on the inclusion of medical students, residents/fellows, and young physicians on the Board and councils. However, the resolution misconstrues the nature of the relationship between these leaders and the sections of which they are members. Medical student regional delegates and resident/fellow sectional delegates do not represent the MSS or the RFS. Nor do the medical student, resident/fellow, and young physician members of the Board and councils represent the MSS, RFS, or YPS. Rather, they simply give voice to those particular segments of AMA membership. For this reason, it is inappropriate to route increased representation of employed physicians through OMSS, even if OMSS may be a logical home for employed physicians.

More broadly than concerns with the proposed representation structure, we believe it is generally inadvisable to create additional governance set-asides. Medical students, residents/fellows, and young physicians are granted special representation because without dedicated positions, and owing to their relatively short AMA tenure, it is unlikely that there would be many of them in AMA leadership positions. Employed physicians, as individuals, do not face the same barrier. While they might not have been elected to explicitly represent the interests of employed physicians and while they might be proportionally underrepresented, there are in fact employed physicians at every level of AMA leadership. We fear that an additional carve-out for any group, including employed physicians, would spark an interest arms race wherein physicians in other practice arrangements seek proportional representation.

An alternative solution: employed physician caucus

AMA Policy G-615.002, “AMA Member Component Groups,” defines a “caucus” as “an informal group of physicians (from specialty and/or geographic medical groups or focused interest areas) who meet at the Annual and/or Interim meetings to discuss issues, pending resolutions and reports, candidates, and possible actions of the HOD.” Caucuses are a critical component of the AMA governance structure, giving voice in the AMA policymaking process to many groups that are not explicitly represented in the HOD. Examples of recently constituted caucuses include the obesity caucus and the mobility caucus.

The creation of an employed physician caucus would validate the supposition that employed physicians as a category have unique needs and interests that should be heard within our AMA. But it would do so without creating problematic set-asides and while conforming to established pathways for recognition of viewpoints within our AMA.

While it is beyond the scope of the Board to establish caucuses, the Board fully supports the creation of an employed physician caucus. It is our understanding that OMSS leadership has begun to engage other interested parties to convene an inaugural meeting of an employed physician caucus at the 2022 Interim Meeting. We are eager to see how this group will amplify the voice of employed physicians in our policymaking process and ultimately help our organization best meet the needs of the growing ranks of employed physicians. Additionally, while it is beyond the scope of the Board to recommend the establishment of a new AMA section, we note that a caucus is an appropriate starting point for that level of representation, with multiple sections having originated as caucuses.

RECOMMENDATIONS

Your Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 615-N-21, and that the remainder of this report be filed:

1. That our AMA adopt the following definition of “employed physician”:

An employed physician is any non-resident, non-fellow physician who maintains a contractual relationship to provide medical services with an entity from which the physician receives a W-2 to report their income, and in which the physician does not have a controlling interest, either individually or as part of a collective.

2. That our AMA re-examine the representation of employed physicians within the organization and report back at the 2024 Annual Meeting.

REFERENCES

1. Kane, C. (2021) Policy research perspectives Recent changes in physician practice arrangements: Private practice dropped to less than 50 percent of physicians in 2020; American Medical Association.
2. Kaiser Family Foundation. (2022); Professionally active physicians; State Health Facts. Accessed August 8, 2022: <https://www.kff.org/other/state-indicator/total-active-physicians/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
3. Gillis, K. (2021); Impacts of the COVID-19 pandemic on 2020 Medicare Physician Spending; Policy Research Perspectives; American Medical Association; Accessed 7/12/2022: <https://www.ama-assn.org/practice-management/sustainability/covid-19-financial-impact-physician-practices>.
4. Avalere Health; (2021); COVID-19's impact on acquisitions of physician practices and physician employment 2019-2021; Prepared for Physicians Advocacy Institute; June 2021.

APPENDIX A - Full text of resolve clauses of Resolution 615-N-22

RESOLVED, That our American Medical Association dedicate full-time staff to the Employed Physician to aggressively address relevant AMA Policy pertaining to the Employed Physician (Directive to Take Action); and be it further

RESOLVED, That our AMA study amending Policy G-615.105 to read as follows:

Employed Physicians and the AMA G-615.105

1. Our AMA will strive to become the lead association for physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities.
2. As a benefit of membership our AMA will provide, through the Sections and Special Groups, assistance, such as information, and advice, but not and legal opinions or representation, as appropriate, to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other entities, including, but not limited to, breach of contracts, contract negotiations and contract renewals, including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.
3. Our AMA will also work through the Organized Medical Staff Section and other sections and special groups as appropriate to represent and address the unique needs of physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities. (Directive to Take Action); and be it further

RESOLVED, That the representation of the Organized Medical Staff Section (OMSS) in the AMA House of Delegates be increased from the current one Delegate to many Delegates based on AMA membership numbers of employed physicians using the mathematical model(s), to calculate the numbers of the New OMSS Delegates, currently being used at AMA for the Medical Student and Resident and Fellows Sections to calculate the numbers of Regional Medical Students and the numbers of Regional Resident/Fellows in the AMA House of Delegates. The AMA would develop a practical meaning of the phrase "Employed Physician" for the purposes of AMA membership counting, but as an editorial comment, the SED suggests starting with employed Non-Resident/Non-Fellow physicians who have no ownership interest (or, say, less than 1% ownership each) in their employer organization (New HOD Policy); and be it further

RESOLVED, That the Organized Medical Staff Section have one designated member who is a defined employed physician on all AMA Boards and Committees and Councils to match the MSS, the RFS and the YPS. (New HOD Policy)

APPENDIX B - Relevant AMA Policy

G-615.105, Employed Physicians and the AMA

1. Our AMA will strive to become the lead association for physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities.
2. As a benefit of membership our AMA will provide, through the Sections and Special Groups, assistance, such as information and advice, but not legal opinions or representation, as appropriate, to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.
3. Our AMA will work through the Organized Medical Staff Section and other sections and special groups as appropriate to represent and address the unique needs of physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities.

G-615.002, AMA Member Component Groups G-615.002

...

A "caucus" is an informal group of physicians (from specialty and/or geographic medical groups or focused interest areas) who meet at the Annual and/or Interim meetings to discuss issues, pending resolutions and reports, candidates, and possible actions of the HOD. With the exception of AMA Section caucuses, these groups will not have a reporting relationship or resources allocated by the AMA.

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

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

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

IMPROVING THE AFFORDABLE CARE ACT

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

Our AMA continues to advocate for policies that would allow patients and physicians to be able to choose from a range of public and private coverage options with the goal of providing coverage to all Americans. Specifically, our AMA has been working with Congress, the Administration, and states to advance our plan to cover the uninsured and improve affordability as included in the "[2022 and Beyond: AMA's Plan to Cover the Uninsured](#)." The COVID-19 pandemic initially led to many people losing their employer-based health insurance. This only increased the need for significant improvements to the Affordable Care Act. Recent data indicate that the uninsured rate has decreased during the COVID-19 pandemic, due to the temporary ACA improvements included in the American Rescue Plan Act, continuous Medicaid enrollment, state Medicaid expansions, and the 2021 special enrollment period for ACA marketplaces.

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

Our AMA has been advocating for the following policy provisions:

Cover Uninsured Eligible for ACA's Premium Tax Credits

- Our AMA advocates for increasing the generosity of premium tax credits to improve premium affordability and incentivize tax credit eligible individuals to get covered. Currently, eligible individuals and families with incomes between 100 and 400 percent federal poverty level (FPL) (133 and 400 percent in Medicaid expansion states) are being provided with refundable and advanceable premium tax credits to purchase coverage on health insurance exchanges.
- Our AMA has been advocating for enhanced premium tax credits to young adults. In order to improve insurance take-up rates among young adults and help balance the individual health insurance market risk pool, young adults ages 19 to 30 who are eligible for advance premium tax credits could be provided with "enhanced" premium tax credits—such as an additional \$50 per month—while maintaining the current premium tax credit structure which is inversely related to income, as well as the current 3:1 age rating ratio.

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

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

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

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

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

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

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

EXPAND MEDICAID TO COVER MORE PEOPLE

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

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

New policy adopted by the AMA HOD during the November 2021 Special Meeting seeks to assist more than 2 million nonelderly uninsured individuals who fall into the “coverage gap” in states that have not expanded Medicaid—those with incomes above Medicaid eligibility limits but below the FPL, which is the lower limit for premium tax credit eligibility. The new AMA policy maintains that coverage should be extended to these individuals at little or no cost,

and further specifies that states that have already expanded Medicaid coverage should receive additional incentives to maintain that status going forward.

AMERICAN RESCUE PLAN OF 2021

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

- Provide a temporary (two-year) 5 percent increase in the Federal Medical Assistance Percentage (FMAP) for Medicaid to states that enact the Affordable Care Act's Medicaid expansion and covers the new enrollment period per requirements of the ACA.
- Invest nearly \$35 billion in premium subsidy increases for those who buy coverage on the ACA marketplace.
- Expand the availability of ACA advanced premium tax credits (APTCs) to individuals whose income is above 400 percent of the FPL for 2021 and 2022.
- Give an option for states to provide 12-month postpartum coverage under State Medicaid and CHIP.

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

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

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

LEGISLATIVE EXTENSION OF ARPA PROVISIONS

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

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

ACA ENROLLMENT

According to the U.S. Department of Health and Human Services (HHS), 14.5 million Americans have signed up for or were automatically re-enrolled in the 2022 individual market health insurance coverage through the marketplaces since the start of the 2022 Marketplace Open Enrollment Period (OEP) on November 1, 2021, through January 15, 2022. That record-high figure includes nearly 2 million new enrollees, many of whom qualified for reduced premiums granted under ARPA. In August, the Department of Health and Human Services issued a report noting that the uninsured rate in the U.S. had dropped to an all-time low of 8 percent.

TEXAS VS. AZAR SUPREME COURT CASE

The Supreme Court agreed on March 2, 2020, to address the constitutionality of the ACA for the third time, granting the petitions for certiorari from Democratic Attorneys General and the House of Representatives. Oral arguments were presented on November 10, 2020, and a decision was expected before June 2021. The AMA filed an amicus brief in support of the Act and the petitioners in this case.

On February 10, 2021, the U.S. Department of Justice under the new Biden Administration submitted a letter to the Supreme Court arguing that the ACA's individual mandate remains valid, and, even if the court determines it is not, the rest of the law can remain intact.

This action reversed the Trump Administration's brief it filed with the Court asking the justices to overturn the ACA in its entirety. The Trump Administration had clarified that the Court could choose to leave some ACA provisions in place if they do not harm the plaintiffs, but as legal experts pointed out, the entire ACA would be struck down if the Court rules that the law is inseparable from the individual mandate—meaning that there would be no provisions left to selectively enforce.

On June 17, 2021, the Supreme Court in a 7-2 decision ruled that neither the states nor the individuals challenging the law have a legal standing to sue. The Court did not touch the larger issue in the case: whether the entirety of the ACA was rendered unconstitutional when Congress eliminated the penalty for failing to obtain health insurance.

With its legal status now affirmed by three Supreme Court decisions, and provisions such as coverage for preventive services and pre-existing conditions woven into the fabric of U.S. health care, the risk of future lawsuits succeeding in overturning the ACA is significantly diminished.

KELLEY VS. BECERRA FEDERAL COURT CASE

A case before a federal district court judge in the Northern District of Texas, *Kelley v. Becerra*, would eliminate the ACA requirement that most health insurance plans cover preventive services without copayments. Those filing the case object to paying for coverage that they do not want or need, particularly for those items or services that violate their religious beliefs, such as contraception or PrEP drugs. If the case is successful, health plan enrollees will also lose access to full coverage for more than 100 preventive health services, including vaccinations and screenings for breast cancer, colorectal cancer, cervical cancer, heart disease, and other diseases and medical conditions.

The AMA and 61 national physician specialty organizations issued a joint statement on July 25, sounding the alarm about the millions of privately insured patients who would be affected by an adverse ruling.

SGR REPEAL

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

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

INDEPENDENT PAYMENT ADVISORY BOARD REPEAL

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

CONCLUSION

Our American Medical Association will remain engaged in efforts to improve the health care system through policies outlined in Policy D-165. 938 and other directives of the House of Delegates.

11. 2022 AMA ADVOCACY EFFORTS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

BACKGROUND

Policy G-640.005, “AMA Advocacy Analysis,” calls on the Board of Trustees (the Board) to provide a report to the House of Delegates (HOD) at each Interim Meeting highlighting the year’s advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The Board has prepared the following report to provide an update on American Medical Association (AMA) advocacy activities for the year. (Note: This report was prepared in August based on approval deadlines, so more recent developments may not be reflected in it.)

DISCUSSION OF 2022 ADVOCACY EFFORTS

Numerous advocacy challenges emerged in 2022, but once again, our AMA rose to the moment and achieved significant progress on the issues most important to America’s physicians and patients. While the COVID-19 public health emergency (PHE) has subsided to a certain degree, it persists. The AMA has stood by America’s physicians and patients throughout the pandemic, securing billions in relief to protect private practices; reducing reporting burdens and penalties; advancing telehealth; enabling investments in therapeutics and vaccines to end the pandemic; standing up for health equity to achieve optimal health for all; and strongly advocating for science in the halls of power. At the same time, the AMA has been advocating extensively on other issues critical to physicians and patients.

At the 2022 Annual Meeting, the AMA launched a Recovery Plan for America’s Physicians targeting some of the toughest issues physicians face today—on both professional and personal levels. Components of the plan include:

- Reforming Medicare payment to promote thriving physician practices and innovation;
- Stopping scope creep that threatens patient safety;
- Fixing prior authorization to reduce the burden on practices and minimize patient care delays;
- Supporting telehealth to maintain coverage and payment; and
- Reducing physician burnout and addressing the stigma around mental health.

Success on these issues will be key to helping physicians get back on track after the practice interruptions and shutdowns they have faced in the last two years.

While the AMA is focusing on tackling the issues contained in the recovery plan, other issues have arisen that need heightened advocacy efforts, too. The mass shootings in Buffalo, NY, and Uvalde, TX, forced policymakers to finally come to the table and consider some initial steps to halt such massacres. Further, the *Dobbs v. Jackson Women’s Health Organization* (hereafter *Dobbs*) decision to overturn *Roe v. Wade* (hereafter *Roe*) allows lawmakers to invade the exam room in ways not seen in decades and has created a whirlwind of clinical questions facing physicians trying to provide the best care while avoiding legal liability.

The AMA is fighting to advance AMA policy on these issues and many more that are updated in this report.

Medicare Payment Reform

The AMA is focused on reforming our nation’s Medicare physician payment system. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) made needed improvements to the system including eliminating the Sustainable Growth Rate (SGR), but time has revealed significant statutory flaws. The promise of a viable glide path to voluntary participation in alternative payment models (APMs) never materialized, with 30 physician-proposed models being rejected for implementation. Meanwhile, the increasingly aggressive financial incentives to participate in APMs continue. The quality and reporting programs for physicians in the Merit-based Incentive Payment System (MIPS) are burdensome and lack clinical relevance. The Medicare fee schedule is chronically underfunded. No annual updates will be provided for physician services for several years, and those received over the past two decades have collectively fallen well below the rising costs of medical practice.

The 2023 Medicare payment schedule proposed rule released in July fails to account for inflation in practice costs and COVID-related challenges to practice sustainability and also includes a significant and damaging across-the-board reduction in payment rates. Such a move would create long-term financial instability in the Medicare physician payment system and threaten patient access to Medicare-participating physicians. The AMA is working with Congress to prevent this harmful outcome in the short term and to advance more comprehensive reform in coming sessions.

To achieve the needed level of reform, the AMA and 120 Federation groups have agreed on the following [“Characteristics of a Rational Medicare Payment System”](#) and will be advocating to see these principles implemented by Congress and the Administration.

Simplicity, relevance, alignment, and predictability, for physician practices and the Centers for Medicare & Medicaid Services

- Ensuring financial stability and predictability
 - Provide financial stability through a baseline positive annual update reflecting inflation in practice costs, and eliminate, replace, or revise budget neutrality requirements to allow for appropriate changes in spending growth.
 - Recognize fiscal responsibility. Payment models should invest in and recognize physicians’ contributions in providing high-value care and the associated savings and quality improvements across all parts of Medicare and the health care system (e.g., preventing hospitalizations).
 - Encourage collaboration, competition, and patient choice rather than consolidation through innovation, stability, and reduced complexity by eliminating the need for physicians to choose between retirement, selling their practices or suffering continued burnout.
- Promoting value-based care
 - Reward the value of care provided to patients, rather than administrative activities, such as data entry, that may not be relevant to the service being provided or the patient receiving care.
 - Encourage innovation, so that practices and systems can be redesigned and continuously refined to provide high-value care and include historically non-covered services that improve care for all or a specific subset of patients (e.g., COPD, Crohn’s Disease), as well as for higher risk and higher cost populations.
 - Offer a variety of payment models and incentives tailored to the distinct characteristics of different specialties and practice settings. Participation in new models must be voluntary and continue to be incentivized. A fee-for-service payment model must also remain a financially viable option.
 - Provide timely, actionable data. Physicians need timely access to analyses of their claims data, so they can identify and reduce avoidable costs. Though Congress took action to give physicians access to their data, they still do not receive timely, actionable feedback on their resource use and attributed costs in Medicare. Physicians should be held accountable only for the costs that they control or direct.
 - Recognize the value of clinical data registries as a tool for improving quality of care, with their outcome measures and prompt feedback on performance.
- Safeguarding access to high-quality care
 - Advance health equity and reduce disparities. Payment model innovations should be risk-adjusted and recognize physicians’ contributions to reducing health disparities, addressing social drivers of care, and tackling health inequities; physicians need support as they care for historically marginalized, higher risk, hard to reach or sicker populations.
 - Support practices where they are by recognizing that high-value care is provided by both small practices and large systems, and in both rural and urban settings.

For the near term, AMA and the Federation are asking Congress to take the following steps before the end of the year to address cuts that are scheduled to take effect in 2023:

- Replace the 0% payment schedule conversion factor update scheduled for next year with one that is based on inflation;
- Stop the 4.5% combined budget neutrality adjustments that offset the costs of improved payments for office-based (-3%) and facility-based (-1.5%) E/M services;
- Waive the 4% PAYGO sequestration requirement that was triggered by the infrastructure and COVID relief bills passed last year;
- Extend the \$500 million exceptional MIPS performance fund; and
- Extend current APM policies related to incentive bonuses and qualifying revenue thresholds.

Scope of Practice

The AMA defends the practice of medicine against inappropriate scope of practice expansions, supports physician-led team care, and ensures patients have access to physicians for their health care. All health care professionals play a critical role in caring for patients and are important members of the care team; however, their skillsets are not interchangeable with that of a fully trained physician. At the state level, the AMA works in strong collaboration and coordination with the state medical associations and national medical specialty societies. This includes sharing resources, reviewing, and advising on legislative language/strategy, testifying before state legislatures, submitting letters of opposition to lawmakers, and amplifying calls to action. The AMA also has a comprehensive library of resources to support our scope of practice campaign, including GEOMAPS, education and training modules, patient surveys, media toolkit, and one-pagers. These provide data and talking points to address the most common arguments to preserve physician-led care and refute assertions made by non-physicians. Since 2007 the AMA's Scope of Practice Partnership (SOPP) has played a key role in bringing organized medicine together on this issue, including by providing grants to SOPP members to support state efforts. There are currently 108 members of the SOPP and more than \$2.7 million in grants have been awarded to date.

In 2022, the AMA has collaborated with more than 25 state medical associations on hundreds of bills to defeat scope expansions or encourage states to adopt truth in advertising legislation. Highlights to date include:

- In Colorado, Louisiana and South Dakota, physician assistant bills were defeated;
- Truth in advertising legislation was enacted in Indiana;
- Kentucky and Tennessee rejected efforts to expand nurse practitioner prescriptive authority;
- Louisiana, Mississippi, Missouri, and Wisconsin defeated efforts to pass advanced practice registered nurse (APRN) expansion bills; and
- Alabama and Missouri defeated legislation that would have expanded pharmacist scope of practice.

In 2021, the Department of Veterans Affairs (VA) created the Federal Supremacy Project which is establishing National Standards of Practice (NSP), irrespective of state scope of practice laws, for approximately 50 categories of health professionals. The AMA established a specialty workgroup that we have been working with since the VA started this effort. Initially the VA was fast tracking the project, but the efforts of the AMA and the specialty societies have greatly slowed the pace. We were also able to secure a much more transparent process. The VA has committed to publishing the NSPs in the Federal Register and allowing for a 60-day comment period. In addition, the VA agreed to stagger the publication of the NSPs so stakeholders would have a better ability to comment. To date, the VA has published 3 NSPs. The AMA will continue to inform the Federation and work with the specialty society workgroup as the VA publishes the NSPs.

Prior Authorization

Payers continue to overuse prior authorization and do so on far too wide a basis despite agreeing to a consensus statement with the AMA in 2018 aimed at alleviating many of the concerns with this practice. For patients, prior authorization delays or denies access to care, often resulting in harm (e.g., hospitalization, permanent impairment, or death) and/or negative clinical outcomes—also, less value for premiums paid. For physicians, prior authorization wastes resources (time and money) and is related to burnout. For employers, restrictive prior authorization requirements will reduce the health of their workforce and provide less value for premiums. The AMA is advocating to right-size and streamline the prior authorization process through state, federal and private sector advocacy to provide patients, physicians, and employers relief.

To further illustrate the problems with indiscriminate prior authorization use, the AMA published its annual survey on the topic, which found:

- 93% of physicians report care delays;
- 82% percent of physicians report that prior authorization can sometimes lead to treatment abandonment;
- 34% of respondents report that prior authorization has led to a serious adverse event for a patient (including hospitalization, life-threatening event, or disability);
- On average, practices complete 41 prior authorizations per physician per week;
- Physicians/staff spend approximately 13 hours each week completing prior authorizations; and
- 40% of physicians have staff dedicated to working exclusively on prior authorization.

To address these issues at the federal level, the AMA strongly supports:

- The “Improving Seniors’ Timely Access to Care Act of 2021” (H.R. 8487/S. 3018), which would require Medicare Advantage (MA) plans to implement a streamlined electronic prior authorization (PA) process; increase transparency for beneficiaries and providers; enhance oversight by the Centers for Medicare & Medicaid Services (CMS) on the processes used for PA; ensure that care and treatments that routinely receive PA approvals are not subjected to unnecessary delays through real-time decisions by MA plans; and mandate that MA plans meet certain beneficiary protection standards. This legislation passed the House Ways and Means Committee in July.
- The “Getting Over Lengthy Delays in Care as Required by Doctors” (GOLD CARD) Act (H.R. 7995) of 2022, which would exempt physicians from MA plan prior authorization requirements so long as 90% of a physician’s prior authorization requests were approved in the preceding 12 months. The MA plan-issued gold cards would only be applicable to items and services (excluding drugs) and remain in effect for at least a year. The federal legislation is based on a similar law enacted in Texas that took effect in 2021.

The AMA is also continuing to advocate at the state level where several states have enacted comprehensive reform legislation while others are at earlier stages in the legislative process. In 2022, strong legislation has been enacted in Georgia, Iowa, Louisiana, and Michigan. The AMA also worked with members of the Federation to push Aetna to stop requiring prior authorization for cataract surgery. Aetna recently changed this policy with the exceptions of Florida and Georgia Medicare Advantage patients.

Telehealth

The AMA has long supported making telehealth services widely available to patients, but prior to the COVID-19 pandemic and the resulting loss of access to in-person medical care, most patients could not access telehealth services from their regular physicians. Due to restrictions in the Medicare statute, the Medicare program only covered telehealth services for patients in rural areas and, even then, the patient had to go to a medical facility to receive the telehealth services from a physician at another site. While private plans may not have had the same geographic restrictions, they often had limitations on coverage and payment of services provided via telehealth, as well as acceptable modalities. Many plans also often limited or incentivized patients to receive telehealth only from a separate telehealth company, not their regular physicians. Early in the pandemic, with strong support from the AMA, the restrictions on coverage for telehealth services were lifted by Medicare and other health plans. State laws and state Medicaid policies were also modified to permit widespread use of telehealth during the pandemic.

The AMA has prioritized making the telehealth expansion permanent. As an intermediate step, the AMA successfully urged Congress to extend the telehealth expansion through five months after the public health emergency ends. Further, CMS has also proposed to extend payment for a number of services that were added to the Medicare Telehealth List for an additional 5 months after the public health emergency ends.

And in July, the full House passed H.R. 4040, a bill that would extend telehealth payment and regulatory flexibilities for an additional two years, through the end of 2024, on a bipartisan vote of 416-12.

At the state level, the AMA has updated its model state telehealth legislation and continues to support state efforts to advance telehealth legislation and policy to ensure patient access to high quality care.

Physician Wellness

Prior to the COVID-19 pandemic, physician burnout, depression and suicide already were major challenges for the U.S. health care system, impacting nearly every aspect of clinical care as well as being a heavy burden for physicians and their families. Physicians are very resilient, but the environments in which physicians work drive these high levels of burnout. Compounding the problems are medical licensing applications, employment and credentialing applications, and professional liability insurance applications. The problem is when these contain questions that include problematic and potentially illegal questions requiring disclosure of whether a potential licensee or applicant has ever been diagnosed or received treatment for a mental illness or substance use disorder (SUD) or even sought counseling for a mental health or wellness issue. These questions about past diagnosis or treatment are strongly opposed by the AMA, Federation of State Medical Boards, The Joint Commission, the Federation of State Physician Health Programs, and The Dr. Lorna Breen Heroes’ Foundation.

At the federal level, the AMA strongly advocated for the Dr. Lorna Breen Health Care Provider Protection Act (H.R. 1667), named for a physician who died by suicide in 2020. The bill provides grants to help create evidence-based strategies to reduce burnout and the associated secondary mental health conditions related to job stress. It includes a national campaign to encourage health professionals to prioritize their mental health and to use available mental and behavioral health services. It also establishes grants for employee education and peer-support programming.

AMA advocacy and partnership with state medical associations has also helped enact state laws in Arizona, Indiana, South Dakota, and Virginia to provide strong confidentiality protections for physicians and medical students who seek care for burnout and wellness-related issues. The AMA is also continuing to urge state medical boards to remove stigmatizing questions that inappropriately ask about past diagnoses. In addition, the AMA is working with key stakeholders to bolster state physician health programs as well as identify health systems and others who can play a powerful role in removing stigma and supporting physicians' health and wellness.

Surprise Billing

The AMA is taking a two-pronged approach to the No Surprises Act of 2021 (NSA). The AMA is educating physicians on how to comply with the NSA while also advocating for implementation of the law as Congress intended. Specifically, the AMA has:

- Initiated litigation (along with the American Hospital Association) arguing that the government's interim final rule is contrary to the law and exceeds statutory authority by creating a rebuttable presumption that the arbiter in the Independent Dispute Resolution (IDR) process considers the "qualifying payment amount" (essentially the median in-network rate) as the appropriate out-of-network payment amount. (The Texas Medical Association has also filed litigation and secured a positive initial ruling.);
- Released an [initial toolkit](#) (PDF) on the implementation of the No Surprises Act and a [second toolkit](#) (PDF) on implementation of the billing process for certain out-of-network care under the No Surprises Act. We have also [compiled](#) a number of other resources, including regulatory summaries and comment letters;
- Held two national webinars on the No Surprises Act, the [first](#) on its implementation and the [second](#) on the payment process for physicians and other providers in surprise medical billing situations;
- Continues to advocate for a fair IDR process, recently arguing in a letter to the Administration that a balanced IDR process is not anti-patient, pushing back on payer and employer efforts to undermine the process;
- Working with other stakeholders to develop recommendations on the good faith estimate and advanced EOB requirements, to highlight administrative burdens and ensure minimal workflow disruption;
- Working directly with CMS to address operational challenges with additional physician and provider resources— CMS has already held two physician-focused webinars on the good faith estimate provisions and notice and consent and enforcement. A webinar on the payment process is expected soon; and
- Calling on CMS to conduct more physician outreach and education which CMS has agreed to do.

COVID-19 Response and Monkeypox Outbreak

As mentioned above, the AMA continues to mount a multi-pronged effort advocating for a comprehensive response to the COVID-19 public health emergency (PHE) as the virus continues to evolve and different variants continue to thwart recovery efforts. The AMA steadfastly supports financial relief for physician practices still negatively affected by the pandemic; robust testing to limit spread; vaccination in line with U.S. Centers for Disease Control and Prevention recommendations including for children; and permanent implementation of the telehealth expansion granted during the PHE. For a full list of AMA activities on this topic please visit this [website](#). More specifically the AMA produces a [regular video segment](#) update on recent developments with COVID-19 and other public health issues.

One recent development is that the Health Resources and Services Administration (HRSA) has announced that it will set up a process for physicians who received funds from the Provider Relief Fund to contest recoupment of the relief funds. Physicians receiving \$10,000 or more from the program are required to spend the funds within a year and report how the relief funds were spent. These requirements have been difficult for many practices to fulfill during the continued instability caused by the pandemic. The AMA pressed HRSA for this decision and is pleased that HRSA will work with physicians to ensure the intent of the relief program is achieved.

The AMA is also active in the courts defending the authority of public health agencies. The Litigation Center of the American Medical Association and State Medical Societies and Wisconsin Medical Society filed an amicus brief

supporting state and local officials and their authority to issue emergency orders during a public health crisis. The Wisconsin Supreme Court sided with public health officials in a [4-3 vote](#) which was a win for organized medicine.

Finally, the AMA is closely monitoring monkeypox and its progression throughout the U.S. and is ready to respond as needed. The AMA is [posting clinical information](#) for physicians as the virus spreads and has established a new CPT code for monkeypox vaccines.

Reproductive Health

When the Supreme Court of the United States issued its ruling in the *Dobbs* case overturning *Roe*, AMA President Jack Resneck Jr., MD, stated “The American Medical Association is deeply disturbed by the U.S. Supreme Court’s decision to overturn nearly a half century of precedent protecting patients’ right to critical reproductive health care—representing an egregious allowance of government intrusion into the medical examination room, a direct attack on the practice of medicine and the patient-physician relationship, and a brazen violation of patients’ rights to evidence-based reproductive health services. States that end legal abortion will not end abortion—they will end safe abortion, risking devastating consequences, including patients’ lives.” The AMA filed an amicus brief in the case when it first came before the Supreme Court stating our opposition to overturning this established right.

In a post-*Roe* landscape, the AMA is pursuing multiple strategies to address the broad spectrum of issues that the *Dobbs* decision created. At the federal level, the AMA immediately called for greater digital privacy for patients out of concern that minimal oversight of data use by digital apps could place women in jeopardy in states seeking to enforce abortion restrictions. The AMA in conjunction with the American College of Obstetricians and Gynecologists (ACOG) also called for the removal or revision of the Risk Evaluation and Mitigation Strategies (REMS) and Elements to Assure Safe Use (ETASU) requirements for mifepristone, to eliminate medically unsupported and unnecessary barriers for physicians, patients, and pharmacies. The Biden Administration also reminded hospitals and health care providers of their obligation to comply with the provisions of the Emergency Medical Treatment and Labor Act (EMTALA) that preempt any state laws that restrict access to stabilizing medical treatment, including abortion procedures and other treatments that may result in the termination of a pregnancy. Dr. Resneck also testified to the Subcommittee on Oversight and Investigations for the House Committee on Energy and Commerce at a hearing titled, “*Roe* Reversal: The Impacts of Taking Away the Constitutional Right to an Abortion” and discussed the impact that the *Dobbs* case is having on patients and physicians.

At the state level, the AMA is working with the Federation to determine how to best protect patients and physicians from aggressive legislative intrusions into the exam room. Some states are seeking to create new protections for patients while others are pressing for tougher abortion bans and other restrictions. The legal situation for physicians and their practices is very muddled in many states. The AMA is collecting information and conducting legislative analyses to help states sort through their best paths forward. We are also preparing to be very active on both the legislative and litigation fronts as the country works through this new set of legislative realities.

Firearm Violence

“Gun violence is a plague on our nation. It’s a public health crisis, and much of it is preventable,” then-AMA President Gerald E. Harmon, MD, said in remarks to the House of Delegates at the 2022 AMA Annual Meeting. With over 45,000 firearm-related deaths in 2020 and a continuing string of mass shootings, this public health crisis needs heightened efforts and new strategies. Congress did take a positive step by passing the first piece of major firearm legislation in over 30 years with the Bipartisan Safer Communities Act, which the AMA supported and President Biden signed on June 25. Key provisions of the bill include:

- Providing grants for states to establish or strengthen extreme risk protection orders;
- Adding convicted domestic violence abusers in dating relationships to the National Instant Criminal Background Check System (NICS);
- Requiring the Federal Bureau of Investigation National Instant Criminal Background Check System to contact authorities to see whether an individual under the age of 21 has a “disqualifying” juvenile record for buying a firearm;
- Making it a federal crime to buy a firearm on behalf of an individual who is prohibited from doing so; and
- Including new spending for school security and mental health treatment.

However, significant work still needs to be done to avoid more senseless tragedies as witnessed in Buffalo, Uvalde, and Highland Park, among other cities. Besides seeking further legislative options, AMA strategies include encouraging intervention by physicians and nurses when patients demonstrate risk factors for firearm violence; amplifying AMA work with other organizations related to firearm safety and violence prevention; and reaching out to law enforcement and educators to explore how collaborative progress can be made. Further, the AMA adopted several new policies in June calling for active-shooter and live-crisis drills to consider the mental health of children; regulating ghost guns; and advocating for warning labels on ammunition packages.

Maternal Mortality

The AMA continues to be very active advocating for improved maternal health in 2022 with a particular focus on the inequitable impact seen by Black women. The AMA has lobbied the Congressional Healthy Future Task Force Security Subcommittee to focus on this issue; called on Congress to increase funding in fiscal year 2023 for federal programs at the Health Resources Services Administration (HRSA), the U.S. Centers for Disease Control and Prevention (CDC), and the National Institutes of Health; and focused our comments on maternal health equity issues in the Hospital Inpatient Prospective Payment Systems (IPPS) Rule. Additionally, the House of Representatives passed the TRIUMPH for New Moms Act as part of the Restoring Hope for Mental Health and Well-Being Act of 2022, a bipartisan mental health and substance abuse package that would reauthorize key programs within the Substance Abuse and Mental Health Services Administration. The AMA previously wrote letters to the House of Representatives and Senate encouraging the passage of TRIUMPH, which would create a Task Force on Maternal Mental Health to identify, evaluate and make recommendations to coordinate and improve federal responses to maternal mental health conditions, as well as create a national strategic plan for addressing maternal mental health disorders.

At the state level, CMS approved California, Florida, Kentucky, and Oregon actions to expand Medicaid and Children's Health Insurance Program coverage to 12 months postpartum. This extension provides over 120,000 more families with guaranteed coverage as they navigate this critical postpartum period. The AMA supports the extension of Medicaid coverage to 12 months postpartum and has provided comments on the importance of the matter.

Drug Overdose

Ending the nation's drug-related overdose and death epidemic—as well as improving care for patients with pain, mental illness or substance use disorder—requires partnership, collaboration, and commitment to individualized patient care decision-making to implement impactful changes. Due to AMA and Federation advocacy, there were several positive steps in 2022:

- CDC proposed removing arbitrary prescribing thresholds from its 2022 revised guideline—per AMA recommendations to CDC;
- Arizona, New Mexico, and Wisconsin are three of the states that AMA has helped enact legislation to decriminalize fentanyl test strips; several other states have passed bills in one house and are continuing to consider these bills;
- More than a dozen states have enacted legislation or other policies to help ensure that opioid litigation settlement funds are focused on public health efforts;
- AMA worked closely with the Rhode Island Medical Society to help develop regulations implementing the nation's first legally authorized harm reduction center;
- The National Association of Insurance Commissioners (NAIC) continues to develop [tools and resources](#) to help state departments of insurance and the U.S. Department of Labor better enforce state and federal parity laws—at the urging of the AMA and our partner medical societies; and
- The AMA continues to work closely with the Administration on policies to increase access to harm reduction efforts and reduce barriers to medications for opioid use disorder (MOUD), including support for federal funding for states to purchase fentanyl test strips, mobile methadone vans and retain telehealth flexibilities that allow for audio-only induction of buprenorphine.

The AMA also supports S. 445/H.R. 1384, the Mainstreaming Addiction Treatment (MAT) Act in the Senate Health, Education, Labor and Pensions Committee (HELP). The MAT Act would increase access to evidence-based treatment for opioid use disorder and end longstanding administrative barriers to prescribing buprenorphine in-office for the treatment of opioid use disorder.

Access

The AMA works tirelessly to preserve health care access and coverage for Americans across the nation—especially the country’s most vulnerable patient populations. The 2022 updates include:

- Successfully urged the Biden Administration to take action to fix the “family glitch” and provide affordable health care coverage;
- Working with health care stakeholder groups, urged the Administration to maintain the public health emergency that expands coverage for care and extends key regulatory flexibilities until there is an extended period of greater stability (the nationwide uninsured rate has dropped to 8%);
- Advocating to Congress to make the Affordable Care Act (ACA) subsidy expansions permanent (extended for three years in Senate Reconciliation bill); and
- Successfully urged adoption of stronger network adequacy rules for Qualified Health Plans and Medicare Advantage plans.

The AMA is also sounding the alarm that a federal court case could cause millions of Americans to lose access to preventive services. *Kelley v. Becerra*, a lawsuit before a federal district court judge in the Northern District of Texas, threatens the section of the Affordable Care Act (ACA) requiring insurers and group health plans to cover more than 100 preventive health services—with no additional cost to consumers. One of the ACA’s most popular and widely recognized benefits, the provision resulted in an estimated 151.6 million people receiving preventive care without cost sharing in 2020 alone.

Drug Pricing

As Congress prepared to leave Washington for its August recess, Senate negotiators reached agreement on a reconciliation package passed by the Senate that addressed a number of important issues, including provisions that promise to rein in the escalating costs of prescription drugs. Specifically, the legislation would allow Medicare to negotiate its purchasing prices for drugs, with the first 10 negotiated prices set to take effect in 2026. The legislation would also cap drug price increases at the annual rate of inflation and end a Trump-era drug rebate rule. All of these provisions promise to save money for both Medicare and for patients, although there are concerns about the impact of lower prices on the amount practices receive for the acquisition of physician-administered drugs under the average sales price (ASP) +6 percent payment methodology, particularly for small physician practices. The AMA will work with affected specialties during the implementation period to assess the impact and identify and advocate for solutions that preserve access to these drugs in physician offices.

Tobacco

The AMA supported the U.S. Food and Drug Administration’s (FDA) proposal to ban menthol-flavored cigarettes, a move that will save hundreds of thousands of lives in the coming decades while reducing health inequities. If the sale of menthol-flavored cigarettes is indeed banned, the FDA projects a 15.1% drop in smoking within 40 years, which would help save between 324,000 to 654,000 lives. The agency also projects the ban would stop between 92,000 and 238,000 smoking-related deaths among African Americans—that is up to 6,000 Black lives saved each year.

The AMA has also warned of the dangers of electronic nicotine delivery systems and long called for these products to have the same marketing and sales restrictions that are applied to tobacco cigarettes, including bans on TV advertising. This year the AMA successfully pressured social media companies to reject advertisements of e-cigarettes to youth. The AMA also recently applauded the FDA’s decision ordering the removal of all JUUL Labs Inc. e-cigarette products from the U.S. market, recognizing that for too long, companies like JUUL have been allowed to sell e-cigarettes that appeal to our nation’s youth—ultimately creating another generation of young people hooked on tobacco products.

Gender-Affirming Care

Despite the evidence base and consensus in the medical community that supports gender-affirming care for transgender youth, some state legislators have pursued legislation to prohibit physicians and other health care professionals from providing such care to minors. The AMA has worked with the Federation to mitigate the harm these bills could have on patients.

To date, two states, Alabama and Arkansas, have enacted laws that prohibit gender-affirming medical care for all minors, including puberty suppressing medication, hormone therapy, and surgery. Both laws are currently tied up with legal challenges. Two additional states, Arizona and Tennessee, have enacted legislation prohibiting surgery on minors and hormone therapy prior to puberty, respectively. Because these interventions are not recommended for the age groups specified, Arizona's and Tennessee's laws essentially—and unnecessarily—codify existing standards of care.

In addition to legislation, two states have sought to prohibit access to gender-affirming care through executive action. In February 2022, the Texas Attorney General issued an opinion deeming puberty suppressing drugs, hormone therapy, and surgeries child abuse. Shortly thereafter, Texas Governor Greg Abbott directed the Texas Department of Family and Protective Services to investigate any reported instances of minors receiving gender-affirming treatments. The directive was blocked by a Texas District Court. Lastly, in April 2022 the Florida Department of Health issued guidance stating that social gender transition, puberty blockers, hormone therapy, and gender reassignment surgery should not be treatment options for children or adolescents. The Florida guidance is not law or regulation and therefore is not legally enforceable. However, following a report by the Florida Agency for Health Care Administration finding insufficient evidence that medical intervention for the treatment for gender dysphoria is safe and effective, the Florida Board of Medicine began the rulemaking process in August 2022 to establish a new standard of care for the treatment of minors with gender dysphoria.

Public Service Loan Forgiveness Program

The AMA is calling on the U.S. Department of Education (DOE) to make improvements to the Public Service Loan Forgiveness (PSLF) program. In 2021, the DOE announced a change to the PSLF program rules for a limited time as a result of COVID-19 that made millions of non-profit and government employees eligible for loan forgiveness or additional credit through the [Limited PSLF Waiver](#). This waiver ends on October 31, 2022, but the AMA has called for an extension. Further, the AMA is urging the DOE to amend the program to assist California and Texas physicians because those states' bans on the corporate practice of medicine interfere with participation in the program. The AMA is also advocating for 501(c)(6) employers to potentially qualify for the program as well. These changes would directly assist physicians with their loan burdens and would encourage more physicians to practice in underserved areas.

Immigration

The AMA continues to fight for equitable treatment of physicians, residents, and students immigrating to the U.S. The AMA wrote to the U.S. House of Representatives Committee on the Judiciary Subcommittee on Immigration and Citizenship urging lawmakers to seek bipartisan policy solutions that will ensure that patients are provided the best care and that immigration barriers are addressed to resolve the physician workforce shortage and preserve patient access to care. The AMA also submitted comments on the Temporary Increase of the Automatic Extension Period of Employment Authorization and Documentation for Certain Renewal Applicants temporary final rule. With the growing backlog of cases within the Department of Homeland Security (DHS) negatively impacting both immigrants and U.S. businesses, the AMA applauded the temporary final rule (TFR) and asked that this same extension be provided to physicians so that they can maintain their lawful immigration status while DHS is working on streamlining their extensions for employment authorization.

The AMA sent a letter strongly opposing any rules, regulations, or policies that would deter immigrants, nonimmigrants, and their dependents from seeking visas or from utilizing noncash public benefits including, but not limited to, Medicaid, Supplemental Nutrition Assistance Program (SNAP), and housing assistance. Impeding access to non-cash public benefits for these individuals and families could undermine population health.

AMA ADVOCACY ONGOING UPDATES

The AMA offers several ways to stay up to date on our advocacy efforts:

- Sign up for AMA Advocacy Update—a biweekly newsletter that provides updates on AMA legislative, regulatory, and private sector efforts. Subscribers can read [stories from previous editions here](#) and those looking to subscribe can use this [link](#).
- Join the [Physicians Grassroots Network](#) for updates on AMA calls to action on federal legislative issues. And if you have connections with members of Congress, or are interested in developing one, the [Very Influential Physician \(VIP\) program](#) can help grow these relationships.

- Connect with the Physicians Grassroots Network on [Facebook](#), [Twitter](#), [LinkedIn](#) and [Instagram](#).

CONCLUSION

There was no shortage of advocacy challenges for America's physicians in 2022. The AMA in conjunction with the Federation represented physicians and patients very well once again; however, significant work needs to be done to advance AMA policy on key issues as well as avoiding further erosion of prior gains. The Recovery Plan for America's Physicians offers a blueprint moving forward, and the AMA will continue to provide updates as efforts proceed.

12. TERMS AND LANGUAGE IN POLICIES ADOPTED TO PROTECT POPULATIONS FROM DISCRIMINATION AND HARASSMENT

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

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED**
See Policy TBD

BACKGROUND

At the November 2021 Special Meeting of the House of Delegates (HOD), the HOD adopted Policy H-65.950, which reads as follows:

Our AMA recommends preferred terminology for protected personal characteristics to be used in AMA policies and position statements.

This report: 1) summarizes key points and findings of Board of Trustees Report 5-N-21, updates from other policies adopted by our AMA in 2021, relevant information from the AMA's Strategic Plan to Embed Racial Justice and Advance Health Equity ("Strategic Plan") and the AMA-AAMC Advancing Health Equity: A Guide to Language, Narrative and Concepts, and feedback from stakeholders ("Narrative Guide"); and 2) recommends preferred terminology for protected personal characteristics to be used in AMA policies and position statements.

DISCUSSION

Language matters especially in medicine. How physicians transcribe and communicate about healthcare with other healthcare workers and with patients adds context and framing to any discussion. The significance of language is even more critical when it concerns sensitive topics, including those involving race, ethnicity, gender, sexual orientation, and gender identity and how their use, misuse, or non-use impact care. Engaging in such discussions within medicine provides a chance to not only showcase language's fluidity in action, essentially the manner in which terms and/or phrases evolve as individuals and groups decide on new ways to identify themselves, but to also advance health equity. Equity work within healthcare requires acknowledging and reconsidering one's beliefs about health, healthcare, health systems and society. Related to this is the consideration of the language and narratives that consistently contribute to our thoughts and actions.

Language and identity often go together and are critical within health equity. Both are fluid and most importantly, social constructs, meaning they are derived from humans and can change as time progresses. For example, the acronym BIPOC is used to collectively refer to those who identify as Black, Indigenous, and People of Color; it was created within the last decade. Some view it as a shift away from using other terms such as "marginalized" and "minority" and is another term used to unify and amplify communities that have long been shunned and/or ignored. However, there are others that have differing opinions. Jonathan Rosa, sociocultural and linguistic anthropologist, and associate professor at Stanford University explains that BIPOC "presupposes a kind of solidarity and a shared positionality that doesn't play out in practice for a lot of people, and in fact obscures more than it reveals from some perspectives." It can also have an impact on research. Some scholars have argued that aggregating data can mask critical in-group differences and disparities, limiting efforts to specifically target resources. AMA has acknowledged this in recent years through the adoption of Policy D-350.979 at the 2021 Interim Meeting directing the organization to add "Middle Eastern/North African (MENA)" as a separate racial category on all AMA demographics forms; (2) advocate for the

use of “Middle Eastern/North African (MENA)” as a separate race category in all uses of demographic data including but not limited to medical records, government data collection and research, and within medical education. Therefore, the acronym can be used in certain circumstances, but should not be used in quantitative reporting to unnecessarily aggregate groups; instead, disaggregated data should be used to depict the experiences of groups (see AMA AAPI Data [Report](#)).

Additional key terms to consider such as sex and gender are often mistakenly used interchangeably. Within medicine, sex or “sex assigned at birth” is a label typically given by a physician based on the genitals a person is born with, but over time that very label may not align with how they identify. According to *The Oxford Handbook of Gender and Politics*, gender, refers to the social, psychological, and emotional traits, attitudes, norms and behaviors, often influenced by society’s expectations, that classify someone as man, woman, both, or neither. The American Academy of Pediatrics defines gender identity as “one’s internal sense of who one is, which results from a multifaceted interaction of biological traits, developmental influences, and environmental conditions. It may be male, female, ... a combination of both, or neither (i.e., not conforming to a binary conceptualization of gender).”

Language usage is critical. At a time when so many are working to not only diversify medicine, but promote antiracism, the terms and phrases that are amplified can have lasting impacts that can cause harm for both physicians and patients.

Board Report 5-N-21 notes: “Federal, state, and local law establish a baseline, identifying the minimum constellation of characteristics with respect to which discrimination should not be tolerated, based on the history of discrimination in the U.S.” The landscape related to protected personal characteristics is constantly evolving (e.g., update to Title IX), so any recommendation on terminology will need to be flexible in its wording and regularly updated to remain in compliance.

Board of Trustees Report 5-N-21 also found protected personal characteristics mentioned in existing policy of the AMA and other organizations at frequencies detailed in Appendix A, with minor adjustments made accounting for additional policy adopted by the AMA since the report was adopted (e.g., Policy H-350.960, Underrepresented Student Access to US Medical Schools).

Finally, while not policy, the Strategic Plan and the Narrative Guide offer language (see Appendices B and C). The Strategic Plan at various points (see pages 11-16) mentions: “race, ethnicity, gender, sexual orientation, ability and country of origin (i.e., International Medical Graduates),” “gender, gender identity, sexual orientation, disability, age, class/socioeconomic status, citizenship status and language,” “marginalized (women, LGBTQ+, people with disabilities, International Medical Graduates) and minoritized (Black, Indigenous, Latinx, Asian) physicians,” “race/ethnicity, gender, sexual identity, immigration status, country of origin, language and disability status,” and “race/ethnicity, gender, socioeconomic status, ability status, LGBTQ+ identity, literacy.” The Narrative Guide at various points (see pages 9-15) mentions: “formerly incarcerated/returning citizen/persons with a history of incarceration,” “sex assigned at birth,” and “ethnicity, nationality, class, or other status/identities.” The Narrative Guide stresses the importance of avoiding “dehumanizing language” and instead “offering equity-based, equity explicit, and person-first alternatives” and advises us to “describe people as having a condition or circumstance, not being a condition” and “humanize those you are referring to by using people or persons.” Person-first or people-first formulations include: “people with...,” “people experiencing...,” and “people identifying as...” However, the Narrative Guide notes that “different communities and individuals have different standards and preferences” regarding person-first language.

RECOMMENDATION

Based on a review of internal policies, the Strategic Plan and Narrative Guide, the Board of Trustees recommends that the following be adopted, and the remainder of this report be filed:

1. That our AMA amend Policy H-65.950 by addition and deletion to read as follows:

Our AMA recognizes broad and evolving protected personal characteristics spanning identity, origin, and status that include those outlined by regulatory authorities overlapping with those prioritized by AMA. To prevent misunderstandings and facilitate collaboration to move medicine forward, AMA recommends acknowledges preferred terminology for protected personal characteristics outlined in the actual sources used in the 2021 AMA

Strategic Plan to Embed Racial Justice and Advance Health Equity and the AMA-AAMC Advancing Health Equity such as the CDC's Health Equity Guiding Principles for Inclusive Communication to that may be used in AMA policies and position statements.

APPENDIX A: Terminology Used in Existing Policy from AMA and Other Organizations

Characteristic	Federal Agencies (DOE, EEOC, HHS)	AMA Policy	Other Professional Societies (Convenience Sample)	Schools (Convenience Sample)
Affiliational preferences				1
Age	3	10	8	10
Ancestry			2	4
Appearance			1	1
Body habitus			1	
Citizenship		1	1	1
Color	3	4	7	10
Country of education or origin		1		
Creed		3	1	4
Culture		1		
Degree of medical dependency		1		
Dependent status				
Disability	3	8	10	10
Disability, present or predicted		1		
Drug abuse		1		
Economic		1		
Education			1	
Employment status				
Ethnic origin		5	8	3
Ethnicity		1		
Expected length of life		1		
Family status / responsibilities				1
Future plans for marriage or children		1		
Gender		7	7	2
Gender expression		2	3	3
Gender identity	1	10	7	10
Genetic information	1	3	1	8
Health / health status		1	1	
Immigration status			2	
International medical graduate		2		
Language preference			2	
Living donor status		1		
Marital status		4	2	4
Matriculation				1
Medical condition			1	2
Military/veteran status			5	10
National origin	3	7	8	10
Order of protection status				1
Other		4		1
Other legally protected basis				1
Other basis prohibited by law			2	
Other human condition or choice			1	
Other personal category			1	
Other protected group / category / characteristic			2	3
Other social category			1	
Participation in a PHP		1		
Political opinion / affiliation			1	1
Pregnancy	1		1	5
Professional experience			1	
Professional experience / profession		1		
Quality of life		1		

Race	3	11	12	10
Religion	1	8	11	10
Rurality		1		
Sex	3	9	5	10
Sexual orientation	1	10	11	10
Social status or condition			1	
Socioeconomic status			4	
Socioeconomic origin		1		
Unemployed status				1
Zip code			2	

APPENDIX B: Definitions and Levels of Racism and Related Terms

	Definitions	Notes
Racism	As defined by Camara Jones, MD, MPH, PhD, "racism is a system of structuring opportunity and assigning value based on phenotype ('race'), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and undermines realization of the full potential of the whole society through the waste of human resources."	Racism can operate at different levels: structural, institutional, interpersonal, and internalized.
Structural Racism	As defined by Zinzi Bailey et al, structural racism "refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources."	
Institutional Racism	Discriminatory treatment, unfair policies and practices, and inequitable opportunities and impacts within organizations and institutions, based on race.	Individuals within institutions take on the power of the institution when they act in ways that advantage and disadvantage people, based on race.
Interpersonal Racism	The expression of racism between individuals. These are interactions occurring between individuals that often take place in the form of harassing, racial slurs, or racial jokes.	It may also take more subtle forms of unequal treatment, including micro-aggressions.
Internalized Racism	Acceptance by members of stigmatized races of negative messages about their own abilities and intrinsic worth.	
Prejudice	An unfavorable opinion or feeling formed beforehand or without knowledge, thought, or reason.	Prejudice also means an action in the sense that they are sequential steps by which an individual behaves negatively toward members of another group: verbal antagonism, avoidance, segregation, physical attack, and extermination. The term "prejudice" also refers to unfavorable opinions or feelings which lead groups to view members of other social groups as threatening adversaries who are inherently inferior or are actively pursuing immoral objectives.

	Definitions	Notes
<p>Bias</p>	<p>A form of prejudice in favor of or against one person or group compared with another usually in a way that's considered to be unfair to one group. Biases may be held by an individual, group, or institutions and can have negative or positive consequences and oftentimes are learned behaviors or habitual thoughts. Biases often emerge in relation to race/ethnicity, gender, socioeconomic status, ability status, LGBTQ+ identity, literacy, amongst other groupings.</p> <p>There are two main types of biases²⁰ discussed in scholarly research and in medicine^{21,22} that inhibit progress towards multiculturalism and equity in our society:</p> <ol style="list-style-type: none"> 1. Explicit or Conscious bias—This refers to the attitudes and beliefs we have about a person or group on a conscious level, that is we are aware and accepting of these beliefs, and they are usually expressed in the form of discrimination, hate speech or other overt expressions. 2. Implicit or Unconscious bias—This refers to the unconscious mental process that stimulates negative attitudes about people outside one's own 'in group'. For example, implicit racial bias leads to discrimination against people not of one's own group. Extensive research supports the notion that we all hold unconscious beliefs about various social and identity groups, and these biases stem from one's tendency to organize social worlds by categorizing and are influenced by power dynamics in a society. 	<p>It is important to note that biases, both explicit and implicit, have to be unlearned at the individual, group and institutional level in order to mitigate negative consequences as a result of existing and prevailing biases. Both first require an awareness and acknowledgment that the bias exists and require personal, group and institutional action to eliminate these biases.</p>

Adapted from Lawrence 2004, David Wellman, Jones 2000 and Bailey, et al 2017, Greenwald and Banaji, 1995

APPENDIX C: Key Principles and Associated Terms

Table 1: Key Principles and Associated Terms

Key principles	Instead of this ...	Try this ...
<p>Avoid use of adjectives such as vulnerable, marginalized and high-risk. These terms can be stigmatizing. These terms are vague and imply that the condition is inherent to the group rather than the actual causal factors. Try to use terms and language that explain why and/or how some groups are more affected than others. Also try to use language that explains the effect (i.e., words such as impact and burden are also vague and should be explained).</p>	<ul style="list-style-type: none"> • Vulnerable groups • Marginalized communities • Hard-to-reach communities • Underserved communities • Underprivileged communities • Disadvantaged groups • High-risk groups • At-risk groups • High-burden groups 	<ul style="list-style-type: none"> • Groups that have been economically/ socially marginalized • Groups that have been historically marginalized or made vulnerable; <i>historically</i> marginalized • Groups that are struggling against economic marginalization • Communities that are underserved by/with limited access to (specific service/resource) • Under-resourced communities • Groups experiencing disadvantage because of (reason) • Groups placed at increased risk/put at increased risk of (outcome) • Groups with higher risk of (outcome) • For scientific publications: <ul style="list-style-type: none"> – Disproportionately affected groups – Groups experiencing disproportionate prevalence/rates of (condition)
<p>Avoid dehumanizing language. Use person-first language instead. Describe people as having a condition or circumstance, not being a condition. A case is an instance of disease, not a person. Use patient to refer to someone receiving health care. Humanize those you are referring to by using people or persons.</p>	<ul style="list-style-type: none"> • The obese or the morbidly obese • COVID-19 cases • The homeless • Disabled person • Handicapped • Inmates • Victims • Cases or subjects (when referring to affected persons) • Individuals 	<ul style="list-style-type: none"> • People experiencing (health outcome or life circumstance) • People with obesity; people with severe obesity • Patients or persons with COVID-19 • People who are experiencing (condition or disability type) • Person with mobility disability • Person with vision impairments • People who are experiencing homelessness • Survivors
<p>Remember that there are many types of subpopulations. General use of the term minority/ minorities should be limited, in general, and should be defined when used. Be as specific as possible about the group you are referring to (e.g., be specific about the type of disability if you are not referring to people with any disability type).</p>	<ul style="list-style-type: none"> • Minorities • Minority • Ethnic groups • Racial groups 	<ul style="list-style-type: none"> • Specify the type of subpopulation: <ul style="list-style-type: none"> – (People from) racial and ethnic groups – (People from) racial and ethnic minority groups – (People from) sexual/gender /linguistic/religious minority groups – (People with/living with) mobility/ cognitive/vision/hearing/independent living/self-care disabilities
<p>Avoid saying target, tackle, combat or other terms with violent connotation when referring to people, groups or communities. These terms should also be avoided, in general, when communicating about public health activities.</p>	<ul style="list-style-type: none"> • Target communities for interventions • Target population • Tackle issues within the community • Aimed at communities • Combat (disease) • War against (disease) 	<ul style="list-style-type: none"> • Engage/prioritize/collaborate with/serve (population of focus) • Consider the needs of/Tailor to the needs of (population of focus) • Communities/populations of focus • Intended audience • Eliminate (issue/disease)
<p>Avoid unintentional blaming. Consider the context and the audience to determine if language used could potentially lead to negative assumptions, stereotyping, stigmatization, or blame. However, these terms may be appropriate in some instances.</p>	<ul style="list-style-type: none"> • Workers who do not use PPE • People who do not seek healthcare 	<ul style="list-style-type: none"> • People with limited access to (specific service/resource) • Workers under-resourced with (specific service/resource)

Adapted from: "Health Equity Guiding Principles for Unbiased, Inclusive Communication" (CDC).

13. STRUCTURAL URBANISM AND THE IMPACT ON RURAL WORKFORCE DISPARITIES

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

This report, presented to the House of Delegates as information, complements Council on Medical Education Report 3-Nov-21, “Rural Health Physician Workforce Disparities” and responds to AMA Policy H-465.981[5], “Enhancing Rural Physician Practices,” which states that the AMA “will undertake a study of structural urbanism, federal payment policies, and the impact on rural workforce disparities.” Accordingly, this report provides an overview of structural urbanism, educational efforts to cultivate the rural physician workforce, advocacy efforts to reduce rural workforce disparities and current challenges with federal payment policies specific to volume, coverage, and access.

UNDERSTANDING STRUCTURAL URBANISM AND HEALTH

Structural urbanism in health care is a bias toward large population centers, stemming from three factors: a market orientation in health care, necessitating a critical mass of paying customers to make services viable; a public health focus on changing outcomes at the population level, differentially allocating funding toward large population centers; and the innate inefficiencies of low-population and remote settings, with equal funding rarely translating into equitable funding. Structural urbanism informs policy decisions about where resources are invested, contributing to numerous rural-urban disparities, including within health and medicine. Rural-urban gaps in health outcomes have existed for years, widening in recent decades.¹ Compared to urban areas, individuals in rural areas generally have higher morbidity and mortality rates.²

While definitions of “rural” tend to be inconsistent many definitions utilize components of the US Census Bureau definition which defines rural as “any population, housing, or territory NOT in an urban area.”³ The US Census definition of rural is closely connected with the definition of urban which initially included incorporated places with populations of 2,500 or more and has since expanded to include urbanized areas and urban clusters. Urbanized areas have population of 50,000 or more and urban clusters have populations of at least 2,500 and less than 50,000.⁴

Within rural areas and as rural diversity has increased over time, people identifying as Native American, Latinx, or Black in these communities have reported worse health and experienced more barriers to care⁵ and higher morbidity and mortality rates than white people.^{6,7} For diabetes, hypertension, heart disease, and stroke, annual age-adjusted mortality rates are higher among Black than white adults in both rural and urban areas, with higher rates across the board for rural compared to urban Black adults.⁸ Indigenous pregnant people in rural areas experience about twice as much severe maternal morbidity and mortality as urban white women, demonstrating compounding effects of intersecting marginalized identities.⁹ Several leading factors are associated with disparate rural-urban outcomes. Median income and percent of the population in poverty account for about half the rural-urban difference in age-adjusted premature mortality,¹⁰ highlighting the role of chronic disinvestment in rural communities. Another major factor is reduced access to care related to insufficient public transport, poor availability of broadband services,¹¹ geographically defined health workforce shortages,¹² and growing distance to increasingly consolidated healthcare facilities, including emergency medical services, in rural areas. Rural-urban insurance coverage gaps historically contributing to disparate mortality¹³ recently narrowed in states expanding Medicaid under the Affordable Care Act,¹⁴ but perinatal care Medicaid coverage disruptions remain much higher for rural-dwelling Black, Indigenous, and people of color than urban white people.¹⁵ Hospital closures are associated with more mortality in rural than urban areas, with worse impact on people of color and people insured by Medicaid.¹⁶ The closure of the sole hospital in a rural community reduces per-capita income by about \$700 (4%) and increases the unemployment rate by 1.6 percentage points.¹⁷

Community hospitals are closing in rural areas at around twice the rate of other areas,¹⁸ reflecting declining profitability in rural compared to increases in urban areas.¹⁹ Rural counties with hospital closures increasingly are in the South, and have more Black and Latinx residents, higher income inequality, lower per capita income, and higher unemployment.²⁰ Among rural hospitals in the country, nearly 200 have closed since the early 2000s²¹ and nearly 900 (40%) are at immediate or high risk of closing in the near future,²² with closures subsequently decreasing the local supply of physicians.²³ Among over 7,000 federally designated health professional shortage areas, 3 of 5 are rural.²⁴

In the U.S., 20% of people live, but only 9% of physicians practice, in rural areas,²⁵ with multiple specialties less available than primary care in rural areas,²⁶ rural physicians aging and delaying retirement,²⁷ and over half of rural counties having no surgeon.²⁸ About 99% of Medicare spending on graduate medical education (GME, i.e., residency) goes to urban areas, with physicians often practicing within 100 miles of where they completed training.²⁹ A long-term decline recently put incoming rural students in U.S. medical schools below 5%, and those from rural areas identifying with underrepresented racial or ethnic groups below 0.5%.³⁰ Comprehensive medical school rural programs and osteopathic programs generate graduates more likely to practice rural primary care, while international medical graduates are more likely to practice primary care in rural persistent poverty locations.^{31,32} Structural urbanism helps to better understand these phenomena. Scholars suggest structural urbanism can be overcome administratively through input from rural residents (including those with additional marginalized or minoritized identities) on regulation and implementation, and legislatively through evidence-based policies that address social drivers through infrastructure investment.^{33,34}

CULTIVATING THE PHYSICIAN WORKFORCE IN RURAL COMMUNITIES

Cultivating physician leaders uniquely qualified to advocate for rural communities is essential to achieving equitable legislation and regulations. Students raised in rural areas, identifying with minoritized racial or ethnic groups, doctors of osteopathic medicine (DO) or international medical graduates (IMG), are most likely to practice in medically underserved areas, including rural communities. Changes in immigration policy can affect the supply of IMGs.³⁵ Board of Trustees Report 11-I-22, “2022 Advocacy Efforts” discusses AMA’s current advocacy efforts to address immigration barriers that may negatively impact efforts to resolve the physician workforce shortage and preserve patient access to care. Fordyce, et al., found that while DOs comprised 4.9% and IMGs 22.2% of the total clinically active workforce, they contributed 10.4% and 19.3%, respectively, to the rural PCP workforce, although their relative representation varied geographically. Additionally, DO PCPs were more likely than allopathic PCPs to practice in rural places (20.5% versus 14.9%, respectively) and IMG PCPs were more likely than other PCPs to practice in rural persistent poverty locations (12.4% versus 9.1%). They also found that the proportion of rural PCP workforce represented by DOs increased with increasing rurality and that of IMGs decreased.³⁶ This finding supports prioritizing these groups as an important recruitment strategy for rural medical school programs to boost the rural physician workforce.^{37,38} While investments in recruiting and retaining students from these groups has been successful in cultivating the rural physician workforce, Rabinowitz, et al., found that it was also necessary to invest in rural medical school programs as these programs have a significant impact on rural family physician and primary care supply. The research suggests that wider adoption of rural programs would substantially increase access to care in rural areas beyond increased reliance on IMGs.³⁹

Early exposure to careers in medicine and physician role models in the community bolsters students’ interest in pursuing careers in medicine and may support increasing the number of rural applicants to medical school. Science and technology enrichment programs in middle school and health professions recruitment and exposure programs in high school can effectively cultivate an interest in careers in medicine for groups historically excluded and underrepresented, including rural students, influencing positive perceptions of achieving a successful career.⁴⁰

Additionally, physicians practiced longer in a rural environment when they felt better prepared medically and socially and were initially aware of the special characteristics of rural practice.⁴¹ Attending a medical school that is osteopathic, has a mission to train rural physicians, or includes rural components such as rural rotations increases the likelihood of choosing rural practice.⁴² More than 40 medical schools have rural tracks to increase physicians practicing in rural communities.

For example, the University of Washington School of Medicine: Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) Program developed the Targeted Rural Underserved Track (TRUST) initiative to ensure access to health care in rural and underserved areas. TRUST utilizes an innovative curriculum that matches incoming medical students with a mentor and a community in a rural environment to connect with over four years. TRUST aims to select students with rural and underserved backgrounds who are most likely to return to these areas. Students are also encouraged to choose specialties that serve those areas, generally in primary care.

AMA is also investing in cultivating the physician workforce in rural communities. The AMA Reimagining Residency grant program awarded Oregon Health & Science University (OHSU) and the University of California, Davis (UC Davis) \$1.8 million to create educational interventions to expand access to quality health care between Sacramento and Portland through a network of mostly rural teaching hospitals and clinics. OHSU and UC Davis partnered to

establish a GME collaborative known as the California Oregon Medical Partnership to Address Disparities in Rural Education and Health (COMPADRE). COMPADRE places hundreds of medical students and resident physicians in positions to train with faculty and community physicians at 10 health care systems, 16 hospitals, and a network of Federally Qualified Health Center partners. COMPADRE aims to address health care workforce shortages in rural, tribal, urban, and other communities that lack resources; increase access to physicians; and improve the health of patients from minoritized ethnic and racial groups disproportionately affected by certain health conditions.⁴³

Additionally, the AMA Reimagining Residency initiative awarded \$1.8 million over five years to the University of North Carolina (UNC) School of Medicine to support the significant expansion of the Fully Integrated Readiness for Service (FIRST) Program to new geographic areas of North Carolina and additional highly needed specialties including family medicine, general surgery, pediatrics, and psychiatry. The FIRST Program was founded in 2015 to link family medicine workforce pathways from medical school to residency and to service in rural/underserved areas. Participating students can complete their medical degree in three years, followed by the opportunity for placement with the Family Medicine Residency program of North Carolina. FIRST scholar graduates commit to three years of service in an underserved area of the state, during which time they receive ongoing support from UNC Family Medicine in partnership with the NC Office of Rural Health and Community Care, AHEC, Piedmont Health Services, and the North Carolina Academy of Family Physicians.

RELEVANT AMA ADVOCACY TO REDUCE RURAL WORKFORCE DISPARITIES

In addition to sponsoring medical education initiatives in rural communities, AMA remains steadfast in our advocacy efforts to support medical students, residents, and physicians in rural communities. Below are recent advocacy activities related to reducing rural workforce disparities:

- On August 29, 2022, the AMA provided [comments](#) on the Centers for Medicare & Medicaid Services Conditions of Participation for Rural Emergency Hospitals (REH) and Critical Access Hospital (CoP) Updates Proposed Rule. The AMA supports the goals and understands the importance of the Proposed Rule to ensure equitable access to high quality care in rural communities, as rural hospitals continue to close leaving vast care deserts.
- On July 29, 2022, the AMA [provided information](#) regarding the Department of Health and Human Services' (HHS) Initiative To Strengthen Primary Health Care.
- On June 23, 2022, the AMA sent a [letter](#) in support of S. 4330, the "Specialty Physicians Advancing Rural Care (SPARC) Act," which would amend the Public Health Service Act to authorize a loan repayment program to encourage specialty medicine physicians to serve in rural communities experiencing a shortage.
- On February 25, 2022, the AMA sent a [letter](#) to the Centers for Medicare & Medicaid Services (CMS) commenting on the 2022 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS), focused on Graduate Medical Education (GME).
- On January 6, 2022, the AMA supported the Primary Care Physician Reentry Act of 2022, a bill establishing a demonstration program to facilitate physician reentry into clinical practice to provide primary care services.
- In December 2021, the AMA provided verbal support and a press release supporting Rep. Tom Cole's bipartisan S.3497, "Medical Student Education Authorization Act" that would authorize HRSA's Medical Student Education program for five years. The program provides grants to public institutions of higher education to expand or support graduate education for medical students preparing to become physicians in the top quintile of states with a projected primary care provider shortage in 2025. There is a focus on rural, Tribal, and medically underserved communities.
- On September 21, 2021, the AMA [provided information](#) on the Public Service Loan Forgiveness (PSLF) program. Regarding PSLF, the AMA urged the Department of Education to consider the importance of the program for physician borrowers, making the program more widely available to physician borrowers, and providing stronger communication to borrowers to support successful completion of the program.

- On September 1, 2021, the AMA joined a [letter](#) urging Congress to include policies that would increase Medicare support for GME in the budget reconciliation legislation and reinforcing our support for the Resident Physician Shortage Reduction Act of 2021.
- In September 2021, the AMA provided verbal support for Chairman Richard Neal’s S. 3376, “Pathways to Practice Act” which would provide additional funding for the recruitment, education, and training of medical students willing to work in underserved communities.
- On July 1, 2021, the AMA sent a [letter](#) supporting H.R. 4122, the “Resident Education Deferred Interest (REDI) Act,” which would allow borrowers to qualify for interest-free deferment on their student loans while serving in a medical or dental internship or residency program.
- On June 28, 2021, the AMA joined a [letter](#) urging CMS to finalize the Alternative 2 methodology in the FY 2022 Inpatient Prospective Payment System (IPPS) proposed rule, with modifications, and increase the number of full time equivalent (FTE) slots awarded per hospital for FY 2023 and all succeeding years.
- On June 28, 2021, the AMA provided [comments](#) about how the new 1,000 GME slots should be distributed.
- On June 23, 2021, the AMA sent a letter ([Senate](#) and [House](#)) voicing our support for the Physician Shortage GME Cap Flex Act of 2021. This legislation would help to address our national physician workforce shortage by providing teaching hospitals an additional five years to set their Medicare Graduate Medical Education (GME) cap if they establish residency training programs in primary care or specialties that are facing shortages.
- On June 10, 2021, the AMA sent a [letter](#) voicing our support for the “Doctors of Community (DOC) Act,” that would permanently authorize the Teaching Health Center Graduate Medical Education (THCGME) program. This legislation is vitally important in ensuring that patients in underserved areas continue to have access to the care they need.
- On May 18, 2021, the AMA signed onto a [letter](#) asking that federal support for physician training be included in upcoming legislative efforts to improve the nation’s infrastructure and reaffirming our support for the Resident Physician Shortage Reduction Act of 2021, which asks for 14,000 additional Medicare-supported GME positions.
- On April 8, 2021, the AMA sent a [letter](#) supporting S. 924, the “Rural America Health Corps Act,” that would establish a demonstration program to provide payments on qualified loans for individuals eligible for but not currently participating in the National Health Service Corps (NHSC) Loan Repayment Program who agree to a five-year period of obligated full-time service in a rural health professional shortage area.
- On March 24, 2021, the AMA joined a [letter](#) supporting the Resident Physician Shortage Reduction Act of 2021, that would gradually raise the number of Medicare-supported GME positions by 2,000 per year for seven years, for a total of 14,000 new slots. A share of these positions would go to hospitals with diverse needs including hospitals in rural areas, hospitals serving patients from health professional shortage areas (HPSAs), hospitals in states with new medical schools or branch campuses, and hospitals already training over their caps. This bipartisan legislation is crucial to expanding the physician workforce and to ensuring that patients across the country are able to access quality care from providers.
- On February 9, 2021, the AMA wrote a [letter](#) voicing support for S. 54, the “Strengthening America’s Health Care Readiness Act,” that would provide additional funding for the National Health Service Corps (NHSC), the Nurse Corps, and establish a National Health Service Corps Emergency Service demonstration project. The COVID-19 pandemic has highlighted the need for additional emergency capacities and underscored the health workforce shortages and disparities that exist throughout the nation. This bill would bring access to care for patients and welcome relief to the physicians, residents, and nurses who have been on the front lines throughout the pandemic caring for our sickest patients.
- On January 28, 2021, the AMA joined a [letter](#) supporting the Strengthening America’s Health Care Readiness Act, that would support the NHSC and Nurse Corps programs to meet the challenges highlighted by the COVID-19 pandemic, providing a onetime, supplemental appropriation for scholarship and loan forgiveness awards to address health provider shortages and gaps in our health care system, while investing in the pipeline of future

health providers. This will help to address longstanding health care shortages and bolster emergency surge capacity when support and providers are desperately needed.

- On January 27, 2021, the AMA joined a [letter](#) thanking the Senate for investing in physician training by adding 1,000 new Medicare-supported graduate medical education (GME) positions in the Consolidated Appropriations Act, 2021.
- On June 24, 2020, the AMA voiced support for the Strengthening America's Health Care Readiness Act which increases supplemental funding for the NHSC by \$10 billion. This increased funding will be used for additional loan repayment and scholarship programs. Moreover, the bill contains a 40% set aside and provides mentoring and early recruitment for people identifying with historically underrepresented groups in the health care field. Additionally, the bill provides \$50 million for a National Disaster Medical System (NDMS) pilot program which would bolster health emergency surge capacity.

CURRENT CHALLENGES WITH FEDERAL PAYMENT POLICIES FOR RURAL PHYSICIAN SERVICES

Understanding of current rural physician workforce disparities includes the physician payment system that limits compensation. From the 1970s to 1992, the basic pattern of Medicare physician payments was frozen based on variously defined “customary, prevailing, and reasonable” charges. Compensation stagnated even as innovations in clinical practice and technology spread beyond urban centers, with very different Medicare payment rates in neighboring regions with similar practice costs for the same services.

In the late 1980s, Harvard University developed an initial resource-based relative value scale (RBRVS) to move from historical charges to a standardized national payment system grounded in relative differences in the resources needed to deliver physician services. The AMA supported RBRVS and called for national payment amounts to be adjusted to reflect geographic differences in physicians' practice costs, such as office rent, wages of nonphysician personnel, and professional liability insurance. Congress adopted this policy and also called for geographic adjustments to reflect one-quarter of the differences in cost-of-living between Medicare payment localities. Three Geographic Practice Cost Indexes (GPCIs) were developed to make these adjustments. RBRVS reduced the range of variation in payment rates for the same service in different communities from 300 percent or more to within 10 to 15 percent. Physicians in rural areas have continued to face significant challenges with the way Medicare rates are adjusted for geographic differences.⁴⁴

The most controversial GPCI is the work GPCI, which adjusts payments based on differences in costs-of-living as measured by differences in earnings of college-educated workers. Although the work GPCI is based on one-quarter of these earnings differences, rural physicians have long believed that it is inappropriate for Medicare payments to reflect these differences at all. To help address these concerns, beginning in 2004, Congress enacted legislation that has been continuously renewed placing a floor of 1.00 on the work GPCI. This floor has the effect of preventing any Medicare payment locality's geographic adjustment for work relative value units from being lower than the national average of 1.00. Geographic adjustments have continued to be the focus of considerable debate. Physicians in rural areas have argued that the GPCIs do not capture important dimensions of their practice costs and cause their Medicare payment rates to be too low, especially relative to urban areas. It is difficult to achieve consensus on significant changes to the GPCIs because, like the other elements of the Medicare payment schedule, the GPCIs are required to be budget neutral from year to year. This means that any GPCI changes that benefit rural areas reduce payments in non-rural areas.

Another problem has been that patients who live in rural areas have traditionally been more likely to be insured by public programs such as Medicare and Medicaid, which may have lower physician payment rates than commercial insurers. Rural physicians' payer mix may leave them with lower average revenue per patient than in communities with more privately insured patients. Also, total volume of services may be lower due to lower population density as well as increased physician travel time between care facilities making it difficult to cover costs. To help address this, Medicare provides bonus payments on top of the regular Medicare payment amounts for services delivered in primary care and mental health care Health Care Professional Shortage Areas (HPSAs). If the patient resides in a HPSA but receives services from a physician office that is not located in the HPSA, the bonus is not added. In addition, Medicare's Quality Payment Program has a low-volume threshold which allows physicians to be exempt from this quality reporting requirement. There are emerging opportunities to incorporate area-based social risk factors into alternative payment models (e.g., through Medicare Advantage program changes, Innovation Center models in

Medicare Advantage or fee-for-service, or Medicaid). These area-based approaches use the sociodemographic data of a geographic area, encompassing the patient's place of residence, to enhance reimbursement to help address health-related social needs, which could be of benefit for rural populations and the physicians serving them. There is no overarching Medicare payment policy aimed at helping rural physicians maintain their practices if they provide a relatively low volume of services.

The dramatic increase in provision of telehealth services from the start of the COVID-19 pandemic helped patients in rural areas connect with physicians, reducing transportation and distance barriers, but also highlighted a lack of access to the connectivity necessary for audio-visual telehealth services. The AMA played a leading role in aggressively advocating for Medicare to begin covering the CPT codes for telephone visits and provided implementation guides to enable physicians to successfully incorporate telehealth into their practices. Many patients in rural communities, including many who identify as Native American or Black, have neither the connectivity nor the equipment needed for audio-visual telehealth and had to rely on landlines to access health services during the pandemic. The AMA has been advocating for audio-only visits to continue to be available after the COVID-19 Public Health Emergency ends, but to date Medicare has not adopted this policy.

In addition, prior to the COVID-19 PHE, although Medicare paid for telehealth services when they were provided to patients in rural areas, Medicare's telehealth policies did not provide adequate support for services provided by specialists. During the PHE, AMA advocacy efforts were instrumental in getting about 150 services added to the Medicare telehealth list, including services that are often provided by specialists such as emergency medicine, critical care, home visits, portions of radiation oncology treatment services, eye exams, and telephone visits. In addition, patients were able to get telehealth services in their homes or wherever they were located instead of having to go to a medical facility. It is not yet clear which of these positive changes will become permanent, but the dramatic increase in adoption of telehealth services and the continuing development of hybrid models that combine in-person, telehealth, remote monitoring and other digital services is likely to continue to improve rural patients' access to specialist services when they do not have enough of the needed specialists physically available in their community.

CONCLUSION

The AMA remains committed to improving rural health and cultivating the current and future rural physician workforce by advocating for equitable access to high quality care in rural communities and investing in initiatives to expand training opportunities in rural medical schools, teaching hospitals, and clinics.

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APPENDIX – Relevant AMA Policy

H-465.981, Enhancing Rural Physician Practices

Our AMA: (1) supports legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status; (2) encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements; (3) will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result; (4) supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders; and (5) will undertake a study of structural urbanism, federal payment policies, and the impact on rural workforce disparities.

H-465.978, Recognizing and Remediating Payment System Bias As a Factor in Rural Health Disparities

1. Our AMA recognizes that systemic bias in healthcare financing has been one of many factors leading to rural health disparities and will advocate for elimination of these biases through payment policy reform to help reduce the shortage of rural physicians and eliminate health inequities in rural America.
2. Our AMA will, as part of our current advocacy for telehealth reform, specify that geographic payment equity be required in any telehealth legislation.

D-400.989, Equal Pay for Equal Work

Our AMA: (1) shall make its first legislative priority to fix the Medicare payment update problem because this is the most immediate means of increasing Medicare payments to physicians in rural states and will have the greatest impact; (2) shall seek enactment of legislation directing the General Accounting Office to develop and recommend to Congress policy options for reducing any unjustified geographic disparities in Medicare physician payment rates and improving physician recruitment and retention in underserved rural areas; and (3) shall advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system and that continued budget neutrality is not an option.

H-200.954, US Physician Shortage

Our AMA:

- (1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
- (2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
- (3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
- (4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
- (5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
- (6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
- (7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;
- (8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
- (9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
- (10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
- (11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
- (12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in

clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.
(13) will work to augment the impact of initiatives to address rural physician workforce shortages.

H-465.994, Improving Rural Health

1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public. 2. Our AMA will work with other entities and organizations interested in public health to: Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities. Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health. Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities. Advocate for adequate and sustained funding for public health staffing and programs. Policy Timeline Sub. Res. 72, I-88 Reaffirmed: Sunset Report, I-98 Reaffirmed: CLRPD Rep. 1, A-08 Reaffirmed: CEJA Rep. 06, A-18 Appended: Res. 433, A-19 Modified: CSAPH Rep. 2, A-22

H-290.997, Medicaid – Towards Reforming the Program

Our AMA believes that greater equity should be provided in the Medicaid program, through adoption of the following principles: (1) the creation of basic national standards of uniform eligibility for all persons below poverty level income (adjusted by state per capita income factors); (2) the creation of basic national standards of uniform minimum adequate benefits; (3) the elimination of the existing categorical requirements; (4) the creation of adequate payment levels to assure broad access to care; and (5) establishment of national standards that result in uniform eligibility, benefits and adequate payment mechanisms for services across jurisdictions. Policy Timeline BOT Rep. UU, A-88 Reaffirmed: CMS Rep. G, A-93 Reaffirmation I-96 Reaffirmation A-00 Reaffirmed: BOT Action in response to referred for decision Res. 215, I-00 Reaffirmation A-05 Reaffirmed: Res. 804, I-09 Reaffirmed: CMS Rep. 01, A-19 Reaffirmed: CMS Rep. 3, A-21.

D-290.979, Medicaid Expansion

Our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded. 2. Our AMA will: (a) continue to advocate strongly for expansion of the Medicaid program to all states and reaffirm existing policies D-290.979, H 290.965 and H-165.823; and (b) work with interested state medical associations and national medical specialty societies to provide AMA resources on Medicaid expansion and covering the uninsured to health care professionals to inform the public of the importance of expanded health insurance coverage to all. Policy Timeline Res. 809, I-12 Reaffirmed: CMS Rep. 02, A-19 Reaffirmed: CMS Rep. 5, I-20 Reaffirmed: CMS Rep. 3, A-21 Reaffirmed: CMS Rep. 9, A-21 Reaffirmed: CMS Rep. 3, I-21 Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21 Appended: Res. 122, A-22

D-385.952, Alternative Payment Models and Vulnerable Populations

Our AMA: (1) supports alternative payment models (APMs) that link quality measures and payments to outcomes specific to vulnerable and high-risk populations and reductions in health care disparities; (2) will continue to encourage the development and implementation of physician-focused APMs that provide services to improve the health of vulnerable and high-risk populations; and (3) will continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of health to avoid penalizing physicians whose performance and aggregated data are impacted by factors outside of the physician's control.

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

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

HOUSE ACTION: RECOMMENDATIONS ADOPTED REMAINDER OF REPORT FILED

See Policy D-600.984

The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) required to submit information and materials for the 2022 American Medical Association (AMA) Interim Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020,

“Summary of Guidelines for Admission to the House of Delegates for Specialty Societies,” and AMA Bylaw 8.5, “Periodic Review Process.”

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

The following organizations were reviewed for the 2022 Interim Meeting:

American Association of Neuromuscular & Electrodiagnostic Medicine
American College of Rheumatology
American Society for Dermatologic Surgery Association
American Society for Radiation Oncology
American Society for Surgery of the Hand
American Society of Maxillofacial Surgeons
Association for Clinical Oncology
Radiological Society of North America
Society for Vascular Surgeons
Society of American Gastrointestinal Endoscopic Surgeons
Society of Nuclear Medicine and Molecular Imaging
Society of Thoracic Surgeons

Each organization was required to submit materials demonstrating compliance with the guidelines and requirements along with appropriate membership information. A summary of each group’s membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty society representation in the AMA HOD (Exhibit B), the five responsibilities of national medical specialty organizations and professional medical interest associations represented in the HOD (Exhibit C), and the AMA Bylaws pertaining to the five-year review process (Exhibit D) are also attached.

The materials submitted indicate that: the American Association of Neuromuscular & Electrodiagnostic Medicine, American College of Rheumatology, American Society for Dermatologic Surgery Association, American Society for Radiation Oncology, American Society for Surgery of the Hand, American Society of Maxillofacial Surgeons, Association for Clinical Oncology, Radiological Society of North America, Society for Vascular Surgeons, Society of American Gastrointestinal Endoscopic Surgeons, and the Society of Thoracic Surgeons meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicate that the Society of Nuclear Medicine and Molecular Imaging did not meet all guidelines and is not in compliance with the five-year review requirements of specialty organizations represented in the HOD.

RECOMMENDATIONS

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

1. The American Association of Neuromuscular and Electrodiagnostic Medicine, American College of Rheumatology, American Society for Dermatologic Surgery Association, American Society for Radiation Oncology, American Society for Surgery of the Hand, American Society of Maxillofacial Surgeons, Association for Clinical Oncology, Radiological Society of North America, Society for Vascular Surgeons, Society of American Gastrointestinal Endoscopic Surgeons, and the Society of Thoracic Surgeons retain representation in the American Medical Association House of Delegates.
2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5 the Society of Nuclear Medicine and Molecular Imaging be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership.

APPENDIX

Exhibit A - Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership
American Association of Neuromuscular & Electrodiagnostic Medicine	545 of 2,614 (21%)
American College of Rheumatology	957 of 4,753 (20%)
American Society for Dermatologic Surgery Association	1,921 of 5,863 (33%)
American Society for Radiation Oncology	860 of 3,890 (22%)
American Society for Surgery of the Hand	488 of 2,292 (21%)
American Society of Maxillofacial Surgeons	56 of 217 (26%)
Association for Clinical Oncology	3,907 of 18,400 (21%)
Radiological Society of North America	1,741 of 13,989 (12%)
Society for Vascular Surgery	562 of 2,738 (20%)
Society of American Gastrointestinal Endoscopic Surgeons	862 of 4,282 (20%)
Society of Nuclear Medicine and Molecular Imaging	211 of 1,285 (16%)
Society of Thoracic Surgeons	1,101 of 5,373 (20%)

Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (Policy G-600.020)

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.
2. The organization must:
 - (a) represent a field of medicine that has recognized scientific validity;
 - (b) not have board certification as its primary focus; and
 - (c) not require membership in the specialty organization as a requisite for board certification.
3. The organization must meet one of the following criteria:
 - (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
 - (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
 - (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.
4. The organization must be established and stable; therefore, it must have been in existence for at least five years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those physician members who are current in payment of applicable dues, and eligible to serve on committees or the governing body
7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

Exhibit C

8.2 Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations. Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:

- 8.2.1 To cooperate with the AMA in increasing its AMA membership.
- 8.2.2 To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.
- 8.2.3 To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.
- 8.2.4 To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.
- 8.2.5 To provide information and data to the AMA when requested.

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

8 - Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates

8.5 Periodic Review Process. Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society, or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.

- 8.5.1 If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting or may take such other action as it deems appropriate.
- 8.5.2 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.
- 8.5.3 Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.
 - 8.5.3.1 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.
 - 8.5.3.2 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:
 - 8.5.3.2.1 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.
 - 8.5.3.2.2 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant

to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

Preliminary Draft
Pending Policy Numbers

REPORT OF THE SPEAKERS

The following report was presented by Bruce A. Scott, MD, Speaker; and Lisa Bohman Egbert, MD, Vice Speaker:

1. ELECTION COMMITTEE - INTERIM REPORT

Reference committee hearing: see report of Reference Committee F.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED**
See Policy TBD

The House of Delegates voted to create an Election Committee (EC) as part of the reforms adopted at the June 2021 Special Meeting. Current Policy D-610.998, paragraph 9, states, "The Election Committee will review the Campaign Complaint Reporting, Validation and Resolution Process as implemented and make further recommendations to the House as necessary." This report of your Election Committee reviews the background of the creation of the EC, provides information regarding the current processes followed by the committee, and makes recommendations to further clarify and codify these processes.

BACKGROUND

At the 2019 Annual Meeting of the House of Delegates the House adopted policy calling on the Speaker to appoint a task force for the purpose of recommending improvements to the AMA HOD election and campaign process. The task force, known as the Election Task Force or ETF, was given broad purview with a plan to report their recommendations back to the HOD for action. The ETF presented a preliminary report at I-19 and held an open forum to hear concerns.

The task force presented their full report, Speakers Report 2: Report of the Election Task Force, with 41 recommendations at the June 2021 Special Meeting (the relevant portion from the report regarding the Election Committee is attached as Appendix A). 39 of the ETF recommendations were adopted by the HOD with broad support, including Recommendations 38 - 40 recommending the creation of an Election Committee (Note: A recommendation regarding interviews was referred, and a recommendation calling for the members of the Council on Constitution & Bylaws to be appointed was not adopted):

Recommendation 38: In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 7 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime maximum tenure of 8 terms) to report to the Speaker. These individuals would agree not to be directly involved in a campaign during their tenure and would be appointed from various regions, specialties, sections, and interest groups. The primary role of the committee would be to work with the Speakers to adjudicate any election complaint. Additional roles to be determined by the Speaker and could include monitoring election reforms, considering future campaign modifications and responding to requests from the Speaker for input on election issues that arise (New Policy).

Recommendation 39: The Speaker in consultation with the Election Committee will consider a more defined process for complaint reporting, validation, resolution, and potential penalties. This process will be presented to the House for approval (New Policy).

Recommendation 40: Policy G-610.020, Rules for AMA Elections, paragraph 1 be amended by addition to read as follows:

(1) The Speaker and Vice Speaker of the House of Delegates are responsible for overall administration of our AMA elections, although balloting is conducted under the supervision of the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker will advise candidates on allowable activities and when appropriate will ensure that clarification of these rules is provided to all known candidates. The Speaker, in consultation with the Vice Speaker and the Election Committee, is responsible for declaring a violation of the rules.

Also of note was Recommendation 41 calling for a review of the modified election processes after an interval of two years (after A-23).

The EC Report and Referral for Decision to the Board of Trustees

Pursuant to Recommendation 38 (Policy D-610.998) the Speaker appointed the initial House of Delegates Election Committee (EC) made up of 7 members of the House who volunteered to serve and agreed to not participate in campaigns during their tenure on the EC. As directed by the adopted policy (original recommendation 39), the EC presented a report ("Speakers' Report 2: Establishing an Election Committee," here forward referred to as the "EC Report," see Appendix B) at the November 2021 Special Meeting proposing a process by which the Speakers and the Election Committee would handle allegations of rules violations.

The EC Report provided details regarding complaint reporting, validation, resolution, and potential penalties and further proposed that the Speakers would work with but not be actual members of the committee. In general, the report received positive comments, but during the HOD deliberations, questions about the role of the Speakers on the committee and the Speakers' role in adjudicating allegations led to the matter being referred for decision.

Testimony heard at the House favored a more active role for the Speakers. The Board concluded because our policy (G-610.020) and tradition call for the Speaker to have oversight of elections, it was appropriate for the Speakers (unless conflicted) to serve as full voting members of the EC.

Some testimony suggested that the Speaker should be the final arbiter of a complaint, while others pointed out that situations could arise where the Speaker may be conflicted. The Board concluded that no single individual, including the Speaker, should be the lone arbiter of a complaint. The responsibility and authority for validation of a complaint and determination of resolution should rest with the Election Committee, a cross section of the House, reflecting the fact that the House of Delegates determines its procedures, among which are election-related matters.

In their review, the Board noted that while the body of the EC Report provided detailed information regarding complaint reporting, validation, and resolution for possible campaign violations, these details were not specified in the formal recommendations adopted by the House. The EC Report detailed that when a complaint was received, the Speaker would consult with the committee chair to form a subcommittee of three members to investigate the allegation. The subcommittee of the EC would be selected to avoid conflicts (e.g., being part of the same delegation as the alleged violator). Using necessary discretion, the subcommittee would investigate the complaint and when necessary, the Office of General Counsel or the HOD Office would assist. The subcommittee would report to the full EC the results of their investigation, with the final determination to be made by the full committee with any potentially conflicted members recused. No objections to these series of actions as presented in the EC Report were heard during testimony. The Board concurred with the described process, with minor clarification, and determined that the process should be codified in policy.

As discussed in the report (Appendix B), historically the only formal penalty for a campaign violation was announcement of the violation to the House by the Speaker. The report went on to state that this singular penalty may be excessive for some violations and thus the committee, in considering mitigating circumstances and the severity of the violation, should be allowed other options to resolve a validated violation. The EC also noted that an exhaustive list of potential violations would be an impossible task to compile and further that a list of associated penalties would be too rigid and ill advised. Consequently, the EC recommended that it be given discretion to determine the appropriate sanction for a validated complaint, with the option of announcement to the House remaining.

The Board agreed that in many circumstances resolution may be accomplished by corrective action, short of announcement to the House, and that the EC be allowed discretion to determine the appropriate resolution of a given validated complaint with announcement to the House of a violation remaining an option for violations that are deemed to rise to that level. In these most significant violations the House of Delegates, through their vote in the election, would remain the final arbiter. In addition, a record of all filed complaints and the results of the validation and the resolution processes should be maintained by the General Counsel and kept confidential within the EC unless the committee determined that the violation should be reported to the House. Again, the Board determined these details should be specified in policy.

No testimony was provided in the House regarding the process for reporting potential campaign violations. The Board concurred that individuals to whom potential campaign violations could be reported should include the Speakers who have traditionally been the recipients of such, but complainants should also have an option to report to the General

Counsel. This third option of reporting might prevent awkward situations where one or both Speakers were potentially conflicted.

Action by the Board of Trustees

At their February 2022 meeting the Board officially adopted the following:

1. That Paragraph 5 of Policy D-610.998, "Directives from the Election Task Force," be amended by addition to read as follows:
 5. In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 7 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime maximum tenure of 8 terms) to report to the Speaker. These individuals would agree not to be directly involved in a campaign during their tenure and would be appointed from various regions, specialties, sections, and interest groups. The primary role of the committee would be to work with the Speakers to adjudicate any election complaint. Additional roles to be determined by the Speaker and could include monitoring election reforms, considering future campaign modifications and responding to requests from the Speaker for input on election issues that arise. **The Speaker and Vice Speaker shall be full members of the Election Committee.** (*emphasis added*)
2. A Campaign Complaint Reporting, Validation and Resolution Process shall be established as follows: Campaign violation complaints should be directed to the Speaker, the Vice Speaker, or the AMA General Counsel and should include the following details:
 - The name of the person(s) thought to have violated the rules
 - The date of the alleged violation and the location if relevant
 - The specific violation being alleged (i.e., the way the rules were violated)
 - The materials, if any, that violate the rules; original materials are preferred over copies. Where necessary, arrangements for collection of these materials will be made.
3. Campaign violation complaints will be investigated by the Election Committee or a subcommittee thereof.
 - a. The Committee will collectively determine whether a campaign violation has occurred.
 - b. For validated complaints, the Committee will determine appropriate penalties, which may include an announcement of the violation by the Speaker to the House.
 - c. Committee members with a conflict of interest may participate in discussions but must recuse themselves from decisions regarding the merits of the complaint or penalties.
 - d. Deliberations of the Election Committee shall be confidential.
 - e. The Speaker shall include a summary of the Election Committee's activities in "Official Candidate Notifications" sent to the House. Details may be provided at the discretion of the Election Committee and must be provided when the penalty includes an announcement about the violator to the House.
4. A record of all complaints and the results of the validation and the resolution processes, including penalties, shall be maintained by the AMA Office of General Counsel and kept confidential.
5. The Election Committee will review the Campaign Complaint Reporting, Validation and Resolution Process as implemented and make further recommendations to the House as necessary.

The final policy was recorded in PolicyFinder (see Policy [D-610.998](#)).

REVIEW OF ELECTION COMMITTEE ACTIVITY

After appointment by the Speakers, the committee met virtually to discuss their role and reviewed the election rules. The committee prepared the EC Report (discussed above) and presented the report to the House of Delegates at the November 2021 Special Meeting. As noted above, the report was referred to the Board of Trustees for decision. Subsequently, the Board adopted the process detailed above.

In early 2022 the Speakers sent communications to candidates and their campaign teams detailing the campaign rules as adopted by the HOD in June 2021. These were also included in the Election Manual. Note the EC did not modify any of the campaign rules adopted by the House of Delegates.

As the elections at A-22 approached the Speakers responded to multiple inquiries from candidates and their campaign teams regarding the election rules. A summary of the inquiries and responses was sent to all candidates and their campaign teams to ensure that all had the same information. The *Speakers' Letter* also included the election rules.

The EC has now completed a single campaign and election cycle. The Speaker reappointed 6 members of the committee (a single member was unavailable for reappointment) and appointed a new member from volunteers who submitted applications. The newly constituted committee has met to review the election process as implemented and discuss possible improvements. This report is the first report of the 2022-2023 Election Committee.

DISCUSSION

The EC reviewed the process for complaint reporting, validation, and resolution as established by the HOD and BOT. The committee believes the process, as defined by AMA policy, provides an appropriate matrix for handling reported campaign violations, and recommends additions and communication of the process.

At A-22 the committee elected to involve the General Counsel and the Director of the Office of HOD Affairs in investigating a complaint, as was suggested in the EC Report. The EC believes the option of including the GC and Director should be added to the formal process specified in AMA policy.

It has been suggested that due process demands that the accused be made aware of the accusations against them and given an opportunity to respond. While not specified in current policy, this suggestion comports with the process followed by the committee. The EC recommends that it be made explicit in policy given its inherent reasonableness and fundamental fairness.

The EC Report from November 2021 (Appendix B) reviewed the option of specified penalties and concluded that creation of a "menu" of penalties would not be possible or prudent. The report discussed principles that would be applied in consideration of sanctions, including the timing of the offense, the advantage sought or gained, and the culpability of the candidate themselves. Policy D-610.998, paragraph 7b, codifies the role of the committee in determining appropriate penalties. Allowing some discretion for the EC, which is made up of a cross section of informed delegates, allows consideration of nuance and mitigating or extenuating circumstances.

Current policy and precedent provide for announcement to the HOD of validated campaign violations that are deemed most serious. Neither AMA policy nor Bylaws provide for removal of a candidate from an election. Announcement to the House maintains the appropriate role of the HOD as the final arbiter by their vote in the associated or relevant election. The EC reviewed these issues and favors the current policy, allowing the House to remain the final arbiter of serious violations. The committee does not seek the authority to remove a candidate.

Anonymity of complainants and confidentiality of deliberations is a basic tenet of claims of malfeasance and is specified in our rules. The desire for more information regarding serious accusations is understandable, but such disclosure would be problematic. It would seem unwieldy to expect complete disclosure. Any summary would invite accusations of bias or being misleading. In addition, disclosure could be embarrassing or even damaging to individuals interviewed solely to ensure a thorough and fair investigation. Knowing that such disclosure would be made would likely cause individuals to hesitate to cooperate in providing information, particularly if corroborating an allegation. While one would hope that ethics and professionalism alone would support truthful cooperation, the EC has no ability to compel individuals to cooperate with an investigation, and individuals do not testify under oath. Although not a jury, the EC is selected from experienced colleagues within the House who have agreed not to be involved in campaigns during their tenure on the committee and to recuse themselves if they have any potential conflict of interest in consideration of a complaint. The EC believes that while a record of all complaints and the results of the validation and the resolution processes should be maintained within the Office of the General Counsel, the committee deliberations should remain confidential and therefore, recommends no change to paragraph 8 of Policy D-610.998.

Prior to 2021 and the establishment of the Election Committee, election complaints were handled by a single individual, the Speaker, without any defined process. Our recently adopted House policy empowers the committee to

“work with the Speakers to adjudicate any election complaint,” calling this the primary role of the committee. Further, AMA policy defines the process to be followed. Vesting such authority in the committee places trust that the individuals will carefully and fairly adjudicate any complaint.

The policy that established the EC and our AMA campaign rules do not provide for oversight of delegations or caucuses beyond the fact that candidates themselves are held responsible for the actions of their campaign teams. In fact, our AMA has no clear authority over caucuses, which exist as independent entities and in some cases incorporated entities. The committee has heard that announcement of a violation may be perceived as damaging to a caucus or entire delegation, with or without their involvement. As such, it has been suggested that the leadership of a caucus or delegation be made aware whenever an allegation suggests the involvement of the group. While the EC does not seek broader oversight over delegations or caucuses, this request for notification and an opportunity to respond is considered reasonable and a recommended addition to policy.

Paragraph 5 of Policy D-610.998 calls for the Speaker to appoint an Election Committee of 7 individuals in accordance with Bylaw 2.13.7. The action of the Board in April making the speakers “full members” of the committee in effect expanded the EC to 9 members. This is allowed under Bylaw 2.13.7.2: “Size. Each committee shall consist of 7 members, **unless otherwise provided**” (*emphasis added*). Paragraph 7c of Policy D-610.998 requires committee members with a conflict of interest to recuse themselves. The EC notes that recusal of members may become a challenge, particularly in campaigns with multiple candidates from differing delegations, and recommends further expansion of the committee by two (2) additional members.

The EC believes the process for reporting, validation and resolution of campaign violations as recommended here should be codified in policy and widely communicated. While this report will raise awareness, the EC believes the formal process established should be included in future editions of the Election Manual.

CONCLUSION

The Election Committee was officially established in June 2021 and has been in place for a single campaign and election cycle. The EC intends this interim report to raise awareness of the current processes for campaign complaint reporting, validation, and resolution as codified by action of the HOD and the BOT. As per Policy D-610.998, paragraph 9, the committee will continue to review the processes as implemented and make further recommendations to the House as necessary. In addition, the House is reminded that a review of the entirety of the modified election processes will be conducted after the upcoming elections at A-23 as per adopted recommendation 41 of the Election Task Force Report. Any adopted recommendations will be subject to that review.

RECOMMENDATIONS

It is recommended that the following recommendations be adopted and the remainder of the report filed.

1. That Policy D-610.998, Paragraph 5, be amended by addition and deletion to read as follows:

In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 7 ⁹ individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime maximum tenure of 8 terms) to report to the Speaker. These individuals would agree not to be directly involved in a campaign during their tenure and would be appointed from various regions, specialties, sections, and interest groups. The primary role of the committee would be to work with the Speakers to adjudicate any election complaint. Additional roles to be determined by the Speaker and could include monitoring election reforms, considering future campaign modifications and responding to requests from the Speaker for input on election issues that arise. The Speaker and Vice Speaker shall be full members of the Election Committee.

2. That Policy D-610.998, Paragraph 7, be amended by addition to read as follows:

Campaign violation complaints will be investigated by the Election Committee or a subcommittee thereof with the option of including the Office of General Counsel or the Director of the House of Delegates.

3. That Policy D-610.998, Paragraph 7(a), be amended by addition to read as follows:
 - 7(a). The Committee will collectively determine whether a campaign violation has occurred. As part of the investigation process the Election Committee or its subcommittee shall inform the candidate of the complaint filed and give the candidate the opportunity to respond to the allegation.
4. That Paragraph 7 be amended by addition of a new sub point "b" to read as follows:
 - 7(b) If the complaint implicates a delegation or caucus, the Election Committee or its subcommittee shall inform the chair of the implicated delegation or caucus of the complaint filed and give the implicated delegation or caucus chair(s) the opportunity to answer to the allegation as a part of the investigative process.
5. That amended Policy D-610.998 be widely communicated, including being published in the Election Manual.

APPENDIX A - Report of the Election Task Force [ETF] (June 2021)

Relevant portion copied below. To review the full report go to page 103 of the pdf at <https://www.ama-assn.org/system/files/2021-06/j21-bot-reports.pdf>, which is page 133 of the J21 Proceedings.

ELECTION COMMITTEE

At the open forum discussion at I-19 the idea of an ongoing election committee was proffered and received broad support. The concept was not to detract from the Speakers' role in overseeing the campaign and election process, but rather to provide them support. Recognizing that improvement in our elections is an iterative process, a committee could monitor the impacts of the recommendations adopted from this report and make further recommendations for the continued evolution of our election process. In addition, it was mentioned that enforcing campaign rules could create real or perceived bias for a Speaker if the complainant or the accused happened to be a friend or from their delegation. The committee working with the Speakers could adjudicate potential campaign violations. The Speakers are receptive to this proposal.

The ETF recommends establishment of an Election Committee of 7 individuals, appointed by the Speaker for 1-year terms to report to the Speaker. We proposed that these individuals be allowed to serve up to 4 consecutive terms but that the maximum tenure be 8 years. These individuals would agree to not be directly involved in a campaign during their tenure and would be appointed from various regions, specialties, sections, and interest groups to reduce potential bias. The primary role of the committee would be to work with the Speaker to adjudicate any election complaint. The ETF envisions selection of a smaller subcommittee from the Election Committee to adjudicate each specific complaint. Additional roles could include monitoring election reforms, considering future campaign modifications, and responding to requests from the Speaker for input on election issues that arise. Our Bylaws (2.13.7) provide for the appointment of such a committee. This Bylaw specifies that the term may be directed by the House of Delegates. Therefore, the ETF recommends that such a committee be established for the terms noted.

In addition, the task force recommends a more defined complaint and violation adjudication process including the proposed Election Committee. Details can be further determined by the committee in consultation with the Speakers and presented to the House at a future date, but the ETF suggests consideration of a more formal process for reporting, validation of the complaint with investigation as needed, resolution of the concern and presentation to the HOD if a formal penalty (up to and including exclusion from the election) is deemed appropriate.

APPENDIX B - Establishing an Election Committee (November 21)

HOUSE ACTION: REFERRED FOR DECISION

At the June 2021 Special Meeting (J21), the House of Delegates (HOD) adopted the following recommendation as part of the report of the Election Task Force (Speakers' Report 2):

In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 7 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime maximum tenure of 8 terms) to report to the Speaker. These individuals would agree not to be directly involved in a campaign during their tenure and would be appointed from various regions, specialties, sections, and interest groups. The primary role of the committee would be to work with the Speakers to adjudicate any election complaint. Additional roles to be determined by the Speaker and could include monitoring election reforms, considering future campaign modifications and responding to requests from the Speaker for input on election issues that arise. The recommendation is recorded as Paragraph 5 in Policy D-610.998, "Directives from the Election Task Force."

The Speakers determined that the term of each committee member should run from June to June, starting and ending with the adjournment of the HOD meeting, and initial appointments, including the chair, have been made. The seven members of the

Committee are delegates or alternate delegates and have agreed to refrain from active participation in election campaigns through the following June, when their (initial) appointments will have concluded. Current members will be eligible for reappointment and other individuals willing to serve on the Committee are invited to complete the application form on the Speakers' page for positions that will begin in mid-2022.

Members of the Committee are listed in Appendix A. All were selected from among members of the House that submitted an application to serve. Appointments were made to cross the geographic regions and broad specialties represented in our House. The selected individuals have extensive experience with campaigns. Among those selected are past presidents of 4 state medical associations and 2 specialty societies, plus two past state medical association speakers in addition to past members of an AMA Council and Section Governing Councils. As part of their commitment, they have also agreed that all complaints and the ensuing discussions, deliberations, and votes will be kept confidential. Only those complaints that are verified and reported to the House will be shared, and then the Speaker will report to the House only the relevant aspects of the matter. The Committee might be likened to the peer review process. (See below for the complaint process.)

In addition, Paragraph 6 of the same policy adopted at J21 reads as follows:

The Speaker in consultation with the Election Committee will consider a more defined process for complaint reporting, validation, resolution, and potential penalties. This process will be presented to the House for approval.

This report is in response to Paragraph 6.

COMMITTEE ACTIVITIES AND PROPOSALS

The Committee convened by conference call to address the matters that had been assigned. Each is discussed below.

Complaint reporting

Long established policy (Policy G 610.020 [1]) states that the Speakers "are responsible for overall administration of our AMA elections." The Committee recommends that complaints continue to be submitted through the Speaker or Vice Speaker. Should either or both have a perceived conflict, complaints may be directed to our AMA's General Counsel. Counsel will then work with the Committee chair and/or the Speaker or Vice Speaker, depending on the nature and extent of the conflict. AMA's General Counsel can be reached through the Member Service Center or the HOD Office. Members of the Committee will not accept complaints directly and members of the House should not bring complaints to them or attempt to discuss campaign related concerns with individual members.

Complaints should generally be based on first-hand information because the necessary information is unlikely to otherwise be available. A complaint will need to include the following details:

- The name of the person(s) thought to have violated the rules
- The date of the alleged violation and the location if relevant
- The specific violation being alleged (i.e., the way the rules were violated)
- The materials, if any, that violate the rules; original materials are preferred over copies. Where necessary, arrangements for collection of these materials will be made.

Some discussion was had regarding the development of a list of potential rules violations and associated penalties, it quickly was recognized that this list would be limitless, necessarily qualified by nuance or exceptions. Furthermore, application of rigid penalties that do not take into account such nuances, would unnecessarily constrain the committee and potentially disenfranchise members of our House with whom rests the ultimate decision regarding verified infractions. Rather, the Committee recommends that they be allowed flexibility to consider the circumstances surrounding reported violations and to determine the appropriate corrective action. To ensure consistency and fairness over time, a history of the details of each verified offense and the ensuing penalty will be retained by the Office of General Counsel.

Inquiries about rules should also be directed to the Speakers. They have long interpreted AMA's election rules, and in fact, the annual election manual further elucidates the campaign rules. In this light some complaints could prove unfounded simply because of a misunderstanding of the rules. More importantly, consistency in explaining the rules is requisite, and the Speakers are familiar with both historical issues and current practice. In addition, questions sometimes arise for which the answer should be widely disseminated, and the Speakers have the ability and tools to share the information. Even-handedness in administering the elections is a hallmark of our processes.

Validation

Upon receiving a complaint, the Speaker will consult with the Committee chair to form a subcommittee of three members to investigate the allegation. The subcommittee members will be selected to avoid conflicts (e.g., being part of the same delegation

as the alleged violator). Using necessary discretion, the subcommittee shall investigate the complaint and will report to the full Committee whether the complaint is founded. When necessary, the Office of General Counsel or the HOD Office will assist.

Following the subcommittee's evaluation, the full Committee will meet as soon as practical but generally within 2 weeks, to hear the subcommittee's report, determine whether a violation has occurred, and establish appropriate next steps. Committee members with a conflict of interest will be expected to recuse themselves from the vote, although they may participate in any discussion that precedes the decision. These internal deliberations are confidential, and details will not be shared. The Speakers are ex officio members of the Committee, without vote except as necessary to break a tie within the Committee, when one of them may vote.

Resolution and potential penalties

Historically, the only formal penalty for a campaign violation was for the Speaker to announce to the House before the election that a violation had occurred by naming the violator and the violation. These announcements thankfully have been rare, but when such an announcement has been made, it is noted that the candidate subsequently lost the election.

The Committee believes the House should continue to be the final arbiter when violations are deemed to be significant; thus, the Speaker announcing a violation to the House will remain a penalty which the Committee may impose. At the same time the Committee may believe that this penalty is excessive for some violations. The Committee should consider mitigating circumstances such as inadvertent breaches and technical or typographical errors. The Committee should also consider when during the year the violation occurs, the likely advantage sought or gained by the action in question, and who committed the violation. Consequently, the Committee recommends that it be given discretion to determine appropriate resolution of a validated complaint. In many circumstances resolution may be accomplished by corrective action, short of announcement to the House.

No exhaustive list of situations is possible, but three principles would seem to capture relevant aspects of violations:

- The more remote in time the violation occurs, the less the need to declare a violation, and conversely, the nearer the election, the greater the need for an announcement by the Speaker.

It seems likely that a violation, particularly a violation that is perceived to be serious, will become generally known if it occurs well before the election. At the same time, awareness of a violation on the eve of the election has little chance of propagating and may warrant an announcement.

- The greater the advantage sought or gained, the more the need for a public announcement.

Some subjectivity is apparent in this principle, but the Committee believes that both the motivation and the benefit of the violating activity need to be addressed. An inadvertent violation that greatly advantages a candidate is more serious than the same inadvertent violation that for some reason handicaps the candidate.

- The greater the culpability of the candidate, the greater the need for an announcement to the House.

Under AMA's election rules, the candidate is responsible for all campaign activities, including those carried out by the candidate's supporters. While it would be unwise to simply ignore a violation committed by a naïve supporter (or group), the role of the candidate her- or himself certainly needs to be considered. In the same way "plausible deniability" alone will not absolve the candidate, though it may decrease the likelihood of Speaker pronouncements.

As noted above, announcing the Committee's conclusion to the House that a violation has occurred should remain an option, but the Committee also favors availability of other options whereby relatively minor infractions may be easily and quickly remedied without being reported to the House. This may also be appropriate in those cases where the violation and corrective action is readily apparent without formal announcement. For example, Paragraph 15 of the rules (Policy G 610.020) requires candidates using electronic communications to "include a simple mechanism to allow recipients to opt out of receiving future [emails]." A candidate failing to provide the "simple mechanism" could easily correct the violation by sending another communication apologizing and adding the opt out, which would be apparent to all recipients, meaning that reporting the violation to the House would be of little need. For another example, a misstatement in an interview or on campaign materials could be subsequently corrected by the candidate by notification to those that received the misinformation.

Where a confirmed violation is deemed by the Election Committee to require a report to the House, the Speaker would report pertinent details, including any corrective action undertaken by the candidate, that are deemed appropriate for the HOD to consider. A notice to the House, separate from a meeting, could be provided when appropriate. For example, such notice could be included with the Speakers' planned announcements of candidates (see Policy G 610.020 [3]), which would allow the House to assess the gravity of the violation but also provide the violator with the opportunity to respond to concerns. Violations that occur once the Annual Meeting has convened, if determined by the Committee to be significant, would be announced during a session of the HOD.

CONCLUSION

The final recommendation of Speakers' Report 2 (Report of the Election Task Force) adopted at the J21 Special Meeting (Policy D-610.998) provides for a review of the reforms related to our election processes. The Election Committee itself and these recommendations will be subject to this review. Our tradition of professionalism and collegiality should result in few violations of our campaign principles and rules necessitating invoking the process detailed here. The Election Committee has recommended a process that draws upon our traditions, provides appropriate flexibility without undue complexity, and yet maintains the integrity of our elections. Accordingly, your Election Committee asks that the following recommendations be approved for use in the upcoming open campaign season and that the Committee be allowed to continue to monitor our election processes with further recommendations in the future as needed.

RECOMMENDATIONS

It is recommended that the following recommendations be adopted and the remainder of the report be filed.

1. A Campaign Complaint Reporting, Validation, and Resolution Process shall be established as follows:

Campaign violation complaints should be directed to the Speaker, the Vice Speaker, or the AMA General Counsel and should include the following details:

- The name of the person(s) thought to have violated the rules
- The date of the alleged violation and the location if relevant
- The specific violation being alleged (i.e., the way the rules were violated)
- The materials, if any, that violate the rules; original materials are preferred over copies. Where necessary, arrangements for collection of these materials will be made.

Campaign violation complaints will be investigated by the Election Committee, which will determine penalties for validated complaints as appropriate. Penalties may include an announcement of the violation by the Speaker to the House.

2. The Election Committee will review the Campaign Complaint Reporting, Validation, and Resolution Process as implemented and make further recommendations to the House as necessary.

3. Policy D-610.998, Paragraph 6 be rescinded.

[Editor's note: At the time of referral, the following amended language had been adopted:

Campaign violation complaints will be investigated by the Election Committee, which will recommend penalties to the Speaker of the House, who will validate complaints and actions as appropriate. Penalties may include an announcement of the violation by the Speaker to the House.