

# AMA House of Delegates Handbook

2022 Interim Meeting  
Hawai'i Convention Center  
Nov. 12-15



Visit [ama-assn.org/hod-business](https://ama-assn.org/hod-business)  
or scan the QR code to access  
the handbook online.

## **MEMORANDUM FROM THE SPEAKER OF THE HOUSE OF DELEGATES**

- **All Delegates, Alternate Delegates and others receiving this material are reminded that it refers only to items to be considered by the House.**
  
- **No action has been taken on anything herein contained, and it is informational only.**
  
- **Only those items that have been acted on finally by the House can be considered official.**
  
- **The Interim Meeting is focused on advocacy issues. A resolution committee (see AMA Bylaw 2.13.3) considers each resolution and recommends that the item be considered or not considered at the Interim Meeting. Items that meet the following definition of advocacy or that are considered urgent are recommended for acceptance:**

*Active use of communication and influence with public and private sector entities responsible for making decisions that directly affect physician practice, payment for physician services, funding and regulation of education and research, and access to and delivery of medical care.*

**Resolutions pertaining to ethics should also be included in the agenda. Remaining items are recommended against consideration, but any delegate may request consideration when resolutions are presented for consideration (during Sunday's "Second Opening" Session). A simple majority of those present and voting is required for consideration.**

- **REMINDER: *Only the Resolve portions of the resolutions are considered by the House of Delegates. The Whereas portions or preambles are informational and explanatory only.***



UNDERSTANDING THE RECORDING OF AMERICAN MEDICAL ASSOCIATION POLICY

Current American Medical Association (AMA) policy is catalogued in PolicyFinder, an electronic database that is updated after each AMA House of Delegates (HOD) meeting and available online. Each policy is assigned to a topical or subject category. Those category headings are alphabetical, starting with “abortion” and running to “women”; the former topic was assigned the number 5, and “women” was assigned 525. Within a category, policies are assigned a 3 digit number, descending from 999, meaning that older policies will *generally* have higher numbers within a category (eg, 35.999 was initially adopted before 35.984). A policy number is not affected when it is modified, however, so a higher number may have been altered more recently than a lower number. Numbers are deleted and not reused when policies are rescinded.

AMA policy is further categorized into one of four types, indicated by a prefix:

- “H” – for statements that one would consider positional or philosophical on an issue
- “D” – for statements that direct some specific activity or action. There can be considerable overlap between H and D statements, with the assignment made on the basis of the core nature of the statement.
- “G” – for statements related to AMA governance
- “E” – for ethical opinions, which are the recommendations put forward in reports prepared by the Council on Ethical and Judicial Affairs and adopted by the AMA-HOD

AMA policy can be accessed at [ama-assn.org/go/policyfinder](http://ama-assn.org/go/policyfinder).

The actions of the AMA-HOD in developing policy are recorded in the *Proceedings*, which are available [online](#) as well. Annotations at the end of each policy statement trace its development, from initial adoption through any changes. If based on a report, the annotation includes the following abbreviations:

- BOT – Board of Trustees
- CCB – Council on Constitution and Bylaws
- CEJA – Council on Ethical and Judicial Affairs
- CLRPD – Council on Long Range Planning and Development
- CME – Council on Medical Education
- CMS – Council on Medical Service
- CSAPH – Council on Science and Public Health

If a resolution was involved, “Res” is indicated. The number of the report or resolution and meeting (A for Annual; I for Interim) and year (two digits) are also included (eg, BOT Rep. 1, A-14 or Res. 319, I-12).

AMA policy is recorded in the following categories, and any particular policy is recorded in only a single category.

5.000 Abortion	10.000 Accident Prevention/Unintentional Injuries
15.000 Accident Prevention: Motor Vehicles	20.000 Acquired Immunodeficiency Syndrome
25.000 Aging	30.000 Alcohol and Alcoholism
35.000 Allied Health Professions	40.000 Armed Forces
45.000 Aviation Medicine	50.000 Blood
55.000 Cancer	60.000 Children and Youth
65.000 Civil and Human Rights	70.000 Coding and Nomenclature
75.000 Contraception	80.000 Crime
85.000 Death and Vital Records	90.000 Disabled
95.000 Drug Abuse	100.000 Drugs
105.000 Drugs: Advertising	110.000 Drugs: Cost
115.000 Drugs: Labeling and Packaging	120.000 Drugs: Prescribing and Dispensing
125.000 Drugs: Substitution	130.000 Emergency Medical Services
135.000 Environmental Health	140.000 Ethics
145.000 Firearms: Safety and Regulation	150.000 Foods and Nutrition

155.000 Health Care Costs	160.000 Health Care Delivery
165.000 Health Care/System Reform	170.000 Health Education
175.000 Health Fraud	180.000 Health Insurance
185.000 Health Insurance: Benefits and Coverage	190.000 Health Insurance: Claim Forms and Claims Processing
195.000 Health Maintenance Organizations	200.000 Health Workforce
205.000 Health Planning	210.000 Home Health Services
215.000 Hospitals	220.000 Hospitals: Accreditation Standards
225.000 Hospitals: Medical Staff	230.000 Hospitals: Medical Staff - Credentialing and Privileges
235.000 Hospitals: Medical Staff - Organization	240.000 Hospitals: Reimbursement
245.000 Infant Health	250.000 International Health
255.000 International Medical Graduates	260.000 Laboratories
265.000 Legal Medicine	270.000 Legislation and Regulation
275.000 Licensure and Discipline	280.000 Long-Term Care
285.000 Managed Care	290.000 Medicaid and State Children's Health Insurance Programs
295.000 Medical Education	300.000 Medical Education: Continuing
305.000 Medical Education: Financing and Support	310.000 Medical Education: Graduate
315.000 Medical Records and Patient Privacy	320.000 Medical Review
330.000 Medicare	335.000 Medicare: Carrier Review
340.000 Medicare: PRO	345.000 Mental Health
350.000 Minorities	355.000 National Practitioner Data Bank
360.000 Nurses and Nursing	365.000 Occupational Health
370.000 Organ Donation and Transplantation	373.000 Patients
375.000 Peer Review	380.000 Physician Fees
383.000 Physician Negotiation	385.000 Physician Payment
390.000 Physician Payment: Medicare	400.000 Physician Payment: Medicare - RBRVS
405.000 Physicians	406.000 Physician-Specific Health Care Data
410.000 Practice Parameters	415.000 Preferred Provider Arrangements
420.000 Pregnancy and Childbirth	425.000 Preventive Medicine
430.000 Prisons	435.000 Professional Liability
440.000 Public Health	445.000 Public Relations
450.000 Quality of Care	455.000 Radiation and Radiology
460.000 Research	465.000 Rural Health
470.000 Sports and Physical Fitness	475.000 Surgery
478.000 Technology - Computer	480.000 Technology - Medical
485.000 Television	490.000 Tobacco Use, Prevention and Cessation
495.000 Tobacco Products	500.000 Tobacco: AMA Corporate Policies and Activities
505.000 Tobacco: Federal and International Policies	510.000 Veterans Medical Care
515.000 Violence and Abuse	520.000 War
525.000 Women	600.000 Governance: AMA House of Delegates
605.000 Governance: AMA Board of Trustees and Officers	610.000 Governance: Nominations, Elections, and Appointments
615.000 Governance: AMA Councils, Sections, and Committees	620.000 Governance: Federation of Medicine
625.000 Governance: Strategic Planning	630.000 Governance: AMA Administration and Programs
635.000 Governance: Membership	640.000 Governance: Advocacy and Political Action

## **LIST OF MATERIAL INCLUDED IN THIS HANDBOOK (I-22)**

Resolutions and reports have been collated by referral according to reference committee assignment. In the listing below, referral is indicated by letter in parenthesis following the title of the report. Resolutions have been numbered according to referrals (i.e., those referred to the Reference Committee on Amendments to Constitution and Bylaws begin with 001, Reference Committee B begins with 201, etc.).

The informational reports contain no recommendations and will be filed on [insert date], unless a request is received for referral and consideration by a Reference Committee (similar to the use of a consent calendar).

- 1. Memorandum from the Speaker**
- 2. Understanding the Recording of American Medical Association Policy**
- 3. Declaration of Professional Responsibility - Medicine's Social Contract with Humanity**
- 4. Delegate / Alternate Delegate Job Description, Roles and Responsibilities**
- 5. Seating Allocation and Seating Chart for the House of Delegates**
- 6. Convention Center Maps**
- 7. Official Call to the Officers and Members of the AMA**
  - Officials of the Association and AMA Councils**
  - Ex Officio Members of the HOD**
  - SSS Representatives**
  - Listing of Delegates and Alternate Delegates**
- 8. House of Delegates Reference Committee Members**
- 9. Reference Committee schedule and room assignments**
- 10. Note on Order of Business**
- 11. Summary of Fiscal Notes**
- 12. List of resolutions by sponsor**

### **FOLLOWING COLLATED BY REFERRAL**

- 13. Report(s) of the Board of Trustees - Sandra Adamson Fryofer, MD, Chair**
  - 01 Opposition to Requirements for Gender-Based Treatments for Athletes (Amendments to C&B)
  - 02 Further Action to Respond to the Gun Violence Public Health Crisis (F)
  - 03 Delegate Apportionment and Pending Members (Amendments to C&B)
  - 04 Preserving Access to Reproductive Health Services (Amendments to C&B)
  - 05 Towards Diversity and Inclusion: A Global Nondiscrimination Policy Statement and Benchmark for our AMA (Amendments to C&B)
  - 06 Informal Inter-Member Mentoring (Info. Report)
  - 07 Transparency of Resolution Fiscal Notes (F)

- 08 The Resolution Committee as a Standing Committee of the House (F)
  - 09 Employed Physicians (F)
  - 10 Redefining the AMA's Position on ACA and Healthcare Reform (Info. Report)
  - 11 2022 AMA Advocacy Efforts (Info. Report)
  - 12 Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment (Amendments to C&B)
- 14. Report(s) of the Council on Constitution and Bylaws - Kevin C. Reilly, Sr., MD, Chair**
- 01 Updated Bylaws: Delegate Apportionment and Pending Members (Amendments to C&B)
- 15. Report(s) of the Council on Ethical and Judicial Affairs - Peter A. Schwartz, MD, Chair**
- 01 Amendment to Opinion 4.2.7, “Abortion” (Amendments to C&B)
  - 02 Amendment to Opinion 10.8, “Collaborative Care” (Amendments to C&B)
  - 03 Pandemic Ethics and the Duty of Care (Amendments to C&B)
  - 04 Research Handling of De-Identified Patient Information (Info. Report)
- 16. Opinion(s) of the Council on Ethical and Judicial Affairs - Peter A. Schwartz, MD, Chair**
- 01 Amendment to E-9.3.2, “Physician Responsibilities to Colleagues with Illness, Disability or Impairment” (Info. Report)
- 17. Report(s) of the Council on Long Range Planning and Development - Edmond B. Cabbabe, MD, Chair**
- 01 Senior Physicians Section Five-Year Review (F)
- 18. Report(s) of the Council on Medical Education - John P. Williams, MD, Chair**
- 01 The Impact of Private Equity on Medical Training (C)
  - 02 Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process (C)
- 19. Report(s) of the Council on Medical Service - Lynn L. C. Jeffers, MD, Chair**
- 01 Incentives to Encourage Efficient Use of Emergency Departments (J)
  - 02 Corporate Practice of Medicine (J)
  - 03 Health System Consolidation (Info. Report)
- 20. Report(s) of the Council on Science and Public Health - Noel N. Deep, MD, Chair**
- 01 Drug Shortages: 2022 Update (K)
  - 02 Climate Change and Human Health (K)
- 21. Report(s) of the HOD Committee on Compensation of the Officers - Ray C. Hsiao, MD, Chair**
- 01 Report of the HOD Committee on Compensation of the Officers (F)
- 22. Report(s) of the Speakers - Bruce A. Scott, MD, Speaker; Lisa Bohman Egbert, MD, Vice Speaker**
- 01 Election Committee - Interim Report (F)
- 23. Resolutions**
- 002 Assessing the Humanitarian Impact of Sanctions (Amendments to C&B)
  - 003 Indigenous Data Sovereignty (Amendments to C&B)
  - 005 Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants (Amendments to C&B)
  - 006 Assessing the Humanitarian Impact of Sanctions (Amendments to C&B)
  - 007 Consent for Sexual and Reproductive Healthcare (Amendments to C&B)
  - 008 Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era (Amendments to C&B)

- 201 Physician Reimbursement for Interpreter Services (B)
- 202 Advocating for State GME Funding (B)
- 203 International Medical Graduate Employment (B)
- 205 Waiver of Due Process Clauses (B)
- 206 The Shortage of Bedside Nurses and Intersection with Concerns in Nurse Practitioner Training (B)
- 207 Preserving Physician Leadership in Patient Care (B)
- 208 Comparing Student Debt, Earnings, Work Hours, and Career Satisfaction Metrics in Physicians v. Other Health Professionals (B)
- 209 Comprehensive Solutions for Medical School Graduates Who Are Unmatched or Did Not Complete Training (B)
- 211 Illicit Drug Use Harm Reduction Strategies (B)
- 213 Hazard Pay During a Disaster Emergency (B)
- 214 Universal Good Samaritan Statute (B)
- 215 Eliminating Practice Barriers for Immigrant Physicians During Public Health Emergencies (B)
- 302 Expanding Employee Leave to Include Miscarriage and Stillbirth (C)
- 303 Medical Student Leave Policy (C)
- 304 Protecting State Medical Licensing Boards from External Political Influence (C)
- 305 Encouraging Medical Schools to Sponsor Pipeline Programs to Medicine for Underrepresented Groups (C)
- 306 Increased Credit for Continuing Medical Education Preparation (C)
- 307 Fair Compensation of Residents and Fellows (C)
- 308 Paid Family/Medical Leave in Medicine (C)
- 309 Bereavement Leave for Medical Students and Physicians (C)
- 601 AMA Withdraw its Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity (F)
- 602 Finding Cities for Future AMA Conventions/Meetings (F)
- 801 Parity in Military Reproductive Health Insurance Coverage for All Service Members and Veterans (J)
- 802 FAIR Health Database (J)
- 803 Patient Centered Medical Home – Administrative Burdens (J)
- 804 Centers for Medicare & Medicaid Innovation Projects (J)
- 805 COVID Vaccine Administration Fee (J)
- 806 Healthcare Marketplace Plan Selection (J)
- 807 Medicare Advantage Record Requests (J)
- 808 Reinstatement of Consultation Codes (J)
- 809 Uniformity and Enforcement of Medicare Advantage Plans and Regulations (J)
- 810 Medicare Drug Pricing and Pharmacy Costs (J)
- 811 Covering Vaccinations for Seniors Through Medicare Part B (J)
- 812 Implant-Associated Anaplastic Large Cell Lymphoma (J)
- 813 Amending Policy on a Public Option to Maximize AMA Advocacy (J)
- 814 Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored? (J)
- 902 Reducing the Burden of Incarceration on Public Health (K)
- 904 Immigration Status is a Public Health Issue (K)
- 905 Minimal Age of Juvenile Justice Jurisdiction in the United States (K)
- 906 Requirement for COVID-19 Vaccination in Public Schools Once Fully FDA-Authorized (K)

- 907 A National Strategy for Collaborative Engagement, Study, and Solutions to Reduce the Role of Illegal Firearms in Firearm Related Injury (K)
- 908 Older Adults and the 988 Suicide and Crisis Timeline (K)
- 909 Decreasing Gun Violence and Suicide in Seniors (K)
- 910 Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use (K)
- 911 Critical Need for National ECC System to Ensure Individualized, State-Wide, care for STEMI, CS and OHCA, and to Reduce Disparities in Health Care for Patients with Cardiac Emergencies (K)

**24. Resolutions not for consideration**

- 001 Updating Physician Job Description for Disability Insurance (Not for consideration)
- 004 Supporting Intimate Partner and Sexual Violence Safe Leave (Not for consideration)
- 204 Elimination of Seasonal Time Change (Not for consideration)
- 210 Elimination of Seasonal Time Changes and Establishment of Permanent Standard Time (Not for consideration)
- 212 SNAP Expansion for DACA Recipients (Not for consideration)
- 301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education (Not for consideration)
- 603 AMA House of Delegates Resolution Process Review (Not for consideration)
- 604 Solicitation Using the AMA Brand (Not for consideration)
- 901 Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies (Not for consideration)
- 903 Supporting Further Study of Kratom (Not for consideration)

**DECLARATION OF PROFESSIONAL RESPONSIBILITY:  
MEDICINE'S SOCIAL CONTRACT WITH HUMANITY**

**Preamble**

**Never in the history of human civilization** has the well-being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well-being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

**Declaration**

**We, the members of the world community of physicians,** solemnly commit ourselves to:

1. Respect human life and the dignity of every individual.
2. Refrain from supporting or committing crimes against humanity and condemn all such acts.
3. Treat the sick and injured with competence and compassion and without prejudice.
4. Apply our knowledge and skills when needed, though doing so may put us at risk.
5. Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.
6. Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.
7. Educate the public and polity about present and future threats to the health of humanity.
8. Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.
9. Teach and mentor those who follow us for they are the future of our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor.

Adopted by the House of Delegates of the American Medical Association  
in San Francisco, California on December 4, 2001

## **Delegate/Alternate Delegate Job Description, Roles and Responsibilities**

*At the 1999 Interim Meeting, the House of Delegates adopted as amended Recommendation 16 of the final report of the Special Advisory Committee to the Speaker of the House of Delegates. This recommendation included a job description and roles and responsibilities for delegates and alternate delegates. The description and roles and responsibilities were modified at the 2002 Annual Meeting by Recommendation 3 of the Joint Report of the Board of Trustees and Council on Long Range Planning and Development. The modified job description, qualifications, and responsibilities are listed below.*

Delegates and Alternate Delegates should meet the following job description and roles and responsibilities:

### **Job Description and Roles and Responsibilities of AMA Delegates/Alternate Delegates**

Members of the AMA House of Delegates serve as an important communications, policy, and membership link between the AMA and grassroots physicians. The delegate/alternate delegate is a key source of information on activities, programs, and policies of the AMA. The delegate/alternate delegate is also a direct contact for the individual member to communicate with and contribute to the formulation of AMA policy positions, the identification of situations that might be addressed through policy implementation efforts, and the implementation of AMA policies. Delegates and alternate delegates to the AMA are expected to foster a positive and useful two-way relationship between grassroots physicians and the AMA leadership. To fulfill these roles, AMA delegates and alternate delegates are expected to make themselves readily accessible to individual members by providing the AMA with their addresses, telephone numbers, and e-mail addresses so that the AMA can make the information accessible to individual members through the AMA web site and through other communication mechanisms. The qualifications and responsibilities of this role are as follows:

#### **A. Qualifications**

- AMA member.
- Elected or selected by the principal governing body or the membership of the sponsoring organization.
- The AMA encourages that at least one member of each delegation be involved in the governance of their sponsoring organization.

#### **B. Responsibilities**

- Regularly communicate AMA policy, information, activities, and programs to constituents so he/she will be recognized as the representative of the AMA.
- Relate constituent views and suggestions, particularly those related to implementation of AMA policy positions, to the appropriate AMA leadership, governing body, or executive staff.
- Advocate constituent views within the House of Delegates or other governance unit, including the executive staff.
- Attend and report highlights of House of Delegates meetings to constituents, for example, at hospital medical staff, county, state, and specialty society meetings.
- Serve as an advocate for patients to improve the health of the public and the health care system.
- Cultivate promising leaders for all levels of organized medicine and help them gain leadership positions.
- Actively recruit new AMA members and help retain current members.
- Participate in the AMA Membership Outreach Program.

## SEATING ALLOCATION – 2022 INTERIM MEETING

### ADDICTION MEDICINE – 3

American Society of Addiction Medicine (ASAM) – 3  
Trustee (Levin) – 1  
Delegates - 2

### ALLERGY AND IMMUNOLOGY – 1

American College of Allergy, Asthma & Immunology (ACAAI) – 1

### AMDA – 1

AMDA – The Society for Post-Acute and Long-Term Care Medicine (AMDA) – 1

### AMGA - 1

American Medical Group Association (AMGA) - 1

### ANESTHESIOLOGY - 11

American Society of Anesthesiologists (ASA) - 9  
Former Board Chair (Patchin) – 1  
Delegates – 8  
American Society of Regional Anesthesia and Pain Medicine (ASRAPM) - 2

### ARS – 1

American Rhinologic Society (ARS) - 1

### CARDIOLOGY - 15

American College of Cardiology (ACC) - 7  
American Society of Echocardiography (ASE) - 2  
American Society of Nuclear Cardiology (ASNC) – 2  
Heart Rhythm Society (HRS) - 2  
Society for Cardiovascular Angiography and Interventions (SCAI) - 1  
Society of Cardiovascular Computed Tomography (SCCT) – 1

### CHEST PHYSICIANS - 3

American College of Chest Physicians (CHEST) (ACCP) - 3

### CRITICAL CARE MEDICINE- 2

Society of Critical Care Medicine (SCCM) - 2

### DERMATOLOGY - 10

American Academy of Dermatology (AAD) – 4  
American College of Mohs Surgery (ACMS) – 1  
American Contact Dermatitis Society (ACDS) - 1  
American Society for Dermatologic Surgery (ASDS) - 2  
American Society of Dermatopathology (ASD) - 1  
Society for Investigative Dermatology (SID) - 1

### EMERGENCY MEDICINE - 11

American College of Emergency Physicians (ACEP) - 11  
Former President (Stack) - 1  
Delegates - 8  
Resident and Fellow Section Delegates - 2

### ENDOCRINOLOGY - 5

American Association of Clinical Endocrinology (AACE) - 1  
American Soc for Reproductive Medicine (ASRM) - 2  
The Endocrine Society (ES) - 2

### FAMILY PHYSICIANS - 17

American Academy of Family Physicians (AAFP) - 17  
Former Board Chair (Langston) - 1  
Delegates - 16

### GASTROENTEROLOGY - 7

American College of Gastroenterology (ACG) - 2  
American Gastroenterological Association (AGA) - 2  
American Society for Gastrointestinal Endoscopy (ASGE) - 3

### GERIATRIC MEDICINE - 3

American Geriatrics Society (AGS) – 3  
Delegates – 2  
Resident and Fellow Section Delegate - 1

### GREAT LAKES - 61

Illinois - 16  
Delegates - 12  
American College of Legal Medicine (ACLM) - 1  
American Coll of Radiation Oncology (ACRO) - 1  
American Med Women’s Association (AMWA) - 1  
Society of Nuclear Medicine and Molecular Imaging (SNMMI) - 1  
Indiana - 6  
Delegates – 5  
Medical Student Regional Delegate- 1  
Michigan – 15  
Trustee (Mukkamala) - 1  
Delegates - 13  
Medical Student Regional Delegate - 1  
Ohio - 15  
Delegates (minus Vice Speaker) - 13  
Medical Student Regional Delegate - 2  
Resident and Fellow Section Delegate - 1  
Wisconsin - 9  
Former Board Chair (Flaherty) - 1  
Delegates - 5  
Resident and Fellow Section Delegates - 2  
Undersea & Hyperbaric Medical Society (UHMS) – 1

### HEART OF AMERICA - 11

Kansas - 3  
Missouri – 8  
Former President (Barbe) - 1  
Delegates - 6  
Medical Student Regional Delegate- 1

### HEMATOLOGY - 2

American Society of Hematology (ASH) - 2

### HOSPITAL MEDICINE - 3

Society of Hospital Medicine (SHM) - 3

### INFECTIOUS DISEASE - 3

Infectious Diseases Society of America (IDSA) - 3  
Delegates - 2  
Resident and Fellow Section Delegate - 1

### INTERNAL MEDICINE - 35

American College of Physicians (ACP) – 34  
Renal Physicians Association (RPA) - 1

### MOBILITY CAUCUS - 14

American Acad of Orthopaedic Surgeons (AAOS) – 5  
American Association for Hand Surgery (AAHS) - 1  
American Orthopaedic Association (AOra) - 1  
American Orthopaedic Foot and Ankle Society (AOFAS) - 1  
American Society for Surgery of the Hand (ASSH) - 1  
American Society of Interventional Pain Physicians (ASIPP) - 2  
International Society for the Advancement of Spine Surgery (ISASS) – 1  
North American Spine Society (NASS) - 2

### NEUROSCIENCES - 33

American Academy of Child and Adolescent Psychiatry (AACAP) - 2  
American Academy of Hospice and Palliative Medicine (AAHPM) - 2  
American Academy of Neurology (AAN) – 5  
Delegates – 4  
Resident and Fellow Section Delegate - 1  
American Academy of Pain Medicine (AAPM) - 1  
American Acad of Psychiatry and the Law (AAPL) - 1  
American Assoc for Geriatric Psychiatry (AAGP) - 1  
American Association of Neurological Surgeons (AANS) - 3  
Former President (Carmel) - 1  
Delegates – 2  
Amer Assn of Neuromuscular & Electrodiagnostic Med (AANEM) - 2  
American Psychiatric Association (APA) - 10  
Former President (Harris) – 1  
Delegates - 8  
Resident and Fellow Section Delegate – 1  
American Society of Neuroimaging (ASNI) - 1  
Congress of Neurological Surgeons (CNS) - 2  
GLMA : Health Professionals Advancing LGBTQ Equality – 1  
North American Neuromodulation Society (NANS) - 1  
Spine Intervention Society (SIS) - 1

### NEW ENGLAND - 30

Connecticut – 7  
Trustee (Koirala) - 1  
Delegates - 4  
Medical Student Regional Delegates- 2  
Maine - 4  
Former President (McAfee) - 1  
Delegates – 2  
Medical Student Regional Delegate - 1  
Massachusetts - 15  
Delegates - 13  
Medical Student Regional Delegate- 1  
Resident and Fellow Section Delegate - 1  
New Hampshire - 1  
Rhode Island - 2  
Vermont – 1

### NEW YORK - 29

Former President (Nielsen) – 1  
Trustee (Madejski) – 1  
Delegates - 22  
Medical Student Regional Delegate - 1  
Resident and Fellow Section Delegate - 1  
American College of Nuclear Medicine (ACNM) - 1  
American Society of Neuroradiology (ASN) - 2

### NORTH CENTRAL - 18

Iowa – 5  
Delegates – 4  
Outpatient Endovascular and Interventional Society (OEIS) - 1  
Minnesota – 6  
Delegates - 5  
Medical Student Regional Delegate- 1  
Nebraska – 4  
Delegates – 2  
Medical Student Regional Delegate- 1  
Resident and Fellow Section Delegate - 1  
North Dakota - 1  
South Dakota - 2

### OBSTETRICIANS AND GYNECOLOGISTS - 17

American Association of Gynecologic Laparoscopists (AAGL) - 2  
American College of Medical Genetics and Genomics (ACMGG) - 1  
American College of Obstetricians and Gynecologists (ACOG) - 14

### ONCOLOGY - 4

Association for Clinical Oncology (ACO) – 4  
Delegates - 3  
Resident and Fellow Section Delegate - 1

### PACWEST CONFERENCE - 87

Alaska - 1  
Arizona - 8  
Delegates - 5  
Medical Student Regional Delegate- 1  
American Institute of Ultrasound in Medicine (AIUM) – 2  
California - 45  
Former Presidents (Bristow, Corlin, Plested) – 3  
Trustee (Aizuss, Ding) - 2  
Delegates - 33  
Medical Student Regional Delegates - 2  
Resident and Fellow Section Delegates - 3  
American Clinical Neurophysiology Soc (ACNS) – 1  
North American Neuro-Ophthalmology Society (NANOS) – 1  
Colorado - 7  
Former President (Lazarus) - 1  
Delegates - 5  
Obesity Medicine Association (OMA) - 1  
Hawaii - 2  
Idaho - 1  
Montana - 1  
Nevada – 3  
Delegates - 2  
Resident and Fellow Section Delegate - 1  
New Mexico – 5  
Former President (McAneny) - 1  
Delegates – 2  
Medical Student Regional Delegate - 1  
American Academy of Allergy, Asthma & Immunology (AAAAI) – 1

### PACWEST CONFERENCE (cont’d)

Oregon - 3  
Utah - 4  
Former Presidents (A. Nelson, J. Nelson) - 2  
Delegates - 2  
Washington – 6  
Delegates – 5  
Resident and Fellow Section Delegate - 1  
Wyoming – 1

### PATHOLOGY - 11

American Society for Clinical Pathology (ASCP) – 3  
American Society of Cytopathology (ASC) - 1  
College of American Pathologists (CAP) – 4  
National Association of Medical Examiners (NAME) - 1  
United States and Canadian Academy of Pathology (USCAP) – 2

### PEDIATRICS - 6

American Academy of Pediatrics (AAP) – 6  
Trustee (Ajayi) - 1  
Delegates - 5

### PENNSYLVANIA - 20

Former President (Gurman) – 1  
Trustee (Heine) - 1  
Delegates - 13  
Medical Student Regional Delegate- 1  
American Association of Physicians of Indian Origin (AAPIO) – 1  
American Osteopathic Association (AOA) – 1  
American Hernia Society (AHS) - 1  
National Medical Association (NMA) - 1

### PHYSICAL MEDICINE AND REHABILITATION - 3

American Academy of Physical Med & Rehabilitation (AAPMR) – 3  
Delegates – 2  
Resident and Fellow Section Delegate - 1

### PREVENTIVE MEDICINE - 8

Aerospace Medical Association (AsMA) - 1  
American Academy of Insurance Medicine (AAIM) - 1  
American Association of Public Health Physicians (AAPHP) – 2  
Delegate - 1  
Resident and Fellow Section Delegate - 1  
American College of Medical Quality (ACMQ) - 1  
American College of Occupational & Environmental Med (ACOEM) - 2  
American College of Preventive Medicine (ACPM) - 1

### RADIOLOGY - 19

American College of Radiology (ACR) – 11  
Delegates - 8  
Resident and Fellow Section Delegates - 3  
American Roentgen Ray Society (ARRS) – 3  
American Soc for Radiation Oncology (ASRO) – 2  
Association of University Radiologists (AUR) - 1  
Society of Interventional Radiology (SIR) - 2

### RHEUMATOLOGY - 2

American College of Rheumatology (ACRr) - 2

### RSNA - 3

Radiological Society of North America (RSNA) – 3

### SECTIONS - 12

Academic Physicians Section (APS) - 1  
Integrated Physician Practice Section (IPPS) - 1  
International Medical Graduates Section (IMG) - 1  
Medical Student Section (MSS) - 2  
Trustee (Harvey) - 1  
Delegate – 1  
Minority Affairs Section (MAS) - 1  
Organized Medical Staff Section (OMSS) – 1  
Private Practice Physician Section (PPPS) - 1  
Resident and Fellow Section (RFS) – 1  
Senior Physicians Section (SPS) - 1  
Women Physicians Section (WPS) -1  
Young Physicians Section (YPS) - 1

### SERVICES - 6

Air Force - 1  
Army - 1  
AMSUS - Society of Federal Health Professionals - 1  
Navy - 1  
Public Health Service - 1  
Veterans Affairs - 1

### SLEEP MEDICINE – 2

American Academy of Sleep Medicine (AASM) - 2

### SOUTHEASTERN - 124

Alabama - 4  
Arkansas – 4  
Trustee (Ferguson) – 1  
Delegates - 3  
Delaware - 2  
Former Board Chair (Permut) – 1  
Delegate - 1  
District of Columbia - 5  
Former Board Chair (Scalettar) - 1  
Delegates - 3  
Resident and Fellow Section Delegate - 1  
Florida – 23  
Former Presidents (Coble, Wilson) – 2  
Trustee (Butler) - 1  
Delegates - 16  
Medical Student Regional Delegates- 2  
Resident and Fellow Section Delegate - 1  
The Triological Society (TS) - 1  
Georgia – 7  
Delegates - 6  
Medical Student Regional Delegate- 1  
Kentucky - 7  
Former President (Hoven) - 1  
Delegates (minus Speaker) – 5  
Resident and Fellow Section Delegates - 2  
Louisiana - 10  
Former Presidents (Johnson, Palmisano) - 2  
Delegates - 6  
Medical Student Regional Delegates- 2  
Maryland - 8  
Trustee (Edwards) - 1  
Delegates – 5  
Medical Student Regional Delegate - 1  
Acad of Physicians in Clinical Research (APCR) - 1

### SOUTHEASTERN (cont’d)

Mississippi - 5  
Former President (Hill) - 1  
Delegates – 3  
Resident and Fellow Section Delegate - 1  
New Jersey – 10  
Delegates - 8  
Medical Student Regional Delegate- 1  
American Acad of Facial Plastic and Reconstructive Surgery (AAFPRS) - 1  
North Carolina - 6  
Oklahoma - 4  
Puerto Rico - 2  
South Carolina – 8  
Former President (Smoak) – 1  
Trustee (Pastides) - 1  
Delegates - 5  
Medical Student Regional Delegate- 1  
Tennessee – 6  
Delegates – 5  
American Vein and Lymphatic Society (AVLS) - 1  
Virginia - 11  
Former President (Wootton) - 1  
Delegates - 8  
Medical Student Regional Delegate- 1  
Resident and Fellow Section Delegate - 1  
West Virginia – 2

### SURGEONS - 43

American Academy of Cosmetic Surgery (AACS) - 1  
American Academy of Ophthalmology (AAO) – 4  
American Academy of Otolaryngic Allergy (AAOA) - 1  
Amer Acad of Otolaryngology - Head & Neck Surgery (AAOHN) - 3  
American Association for Thoracic Surgery (AATS) - 1  
American Association of Plastic Surgeons (AAPS) - 1  
American College of Surgeons (ACS) – 7  
American Society for Metabolic and Bariatric Surgery (ASMBS) - 1  
American Society for Reconstructive Microsurgery (ASRMS) - 1  
American Society of Breast Surgeons (ASBS) - 2  
American Society of Cataract and Refractive Surgery (ASCTRS) - 2  
American Society of Colon and Rectal Surgeons (ASCRS) - 2  
American Society of General Surgeons (ASGS) - 1  
American Soc of Maxillofacial Surgeons (ASMS) - 1  
Amer Soc of Ophthalmic Plastic & Reconstructive Surg (ASOPRS) - 1  
American Society of Plastic Surgeons (ASPS) – 4  
Delegates – 3  
Resident and Fellow Section Delegate - 1  
American Society of Retina Specialists (ASRS) - 1  
American Society of Transplant Surgeons (ASTS) - 1  
International Coll of Surgeons-US Section (ICS-US) - 1  
Society for Vascular Surgery (SVS) - 1  
Society of Amer Gastrointestinal Endoscopic Surgeons (SAGES) - 2  
Society of Laparoendoscopic Surgeons (SLR) - 2  
Society of Thoracic Surgeons (STS) - 2

### TERRITORIES - 2

Guam - 1  
Virgin Islands - 1

### TEXAS - 29

Former Presidents (Bailey, Dickey, Rohack) - 3  
Former Board Chair (Kridel) – 1  
Delegates - 20  
Medical Student Regional Delegates – 2  
Resident and Fellow Section Delegates - 2  
International Society of Hair Restoration Surgery (ISHRS) – 1

### THORACIC MEDICINE - 2

American Thoracic Society (ATS) - 2

### UROLOGY - 4

American Assoc of Clinical Urologists (AACU) - 1  
American Urological Association (AUA) – 3  
Delegates -2  
Resident and Fellow Section Delegate – 1

### OFFICIAL OBSERVERS - 28

Accreditation Association for Ambulatory Health Care  
Alliance for Continuing Education in the Health Professions  
Alliance for Regenerative Medicine  
Ambulatory Surgery Center Association  
American Academy of Physician Assistants  
American Association of Medical Assistants  
American Board of Medical Specialties  
American Dental Association  
American Health Quality Association  
American Hospital Association  
American Nurses Association  
American Podiatric Medical Association  
American Public Health Association  
Association of periOperative Registered Nurses  
Association of State and Territorial Health Officials  
Commission on Graduates of Foreign Nursing Schools  
Council of Medical Specialty Societies  
Educational Commission for Foreign Medical Graduates  
Federation of State Medical Boards  
Federation of State Physician Health Programs  
Medical Group Management Association  
Medical Professional Liability Association  
National Association of County and City Health Officials  
National Commission on Correctional Health Care  
National Council of State Boards of Nursing  
National Indian Health Board  
Society for Academic Continuing Medical Education  
US Pharmacopeia

### TELLERS - 4



# FLOOR PLAN LEVEL 1

# Kamehameha Exhibition Hall and Lobby



### LEGEND

- Parking
- Bicycle parking
- Escalator (2nd FL parking)
- Escalator (3rd & 4th FL)
- Elevator
- Accessible passenger loading zone
- Restroom (Men)
- Restroom (Women)
- Restroom (Universal)
- ATM
- Vending area
- Water fountain
- Bottle filler
- Nursing pod
- Defibrillator
- Smoking area
- LCD board
- Automatic entry door
- Entrance
- Wi-Fi area

1801 CAFE + BAR

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**Complimentary Wi-Fi Area**  
Connect to : Hawaii Free Wi-Fi

# FLOOR PLAN LEVEL 2 Parking

~ ALA WAI CANAL ~



### LEGEND

- Parking
- Bicycle parking
- Accessible passenger parking space
- Parking cashier
- Electric vehicle charging station
- Escalator (2nd FL parking)
- Escalator (3rd & 4th FL)
- Elevator
- Vending area
- Smoking area
- LCD board
- Entrance
- Wi-Fi area

**Complimentary Wi-Fi Area**  
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**KA'AHUMANU EXECUTIVE BOARDROOM**

# FLOOR PLAN LEVEL 3

## Meeting Rooms

**Complimentary Wi-Fi Area**  
Connect to : Hawaii Free Wi-Fi



LEGEND	
	Business center
	808 Café
	Escalator (2nd FL parking)
	Escalator (3rd & 4th FL)
	Elevator
	Restroom (Men)
	Restroom (Women)
	Water fountain
	Bottle filler
	Defibrillator
	First aid
	Art display
	Smoking area
	LCD board
	Entrance
	Wi-Fi area

**HAWAII**  
CONVENTION CENTER  
Where Business and Aloha Meet

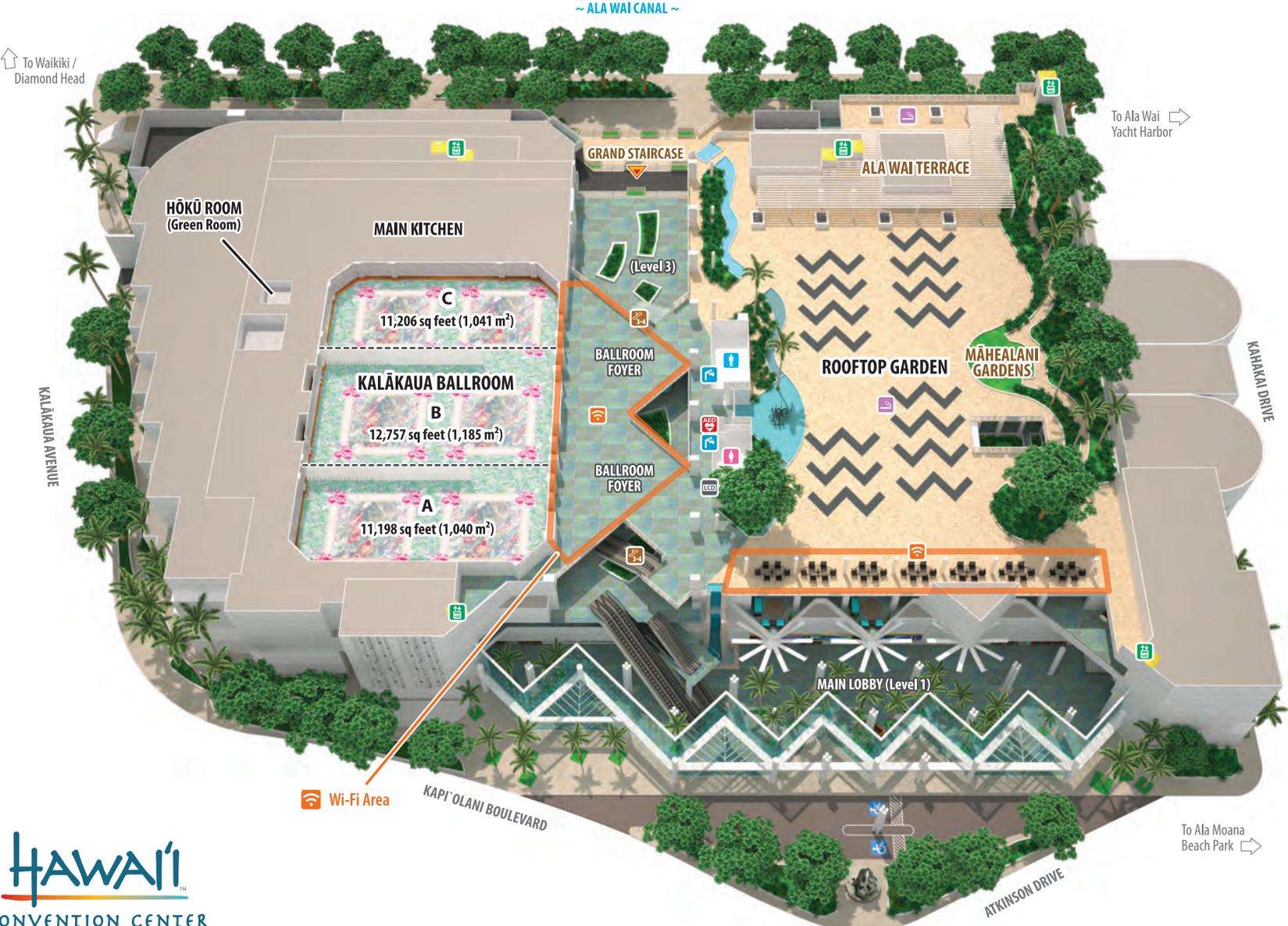
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# FLOOR PLAN LEVEL 4

## Ballroom and Rooftop Garden



**LEGEND**

- Escalator (3rd & 4th FL)
- Elevator
- Restroom (Men)
- Restroom (Women)
- Water fountain
- Defibrillator
- Smoking area
- LCD board
- Wi-Fi area

**ROOFTOP GARDEN FEATURES:**

- 2.5 acre open air rooftop garden
- Floor Load Limit, 100 lbs per net sq. ft.
- Grassy stage area approx. 37 x 42 ft.

**Complimentary Wi-Fi Area**  
 Connect to : Hawaii Free Wi-Fi

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## 2022 INTERIM MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Official Call to the Officers and Members of the American Medical Association to attend the November 2022 Interim Meeting of the House of Delegates in Honolulu, Hawai'i, –November 12-15, 2022.

The House of Delegates will convene at 1:00 p.m., on November 12 at the Hawai'i Convention Center.

### STATE ASSOCIATION REPRESENTATION IN THE HOUSE OF DELEGATES

Alabama 4	Guam 1	Massachusetts 13	New York 22	Tennessee 5
Alaska 1	Hawaii 2	Michigan 13	North Carolina 6	Texas 20
Arizona 5	Idaho 1	Minnesota 5	North Dakota 1	Utah 2
Arkansas 3	Illinois 12	Mississippi 3	Ohio 13	Vermont 1
California 33	Indiana 5	Missouri 6	Oklahoma 4	Virgin Islands 1
Colorado 5	Iowa 4	Montana 1	Oregon 3	Virginia 8
Connecticut 4	Kansas 3	Nebraska 2	Pennsylvania 13	Washington 5
Delaware 1	Kentucky 5	Nevada 2	Puerto Rico 2	West Virginia 2
District of Columbia 3	Louisiana 6	New Hampshire 1	Rhode Island 2	Wisconsin 5
Florida 16	Maine 2	New Jersey 8	South Carolina 5	Wyoming 1
Georgia 6	Maryland 5	New Mexico 2	South Dakota 2	

### SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

American Academy of Child and Adolescent Psychiatry 2	American Society for Gastrointestinal Endoscopy 3
American Academy of Dermatology 4	American Society for Radiation Oncology 2
American Academy of Family Physicians 16	American Society for Reproductive Medicine 2
American Academy of Hospice and Palliative Medicine 2	American Society of Addiction Medicine 2
American Academy of Neurology 4	American Society of Anesthesiologists 8
American Academy of Ophthalmology 4	American Society of Breast Surgeons 2
American Academy of Orthopaedic Surgeons 5	American Society of Cataract and Refractive Surgery 2
American Academy of Otolaryngology-Head and Neck Surgery 3	American Society of Colon and Rectal Surgeons 2
American Academy of Pediatrics 5	American Society of Echocardiography 2
American Academy of Physical Medicine and Rehabilitation 2	American Society of Hematology 2
American Academy of Sleep Medicine 2	American Society of Interventional Pain Physicians 2
American Association of Gynecologic Laparoscopists 2	American Society of Neuroradiology 2
American Association of Neurological Surgeons 2	American Society of Nuclear Cardiology 2
American Association of Neuromuscular & Electrodiagnostic Medicine 2	American Society of Plastic Surgeons 3
American College of Cardiology 7	American Society of Regional Anesthesia and Pain Medicine 2
American College of Chest Physicians (CHEST) 3	American Thoracic Society 2
American College of Emergency Physicians 8	American Urological Association 2
American College of Gastroenterology 2	Association for Clinical Oncology 3
American College of Obstetricians and Gynecologists 14	College of American Pathologists 4
American College of Occupational and Environmental Medicine 2	Congress of Neurological Surgeons 2
American College of Physicians 34	Heart Rhythm Society 2
American College of Radiology 8	Infectious Diseases Society of America 2
American College of Rheumatology 2	North American Spine Society 2
American College of Surgeons 7	Radiological Society of North America 3
American Gastroenterological Association 2	Society of American Gastrointestinal Endoscopic Surgeons 2
American Geriatrics Society 2	Society of Critical Care Medicine 2
American Institute of Ultrasound in Medicine 2	Society of Hospital Medicine 3
American Psychiatric Association 8	Society of Interventional Radiology 2
American Roentgen Ray Society 3	Society of Laparoscopic and Robotic Surgeons 2
American Society for Clinical Pathology 3	Society of Thoracic Surgeons 2
American Society for Dermatologic Surgery 2	The Endocrine Society 2
	United States and Canadian Academy of Pathology 2

*Remaining eligible national medical specialty societies (62) are entitled to one delegate each.*

The Academic Physicians Section, Integrated Physician Practice Section, International Medical Graduates Section, Medical Student Section, Minority Affairs Section, Organized Medical Staff Section, Private Practice Physicians Section, Resident and Fellow Section, Senior Physicians Section, Women Physicians Section, Young Physicians Section, Army, Navy, Air Force, Public Health Service, Department of Veterans Affairs, Professional Interest Medical Associations, AMWA, AOA and NMA are entitled to one delegate each.

State Medical Associations	306
National Medical Specialty Societies	302
Professional Interest Medical Associations	3
Other National Societies (AMWA, AOA, NMA)	3
Medical Student Regional Delegates	28
Resident and Fellow Delegate Representatives	33
Sections	11
Services	5
<b>Total Delegates</b>	<b>692</b>

**Registration facilities will be maintained at the Hawai'i Convention Center.**

Jack Resneck, Jr., MD  
President

Bruce A. Scott, MD  
Speaker, House of Delegates

Michael Suk, MD, JD, MPH, MBA  
Secretary

2022 - 2023

**OFFICIALS OF THE ASSOCIATION**

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Vice Speaker, House of Delegates - Lisa Bohman Egbert ..... Kettering, Ohio

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Toluwalase A. Ajayi (2026) ..... San Diego, California  
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Alexander Ding (2026) ..... Louisville, Kentucky  
Willarda V. Edwards (2024) ..... Baltimore, Maryland  
Scott Ferguson (2026) ..... West Memphis, Arkansas  
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Drayton Charles Harvey (2023) ..... Los Angeles, California  
Marilyn J. Heine (2026) ..... Dresher, Pennsylvania  
Pratistha Koirala (2023) ..... Danbury, Connecticut  
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Harris Pastides (2024) ..... Columbia, South Carolina  
Willie Underwood, III (2023), *Chair-Elect* ..... Buffalo, New York

**COUNCILS OF THE AMA**

**COUNCIL ON CONSTITUTION AND BYLAWS**

Kevin C. Reilly, Sr., Elizabethtown, Kentucky, Chair (2026); Mark N. Bair, Highland, Utah, Vice Chair, (2023);  
Jerry P. Abraham, Los Angeles, California (2025); Pino D. Colone, Howell, Michigan (2024);  
Mary Ann Contogiannis, Greensboro, North Carolina (2025); Titus Hou, Chicago, Illinois (Student) (2023);  
Christopher P. Libby, Anaheim, California (Resident) (2024); Steven C. Thornquist, Bethany, Connecticut (2026).  
Ex Officio, without vote: Bruce A. Scott, Louisville, Kentucky; Lisa Bohman Egbert, Kettering, Ohio.  
Secretary: Janice Robertson, Chicago, Illinois.

**COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS**

Peter A. Schwartz, Sinking Springs, Pennsylvania, Chair (2023); David A. Fleming, Columbia, Missouri, Vice Chair  
(2024); Rebecca W. Brendel, Boston, Massachusetts (2026); Michael G. Knight, Washington, DC (2029);  
Jeremy A. Lazarus, Greenwood Village, Colorado (2025); Kelsey C. Mumford, Washington, DC (Student) (2023);  
Larry E. Reaves, Fort Worth, Texas (2027); Daniel P. Sulmasy, Washington, DC (2028); Danish M. Zaidi,  
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South Dakota (2023); John R. Gatti, Baltimore, Maryland (Student) (2023); Merrilee Aynes Gober, Atlanta, Georgia  
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Secretary: Susan Close, Chicago, Illinois.

### **COUNCIL ON MEDICAL EDUCATION**

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Secretary: Tanya Lopez, Chicago, Illinois.

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Secretary: Val Carpenter, Chicago, Illinois.

### **COUNCIL ON SCIENCE AND PUBLIC HEALTH**

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Secretary: Andrea Garcia, Chicago, Illinois.

### **AMERICAN MEDICAL ASSOCIATION POLITICAL ACTION COMMITTEE**

Stephen A. Imbeau, Florence, South Carolina, Chair; Brooke M. Buckley, Bloomfield Hills, Michigan, Secretary; Elie C. Azrak, St. Louis, Missouri; Paul J. Carniol, Summit, New Jersey; Ricardo R. Correa, Cleveland, Ohio; Hart L. Edmonson, Seattle, Washington (Student); Benjamin Z. Galper, McLean, Virginia; James L. Milam, Bradenton, Florida; L. Elizabeth Peterson, Spokane, Washington; Stephen J. Rockower, Rockville, Maryland; Janice E. Tildon-Burton, Wilmington, Delaware; Anna L. Yap, Los Angeles, California (Resident).  
Executive Director and Treasurer: Kevin Walker, Washington, District of Columbia.

## EX OFFICIO MEMBERS OF THE HOUSE OF DELEGATES

The Former Presidents and Former Trustees of the Association, the Chairs of the Councils of the AMA and the current General Officers, with the exception of the Speaker and Vice Speaker of the House of Delegates, are ex officio, nonvoting members of the House of Delegates.

### FORMER PRESIDENTS

Susan R. Bailey	2020-2021	J. Edward Hill	2005-2006	Donald J. Palmisano	2003-2004
David O. Barbe	2017-2018	Ardis D. Hoven	2013-2014	William G. Plested, III	2006-2007
Lonnie R. Bristow	1995-1996	Daniel H. Johnson, Jr.	1996-1997	J. James Rohack	2009-2010
Peter W. Carmel	2011-2012	Jeremy A. Lazarus	2012-2013	Randolph D. Smoak, Jr.	2000-2001
Yank D. Coble, Jr.	2002-2003	Robert E. McAfee	1994-1995	Steven J. Stack	2015-2016
Richard F. Corlin	2001-2002	Barbara L. McAneny	2018-2019	Robert M. Wah	2014-2015
Nancy W. Dickey	1998-1999	Alan R. Nelson	1989-1990	Cecil B. Wilson	2010-2011
Andrew W. Gurman	2016-2017	John C. Nelson	2004-2005	Percy Wootton	1997-1998
Patrice A. Harris	2019-2020	Nancy H. Nielsen	2008-2009		

### FORMER TRUSTEES

Herman I. Abromowitz	1997-2005	Alan C. Hartford	1989-1990	Donald J. Palmisano	1996-2002
Susan Hershberg Adelman	1998-2002	William A. Hazel, Jr.	2004-2009	Rebecca J. Patchin	1988-1989
Kendall S. Allred	2008-2009	Cyril M. Hetsko	2003-2011	Rebecca J. Patchin	2003-2011
Raj S. Ambay	2009-2011	J. Edward Hill	1996-2004	Stephen R. Permut	2010-2018
Joseph P. Annis	2006-2014	Ardis D. Hoven	2005-2012	Pamela Petersen-Crair	1996-1998
Grayson W. Armstrong	2019-2021	William E. Jacott	1989-1998	Dina Marie Pitta	2015-2016
John H. Armstrong	2002-2006	Hillary D. Johnson	2001-2002	William G. Plested, III	1998-2005
Maya A. Babu	2013-2017	Matthew D. Kagan	1999-2000	Stephen Pool	1995-1996
Susan R. Bailey	2011-2018	Christopher K. Kay	2008-2012	Liana Puscas	1999-2001
Timothy E. Baldwin	1987-1989	William E. Kobler	2012-2020	Kevin C. Reilly	2003-2005
David O. Barbe	2009-2016	Russell W.H. Kridel	2014-2022	Ryan J. Ribeira	2013-2014
Regina M. Benjamin	1995-1998	Edward L. Langston	2003-2011	J. James Rohack	2001-2008
Scott L. Bernstein	1991-1992	Matthew C. Lawyer	2004-2005	David A. Rosman	2002-2004
Stefano M. Bertozzi	1986-1988	Jeremy A. Lazarus	2005-2011	Samantha L. Rosman	2005-2009
David J. Brailer	1985-1986	W. J. Lewis	1979-1984	Raymond Scalettar	1985-1994
Lonnie R. Bristow	1985-1994	Audrey J. Ludwig	1990-1991	Bruce A. Scott	1998-2002
Peter Carmel	2002-2010	Justin B. Mahida	2009-2010	Carl A. Sirio	2010-2018
Alice A. Chenault	1984-1985	Omar Z. Maniya	2016-2017	Sarah Mae Smith	2019-2020
Yank D. Coble	1994-2001	Robert E. McAfee	1984-1993	Randolph D. Smoak, Jr.	1992-1999
David S. Cockrum	1993-1994	Barbara L. McAneny	2010-2017	Steven J. Stack	2006-2014
MaryAnn Contogiannis	1989-1993	William A. McDade	2016-2020	Michael Suk	1994-1995
Malini Daniel	2012-2013	Mary Anne McCaffree	2008-2016	Andrew M. Thomas	1997-1999
Christopher M. DeRienzo	2006-2008	Joe T. McDonald	2005-2006	Jeffrey A. Towson	1998-1999
Nancy W. Dickey	1989-1997	Samuel J. Mackenzie	2014-2015	Georgia A. Tuttle	2011-2019
Alexander Ding	2011-2013	Robert R. McMillan	2002-2008	Jordan M. VanLare	2011-2012
William A. Dolan	2007-2011	Sandeep "Sunny" Mistry	2000-2001	Robert M. Wah	2005-2013
Timothy T. Flaherty	1994-2003	Mario Motta	2018-2022	Peter Y. Watson	2001-2003
Melissa J. Garretson	1992-1993	Elizabeth Blake Murphy	2020-2021	Monica C. Wehby	2011-2013
Michael S. Goldrich	1993-1997	Alan R. Nelson	1980-1988	Kevin W. Williams	2016-2020
Julie K. Goonewardene	2012-2016	John C. Nelson	1994-2003	Meredith C. Williams	2010-2011
Andrew W. Gurman	2007-2015	Nancy H. Nielsen	2005-2007	Cecil B. Wilson	2002-2009
Patrice A. Harris	2011-2018	Albert J. Osbahr, III	2011-2019	Percy Wootton	1991-1996

SPECIALTY AND SERVICE SOCIETY REPRESENTATIVES

*(The following are not members of the House of Delegates but are representatives of the following societies which are represented in the SSS.)*

Academy of Consultation Liaison Psychiatry .....	Lee Tynes, MD
American Academy of Addiction Psychiatry.....	Alena Balasanova, MD
American Academy of Emergency Medicine .....	Joseph Wood, MD, JD
American Association of Endocrine Surgeons.....	Dina Elaraj, MD
American Association of Hip and Knee Surgeons.....	Beau Kildow, MD
American College of Correctional Physicians .....	Charles Lee, MD
American College of Lifestyle Medicine .....	Cate Collings, MD
American Epilepsy Society .....	David M. Labiner, MD
American Society for Aesthetic Plastic Surgery .....	Clark F. Schierle, MD
American Society for Laser Medicine and Surgery .....	George Hruza, MD
American Venous Forum .....	Eleftherios Xenos, MD
Association of Academic Psychiatrists.....	Prakash Jayabalan, MD, PhD
Association of Professors of Dermatology.....	Christopher R. Shea, MD
International Academy of Independent Medical Evaluators .....	Gary Pushkin, MD
Korean American Medical Association .....	John Yun, MD
Society for Cardiovascular Magnetic Resonance .....	Edward T. Martin, MD
Society for Pediatric Dermatology .....	Dawn Davis, MD
Society of Gynecologic Oncologists	

**MEMBERS OF THE HOUSE OF DELEGATES SPECIAL MEETING - NOVEMBER 2022**

**The following is a list of delegates and alternate delegates to the House of Delegates  
as reported to the Executive Vice President**

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**Delegate(s)**

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John Meigs Jr, Brent AL

William Schneider, Huntsville AL

George C. Smith, Lineville AL

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Jane Weida, Tuscaloosa AL

Tom Weida, Tuscaloosa AL

**Regional Medical Student Alternate Delegate(s)**

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**Delegate(s)**

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**Alternate Delegate(s)**

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**Delegate(s)**

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Gary R. Figge, Tucson AZ

Michael Hamant, Tucson AZ

M Zuhdi Jasser, Phoenix AZ

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Jennifer Hartmark-Hill, Phoenix AZ

Jacquelyn Hoffman, Tucson AZ

Marc Leib, Phoenix AZ

**Arizona Medical Association**

**Regional Medical Student Delegate(s)**

Will Collins, Tucson AZ

**Regional Medical Student Alternate Delegate(s)**

Amrutha Doniparthi, Yuma AZ

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**Delegate(s)**

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Eugene Shelby, Little Rock AR

Alan Wilson, Monticello AR

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Stephen Magie, Conway AR

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Justin Magrath, New Orleans LA

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**Delegate(s)**

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Maisha Draves, Fairfield CA

Kyle P. Edmonds, San Diego CA

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Dev A. GnanaDev, Upland CA  
Robert Hertzka, Rancho Santa Fe CA  
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Tatiana W. Spirtos, Redwood City CA  
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Paul Yost, Seal Beach CA

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Jacob Burns, Sacramento CA  
Akshayaa Chittibabu, Los Angeles CA  
Jack Chou, Baldwin Park CA  
James Cotter, Napa CA  
Suparna Dutta, Oakland CA  
Sergio Flores, San Diego CA  
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Bryan Grady, San Francisco CA  
Catherine Gutfreund, Santa Rosa CA  
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Pauline Huynh, Oakland CA

### **Regional Medical Student Delegate(s)**

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Rana Andary, Irvine CA

### **California Medical Association**

#### **Regional Medical Student Alternate Delegate(s)**

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Dhruv Puri, Pleasanton CA

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#### **Alternate Delegate(s)**

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Annie Yao, Farmington CT

### **Connecticut State Medical Society**

#### **Regional Medical Student Alternate Delegate(s)**

Brent Heineman, Farmington CT

### **Medical Society of Delaware**

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## **Medical Association of Georgia**

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Fonda A. Mitchell, Atlanta GA  
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William Mohr, Kokomo IN  
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David Welsh, Batesville IN

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Deepak Azad, Floyds Knobs IN  
Roberto Darroca, Muncie IN  
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### **Regional Medical Student Alternate Delegate(s)**

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### **Delegate(s)**

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## **Kansas Medical Society**

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### **Alternate Delegate(s)**

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Caleb Natale, New Orleans LA

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Ellen Pil, Baltimore MD

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### **Regional Medical Student Delegate(s)**

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### **Regional Medical Student Alternate Delegate(s)**

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### **Regional Medical Student Alternate Delegate(s)**

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Ashok Patel, Rochester MN  
Laurel Ries, Saint Paul MN

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Ravi S Johar, Chesterfield MO  
Kayce Morton, Springfield MO  
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Steven Orland, Pennington NJ

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#### **Regional Medical Student Alternate Delegate(s)**

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### **New Mexico Medical Society**

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Andrew Rudawsky, Lakewood OH

William C. Sternfeld, Sylvania OH

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Maneesh Tiwari, Columbus OH

Christopher Wee, Shaker Hts OH

Kiersten Woodyard, Cincinnati OH

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### **Regional Medical Student Alternate Delegate(s)**

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### **Delegate(s)**

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## **Oregon Medical Association**

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### **Association for Clinical Oncology**

#### **Delegate(s)**

Steve Y. Lee, Oakland CA

Kristina Novick, Rochester NY

Erin Schwab, Grand Rapids MI

#### **Alternate Delegate(s)**

Edward P. Balaban, Penllynn PA

Thomas A. Marsland, Petaluma CA

**Association for Clinical Oncology**

**Resident and Fellow Sectional Delegate(s)**

David J. Savage, LaJolla CA

**Association of University Radiologists**

**Delegate(s)**

Stephen Chan, Closter NJ

**Alternate Delegate(s)**

Shyam Sabat, Gainesville FL

**College of American Pathologists**

**Delegate(s)**

James L. Caruso, Castle Rock CO

William V. Harrer, Haddonfield NJ

Jonathan Myles, Solon OH

Mark S. Synovec, Topeka KS

**Alternate Delegate(s)**

Jean Elizabeth Forsberg, Pineville LA

Joe Saad, Dallas TX

Joseph Sanfrancesco, Charleston SC

Susan Strate, Wichita Falls TX

**Resident and Fellow Sectional Alternate Delegate(s)**

Dana Martin, Richmond VA

**Congress of Neurological Surgeons**

**Delegate(s)**

Jason Schwalb, West Bloomfield MI

Ann R. Stroink, Bloomington IL

**Alternate Delegate(s)**

Maya A. Babu, Melbourne FL

**GLMA: Health Professionals Advancing LGBT Equality**

**Delegate(s)**

Jeremy Toler, New Orleans LA

**GLMA: Health Professionals Advancing LGBT Equality**

**Alternate Delegate(s)**

Jason S. Schneider, Atlanta GA

**Heart Rhythm Society**

**Delegate(s)**

Jim Cheung, New York NY

Steve Hao, San Francisco CA

**Alternate Delegate(s)**

Timothy Larsen, Chicago IL

**Infectious Diseases Society of America**

**Delegate(s)**

Michael L. Butera, San Diego CA

Steven W. Parker, Reno NV

**Resident and Fellow Sectional Delegate(s)**

Megan Srinivas, Fort Dodge IA

**International College of Surgeons-US Section**

**Delegate(s)**

Joshua Mammen, Omaha NE

**Alternate Delegate(s)**

Rifat Latifi, Valhalla NY

**International Society for the Advancement of Spine Surgery**

**Delegate(s)**

Morgan P. Lorio, Nashville TN

**Alternate Delegate(s)**

David Polly, Minneapolis MN

**International Society of Hair Restoration Surgery**

**Delegate(s)**

Carlos J. Puig, Houston TX

**Alternate Delegate(s)**

Sara M. Wasserbauer, Walnut Creek CA

### **National Association of Medical Examiners**

#### **Delegate(s)**

Michelle Jordan, San Jose CA

#### **Alternate Delegate(s)**

J Scott. Denton, Bloomington IL

### **National Medical Association**

#### **Delegate(s)**

Edith Mitchell, Philadelphia PA

#### **Alternate Delegate(s)**

Cedric Bright, Chapel Hill NC

### **North American Neuromodulation Society**

#### **Delegate(s)**

Nameer R. Haider, New Hartford NY

#### **Alternate Delegate(s)**

Brice Kessler, Durham NC

### **North American Neuro-Ophthalmology Society**

#### **Delegate(s)**

Benjamin Frishberg, Carlsbad CA

### **North American Spine Society**

#### **Delegate(s)**

R Dale Blasier, Little Rock AR

William Mitchell, Marlton NJ

### **Obesity Medicine Association**

#### **Delegate(s)**

Ethan Lazarus, Lone Tree CO

#### **Alternate Delegate(s)**

Anthony Auriemma, Elmhurst IL

### **Outpatient Endovascular and Interventional Society**

#### **Delegate(s)**

Eric J. Dippel, Davenport IA

### **Outpatient Endovascular and Interventional Society**

#### **Alternate Delegate(s)**

Samuel Ahn, Diamond Bar CA

### **Radiological Society of North America**

#### **Delegate(s)**

Nandini M. Meyersohn, Cambridge MA

Kevin C. Reilly, Elizabethtown KY

Laura E. Traube, San Luis Obispo CA

#### **Alternate Delegate(s)**

Shadi Abdar Esfahani, Boston MA

Michael C. Brunner, Madison WI

### **Society for Cardiovascular Angiography and Interventions**

#### **Delegate(s)**

J. Jeffrey Marshall, Atlanta GA

#### **Alternate Delegate(s)**

Edward Tuohy, Milford CT

### **Society for Vascular Surgery**

#### **Delegate(s)**

Timothy F. Kresowik, Iowa City IA

#### **Alternate Delegate(s)**

Nicolas J. Mouawad, Bay City MI

### **Society of American Gastrointestinal Endoscopic Surgeons**

#### **Delegate(s)**

Kevin Reavis, Portland OR

Paresh Shah, New York NY

#### **Alternate Delegate(s)**

Kellie Marie McFarlin, Detroit MI

**Society of Cardiovascular Computed Tomography**

**Delegate(s)**

Kanae Mukai, Salinas CA

**Society of Critical Care Medicine**

**Delegate(s)**

Kathleen Doo, Oakland CA

Tina R. Shah, Atlanta GA

**Alternate Delegate(s)**

Devang Sanghavi, Jacksonville FL

**Society of Interventional Radiology**

**Delegate(s)**

Meridith Englander, Albany NY

Charles Ray, Chicago IL

**Alternate Delegate(s)**

Christine Kim, Los Angeles CA

Annie K Lim, Denver CO

**Society of Nuclear Medicine and Molecular Imaging**

**Delegate(s)**

Gary L. Dillehay, Chicago IL

**Alternate Delegate(s)**

Munir Ghesani, Princeton Jct NJ

**Resident and Fellow Sectional Alternate Delegate(s)**

Domnique Newallo, Atlanta GA

Gbenga Shogbesan, Atlanta GA

**Society of Thoracic Surgeons**

**Delegate(s)**

Jeffrey P. Gold, Omaha NE

David D. Odell, Chicago IL

**Spine Intervention Society**

**Delegate(s)**

William D. Mauck, Rochester MN

**Alternate Delegate(s)**

Kate Sully, Niceville FL

**The Society of Laparoscopic and Robotic Surgeons**

**Delegate(s)**

Camran Nezhat, Palo Alto CA

Ceana Nezhat, Atlanta GA

**Undersea and Hyperbaric Medical Society**

**Delegate(s)**

Laurie Gesell, Brookfield WI

**US and Canadian Academy of Pathology**

**Delegate(s)**

Nicole Riddle, Tampa FL

Daniel Zedek, Chapel Hill NC

**Alternate Delegate(s)**

Keagan H. Lee, Austin TX

Nirali M. Patel, Chicago IL

**US Public Health Service**

**Delegate(s)**

Elizabeth Davlantes, Atlanta GA

**Veterans Affairs**

**Delegate(s)**

Carolyn Clancy, Silver Spring MD

### **Academic Physicians Section**

#### **Delegate(s)**

Alma B. Littles, Tallahassee FL

#### **Alternate Delegate(s)**

Gary Gaddis, St. Louis MO

### **Integrated Physician Practice Section**

#### **Delegate(s)**

Steven Wang, Bakersfield CA

#### **Alternate Delegate(s)**

Russell C. Libby, Fairfax VA

### **International Medical Graduates Section**

#### **Delegate(s)**

Afifa Adiba, Wallingford CT

#### **Alternate Delegate(s)**

Natalia Solenkova, Aventura FL

### **Medical Student Section**

#### **Delegate(s)**

Ryan Englander, Farmington CT

#### **Alternate Delegate(s)**

Brittany Ikwuagwu, Houston TX

### **Minority Affairs Section**

#### **Delegate(s)**

Luis Seija, New York NY

#### **Alternate Delegate(s)**

Siobhan Wescott, Grand Forks ND

### **Organized Medical Staff Section**

#### **Delegate(s)**

Matthew Gold, Winchester MA

#### **Alternate Delegate(s)**

Nancy Fan, Wilmington DE

### **Private Practice Physician Section**

#### **Delegate(s)**

Timothy G. Mc Avoy, Waukesha WI

#### **Alternate Delegate(s)**

Daniel Eunsuk Choi, New Hyde Park NY

### **Resident and Fellow Section**

#### **Delegate(s)**

Daniel Pfeifle, Rochester MN

#### **Alternate Delegate(s)**

Christopher T. Clifford, New York NY

### **Senior Physicians Section**

#### **Delegate(s)**

Virginia E. Hall, Hummelstown PA

#### **Alternate Delegate(s)**

Douglas M. DeLong, Cherry Valley NY

### **Women Physicians Section**

#### **Delegate(s)**

Nicole L. Plenty, Katy TX

#### **Alternate Delegate(s)**

Anna Laucis, Howard WI

### **Young Physicians Section**

#### **Delegate(s)**

Alisha Reiss, Greenville OH

#### **Alternate Delegate(s)**

Sean Figy, Omaha NE

**Reference Committee Hearing Room Assignments  
Sunday, November 13**

**8:30am**

**Room**

Amendments to Constitution & Bylaws

Room 313 A-C

B Legislative advocacy

Exhibit Hall III (Kamehameha III)

C Advocacy on medical education

Room 311

F AMA governance and finance

Kalakaua Ballroom

J Advocacy on medical service, practice, and insurance

Room 316 A-C

K Advocacy on science and public health

Room 323 A-C

**REFERENCE COMMITTEES OF THE HOUSE OF DELEGATES  
(November 2022 Interim Meeting)**

**Reference Committee on Amendments to Constitution and Bylaws**

Susan L. Hubbell, MD, American Academy of Physical Medicine and Rehabilitation, Chair  
Afifa Adiba, MD, International Medical Graduate Section\*  
Emily Briggs, American Academy of Family Physicians  
Amish Dave, MD, Washington\*  
John C. Kincaid, MD, American Association of Neuromuscular & Electrodagnostic Medicine\*  
Laila Koduri, Regional Medical Student  
Carlos Latorre, MD, Mississippi

**Reference Committee B (Legislation)**

Hillary Johnson-Jahangir, MD, PhD, American Academy of Dermatology, Chair  
Kenneth S. Blumenfeld, MD, American Association of Neurological Surgeons  
Tilden L. Childs, III, MD, American College of Radiology  
Daniel Choi, MD, Private Practice Physicians Section\*  
Kelly J. Clark, MD, American Society of Addiction Medicine\*  
Karl Steinberg, MD, AMDA - The Society for Post-Acute and Long-Term Care Medicine  
Kiersten Woodyard, Ohio\*

**Reference Committee C (Medical Education)**

Ramin Manshadi, MD, California, Chair  
T. Jann Caison-Sorey, MD, Michigan  
Marygrace Elson, MD, American College of Obstetricians and Gynecologists  
Renato Guerrieri, American College of Physicians  
Heidi Hullinger, MD, American Academy of Orthopaedic Surgeons  
Pauline Huynh, MD, Sectional Resident  
Alex Malter, MD, MPH, Alaska

**Reference Committee F (AMA Finance; AMA Governance)**

Cheryl Gibson Fountain, MD, American College of Obstetricians and Gynecologists, Chair  
Brooks F. Bock, MD, American College of Emergency Physicians  
Robyn F. Chatman, MD, MPH, Ohio  
Rebecca L. Johnson, MD, Florida\*  
Shilpen A. Patel, MD, American Society for Radiation Oncology  
William Reha, MD, American Association of Clinical Urologists\*  
Michael B. Simon, MD, American Society of Anesthesiologists

**Reference Committee J (Advocacy Related to Medical Service, Medical Practice, Insurance and Related Topics)**

Brigitta J. Robinson, MD, Colorado\*, Chair  
Sarah G. Candler, MD, American College of Physicians  
M. Laurin Council, MD, American Society for Dermatologic Surgery  
Amar Kelkar, MD, American Society of Hematology  
Anne Mongiu, MD, American Society of Colon and Rectal Surgeons  
Jason Schwalb, MD, Congress of Neurological Surgeons  
Natalia Solenkova, MD, International Medical Graduate Section\*

**Reference Committee K (Advocacy Related to Medical Education, Science and Public Health Topics)**

Robert H. Emmick, Jr., MD, Texas\*, Chair  
Elisa Choi, MD, American College of Physicians  
Cee Ann Davis, MD, MPH, American College of Obstetricians and Gynecologists  
Leanna (Leif) Knight, Regional Medical Student  
Christopher Paprzycki, MD, Ohio\*  
Jennifer N. Stall, MD, American Society for Clinical Pathology  
Raymond K. Tu, MD, District of Columbia

**Committee on Rules and Credentials**

Marilyn K. Laughead, MD, American Institute of Ultrasound in Medicine, Chair  
Jerry P. Abraham, MD, MPH, California  
Mark N. Bair, MD, Utah  
Cheryl Hurd, MD, American Psychiatric Association  
Niva Lubin-Johnson, MD, Illinois  
Chand Rohatgi, MD, American Association of Physicians of Indian Origin  
Whitney Stuard, Texas\*

**Chief Teller**

Andrea Hillerud, MD, Minnesota

\* *Alternate Delegate*

# **AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES**

**2022 Interim Meeting  
Note on Orders of Business  
Kalakaua Ballroom, Hawai'i Convention Center**

FIRST SESSION, Saturday, November 12 – 1:00-2:30 pm

SECOND SESSION, Sunday, November 13 – 8:00-8:30 am

THIRD SESSION, Monday, November 14 – 1:00-6:00 pm

FOURTH SESSION, Tuesday, November 15 – 8:00 am - completion of business

## SUMMARY OF FISCAL NOTES (I-22)

### **BOT Report(s)**

- 01 Opposition to Requirements for Gender-Based Treatments for Athletes: Minimal
- 02 Further Action to Respond to the Gun Violence Public Health Crisis: None
- 03 Delegate Apportionment and Pending Members: Minimal
- 04 Preserving Access to Reproductive Health Services: Minimal
- 05 Towards Diversity and Inclusion: A Global Nondiscrimination Policy Statement and Benchmark for our AMA: Within current budget
- 06 Informal Inter-Member Mentoring: Informational report
- 07 Transparency of Resolution Fiscal Notes: None
- 08 The Resolution Committee as a Standing Committee of the House: Within current budget
- 09 Employed Physicians: Modest
- 10 Redefining the AMA's Position on ACA and Healthcare Reform: Informational report
- 11 2022 AMA Advocacy Efforts: Informational report
- 12 Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment: Minimal

### **CC&B Report(s)**

- 01 Updated Bylaws: Delegate Apportionment and Pending Members: Minimal

### **CEJA Opinion(s)**

- 01 Amendment to E-9.3.2, "Physician Responsibilities to Colleagues with Illness, Disability or Impairment": Informational report

### **CEJA Report(s)**

- 01 Amendment to Opinion 4.2.7, "Abortion": Minimal
- 02 Amendment to Opinion 10.8, "Collaborative Care": Minimal
- 03 Pandemic Ethics and the Duty of Care: Minimal
- 04 Research Handling of De-Identified Patient Information: Informational report

### **CLRPD Report(s)**

- 01 Senior Physicians Section Five-Year Review: Within current budget

### **CME Report(s)**

- 01 The Impact of Private Equity on Medical Training: Minimal
- 02 Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process: Minimal

### **CMS Report(s)**

- 01 Incentives to Encourage Efficient Use of Emergency Departments: Minimal
- 02 Corporate Practice of Medicine: Minimal
- 03 Health System Consolidation: Informational report

### **CSAPH Report(s)**

- 01 Drug Shortages: 2022 Update: Minimal
- 02 Climate Change and Human Health: Minimal

## SUMMARY OF FISCAL NOTES (I-22)

### HOD Comm on Compensation of the Officers

01 Report of the HOD Committee on Compensation of the Officers: none

### Report of the Speakers

01 Election Committee - Interim Report: Up to \$5,000 annually

### Resolution(s)

- 002 Assessing the Humanitarian Impact of Sanctions: Modest
- 003 Indigenous Data Sovereignty: Minimal
- 005 Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants: Modest
- 006 Assessing the Humanitarian Impact of Sanctions: Modest
- 007 Consent for Sexual and Reproductive Healthcare: Modest
- 008 Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era: Estimated cost of \$58,000 for staff costs and for work with external legal counsel to develop strategies and guidance to assist affected physicians.
- 201 Physician Reimbursement for Interpreter Services: Modest
- 202 Advocating for State GME Funding: Modest
- 203 International Medical Graduate Employment: Minimal
- 205 Waiver of Due Process Clauses: Minimal
- 206 The Shortage of Bedside Nurses and Intersection with Concerns in Nurse Practitioner Training: Estimated cost of \$50,000 includes staffing and professional fees.
- 207 Preserving Physician Leadership in Patient Care: Estimated cost of \$255K for a national targeted ad campaign includes professional fees and staffing.
- 208 Comparing Student Debt, Earnings, Work Hours, and Career Satisfaction Metrics in Physicians v. Other Health Professionals: Estimated cost to implement resolution is \$306K. Primary expense is for contracting externally to conduct research.
- 209 Comprehensive Solutions for Medical School Graduates Who Are Unmatched or Did Not Complete Training: Modest
- 211 Illicit Drug Use Harm Reduction Strategies: Minimal
- 213 Hazard Pay During a Disaster Emergency: Modest
- 214 Universal Good Samaritan Statute: Modest
- 215 Eliminating Practice Barriers for Immigrant Physicians During Public Health Emergencies: Modest
- 302 Expanding Employee Leave to Include Miscarriage and Stillbirth: Minimal
- 303 Medical Student Leave Policy: Minimal
- 304 Protecting State Medical Licensing Boards from External Political Influence: Modest
- 305 Encouraging Medical Schools to Sponsor Pipeline Programs to Medicine for Underrepresented Groups: Minimal
- 306 Increased Credit for Continuing Medical Education Preparation: Modest
- 307 Fair Compensation of Residents and Fellows: Modest
- 308 Paid Family/Medical Leave in Medicine: Minimal
- 309 Bereavement Leave for Medical Students and Physicians: Minimal
- 601 AMA Withdraw its Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity: Estimated cost of \$415,000 to clarify sections of SP to be rewritten, rewrite, engage stakeholders, redo layout and design, production and printing, includes staffing, travel/meetings, and professional staff.
- 602 Finding Cities for Future AMA Conventions/Meetings: Minimal
- 801 Parity in Military Reproductive Health Insurance Coverage for All Service Members and Veterans: Minimal
- 802 FAIR Health Database: Modest
- 803 Patient Centered Medical Home – Administrative Burdens: Modest
- 804 Centers for Medicare & Medicaid Innovation Projects: Modest

## SUMMARY OF FISCAL NOTES (I-22)

### **Resolution(s)**

- 805 COVID Vaccine Administration Fee: Minimal
- 806 Healthcare Marketplace Plan Selection: Modest
- 807 Medicare Advantage Record Requests: Modest
- 808 Reinstatement of Consultation Codes: Modest
- 809 Uniformity and Enforcement of Medicare Advantage Plans and Regulations: Modest
- 810 Medicare Drug Pricing and Pharmacy Costs: Modest
- 811 Covering Vaccinations for Seniors Through Medicare Part B: Modest
- 812 Implant-Associated Anaplastic Large Cell Lymphoma: Minimal
- 813 Amending Policy on a Public Option to Maximize AMA Advocacy: Minimal
- 814 Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?: Modest
- 902 Reducing the Burden of Incarceration on Public Health: Modest
- 904 Immigration Status is a Public Health Issue: Moderate
- 905 Minimal Age of Juvenile Justice Jurisdiction in the United States: Modest
- 906 Requirement for COVID-19 Vaccination in Public Schools Once Fully FDA-Authorized: Minimal
- 907 A National Strategy for Collaborative Engagement, Study, and Solutions to Reduce the Role of Illegal Firearms in Firearm Related Injury: not yet determined
- 908 Older Adults and the 988 Suicide and Crisis Timeline: Modest
- 909 Decreasing Gun Violence and Suicide in Seniors: not yet determined
- 910 Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use: Minimal
- 911 Critical Need for National ECC System to Ensure Individualized, State-Wide, care for STEMI, CS and OHCA, and to Reduce Disparities in Health Care for Patients with Cardiac Emergencies: Minimal

### **Resolutions not for consideration**

- 001 Updating Physician Job Description for Disability Insurance: Modest
- 004 Supporting Intimate Partner and Sexual Violence Safe Leave: Minimal
- 204 Elimination of Seasonal Time Change: Modest
- 210 Elimination of Seasonal Time Changes and Establishment of Permanent Standard Time: Minimal
- 212 SNAP Expansion for DACA Recipients: Modest
- 301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education: Minimal
- 603 AMA House of Delegates Resolution Process Review: Minimal
- 604 Solicitation Using the AMA Brand: Minimal
- 901 Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies: Minimal
- 903 Supporting Further Study of Kratom: Minimal

## **SUMMARY OF FISCAL NOTES (I-22)**

**Minimal - less than \$1,000**

**Modest - between \$1,000 - \$5,000**

**Moderate - between \$5,000 - \$10,000**

## **RESOLUTIONS - BY SPONSOR (I-22)**

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### **American Academy of Physical Medicine and Rehabilitation**

- 603 AMA House of Delegates Resolution Process Review
  - 907 A National Strategy for Collaborative Engagement, Study, and Solutions to Reduce the Role of Illegal Firearms in Firearm Related Injury
- 

### **American Association of Clinical Urologists**

- 201 Physician Reimbursement for Interpreter Services
- 

### **American College of Cardiology**

- 814 Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?
- 

### **American College of Radiology**

- 308 Paid Family/Medical Leave in Medicine
- 

### **Arkansas**

- 307 Fair Compensation of Residents and Fellows
- 

### **Colorado**

- 008 Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era
- 

### **Georgia**

- 214 Universal Good Samaritan Statute
  - 806 Healthcare Marketplace Plan Selection
  - 807 Medicare Advantage Record Requests
  - 808 Reinstatement of Consultation Codes
- 

### **Illinois**

- 305 Encouraging Medical Schools to Sponsor Pipeline Programs to Medicine for Underrepresented Groups
  - 905 Minimal Age of Juvenile Justice Jurisdiction in the United States
- 

### **International Medical Graduate Section**

- 007 Consent for Sexual and Reproductive Healthcare
  - 215 Eliminating Practice Barriers for Immigrant Physicians During Public Health Emergencies
  - 904 Immigration Status is a Public Health Issue
- 

### **Louisiana**

- 601 AMA Withdraw its Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity

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## Medical Student Section

- 003 Indigenous Data Sovereignty
- 004 Supporting Intimate Partner and Sexual Violence Safe Leave
- 005 Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants
- 006 Assessing the Humanitarian Impact of Sanctions
- 212 SNAP Expansion for DACA Recipients
- 302 Expanding Employee Leave to Include Miscarriage and Stillbirth
- 303 Medical Student Leave Policy
- 901 Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies
- 902 Reducing the Burden of Incarceration on Public Health
- 903 Supporting Further Study of Kratom

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## Missouri

- 203 International Medical Graduate Employment
- 204 Elimination of Seasonal Time Change
- 205 Waiver of Due Process Clauses

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## New England Delegation

- 813 Amending Policy on a Public Option to Maximize AMA Advocacy

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## New York

- 213 Hazard Pay During a Disaster Emergency
- 304 Protecting State Medical Licensing Boards from External Political Influence
- 306 Increased Credit for Continuing Medical Education Preparation
- 802 FAIR Health Database
- 803 Patient Centered Medical Home – Administrative Burdens
- 804 Centers for Medicare & Medicaid Innovation Projects
- 906 Requirement for COVID-19 Vaccination in Public Schools Once Fully FDA-Authorized

---

## Resident and Fellow Section

- 002 Assessing the Humanitarian Impact of Sanctions
- 206 The Shortage of Bedside Nurses and Intersection with Concerns in Nurse Practitioner Training
- 207 Preserving Physician Leadership in Patient Care
- 208 Comparing Student Debt, Earnings, Work Hours, and Career Satisfaction Metrics in Physicians v. Other Health Professionals
- 209 Comprehensive Solutions for Medical School Graduates Who Are Unmatched or Did Not Complete Training
- 210 Elimination of Seasonal Time Changes and Establishment of Permanent Standard Time
- 211 Illicit Drug Use Harm Reduction Strategies
- 301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education
- 309 Bereavement Leave for Medical Students and Physicians
- 604 Solicitation Using the AMA Brand
- 812 Implant-Associated Anaplastic Large Cell Lymphoma
- 910 Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use

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**Senior Physicians Section**

- 809 Uniformity and Enforcement of Medicare Advantage Plans and Regulations
  - 810 Medicare Drug Pricing and Pharmacy Costs
  - 811 Covering Vaccinations for Seniors Through Medicare Part B
  - 908 Older Adults and the 988 Suicide and Crisis Timeline
  - 909 Decreasing Gun Violence and Suicide in Seniors
- 

**Society for Cardiovascular Angiography & Interventions**

- 911 Critical Need for National ECC System to Ensure Individualized, State-Wide, care for STEMI, CS and OHCA, and to Reduce Disparities in Health Care for Patients with Cardiac Emergencies
- 

**Southeast Delegation**

- 602 Finding Cities for Future AMA Conventions/Meetings
- 

**Utah**

- 805 COVID Vaccine Administration Fee
- 

**Young Physicians Section**

- 001 Updating Physician Job Description for Disability Insurance
- 202 Advocating for State GME Funding
- 801 Parity in Military Reproductive Health Insurance Coverage for All Service Members and Veterans

## **Reference Committee on Amendments to Constitution and Bylaws**

### **BOT Report(s)**

- 01 Opposition to Requirements for Gender-Based Treatments for Athletes
- 03 Delegate Apportionment and Pending Members
- 04 Preserving Access to Reproductive Health Services
- 05 Towards Diversity and Inclusion: A Global Nondiscrimination Policy Statement and Benchmark for our AMA
- 12 Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment

### **CC&B Report(s)**

- 01 Updated Bylaws: Delegate Apportionment and Pending Members

### **CEJA Report(s)**

- 01 Amendment to Opinion 4.2.7, “Abortion”
- 02 Amendment to Opinion 10.8, “Collaborative Care”
- 03 Pandemic Ethics and the Duty of Care

### **Resolution(s)**

- 002 Assessing the Humanitarian Impact of Sanctions
- 003 Indigenous Data Sovereignty
- 005 Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants
- 006 Assessing the Humanitarian Impact of Sanctions
- 007 Consent for Sexual and Reproductive Healthcare
- 008 Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era

REPORT OF THE BOARD OF TRUSTEES

B of T Report 1-I-22

Subject: Opposition to Requirements for Gender-Based Treatments for Athletes  
(Resolution 19-A-19)

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Resolution 19-A-19, “Opposition to Requirements for Gender-Based Treatment for Athletes,”  
2 sponsored by the Medical Student Section, was referred to the Board of Trustees. Resolution 19-A-  
3 19 asked:

- 4
- 5 1. That our American Medical Association (AMA) oppose any regulations requiring  
6 mandatory medical treatment or surgery for athletes with Differences of Sex Development  
7 (DSD) to be allowed to compete in alignment with their identity; (New HOD Policy) and  
8
- 9 2. That our AMA oppose the creation of distinct hormonal guidelines to determine gender  
10 classification for athletic competitions. (New HOD Policy)

11  
12 BACKGROUND

13  
14 Resolution 19 reacts to guidelines issued in 2018 by the International Association of Athletics  
15 Federations (IAAF)—now World Athletics—updating eligibility criteria for athletes with  
16 differences of sex development (DSD) who wish to compete as women in certain international  
17 track and field events. Under these guidelines, to be eligible to compete in the 400m, hurdles races,  
18 800m, 1500m, one-mile races and combined events over the same distances, women with DSD  
19 who have serum testosterone levels above 5 nmol/L and who are androgen sensitive must:

- 20
- 21 • be legally recognized as female or intersex
- 22 • reduce their circulating serum testosterone levels to below 5 nmol/L for a continuous  
23 period of 6 months, and
- 24 • maintain their serum testosterone level below 5 nmol/L continuously for as long as they  
25 wish to remain eligible to compete (regardless of whether they are in competition) [1].

26  
27 Female athletes with DSD who choose not to reduce their serum testosterone levels will be eligible  
28 to compete in all events that are not international competitions and in events in international  
29 competitions other than those specifically prohibited [1].

30  
31 In a separate report, World Athletics outlines eligibility criteria for transgender athletes competing  
32 in international competitions. They specify that

- 33
- 34 • to be eligible to participate in the female category of competition, a transgender female  
35 athlete must provide a written and signed declaration that her gender identity is female;

- 1 • she must demonstrate to the satisfaction of an expert panel that the concentration of  
2 testosterone in her serum has been less than 5 nmol/L continuously for a period of at least  
3 12 months; and
- 4 • she must keep her serum testosterone concentration below 5 nmol/L for so long as she  
5 wishes to maintain her eligibility to compete in the female category [2].  
6

7 They further specify that “no athlete will be forced to undergo any medical assessment and/or  
8 treatment” and that neither “legal recognition of the athlete's gender identity” nor “surgical  
9 anatomical changes” are required to compete [2].  
10

11 These guidelines represent the most recent in a series of efforts by the international athletic  
12 community to ensure fairness in women’s competitions that began with “gender verification”  
13 policies in the 1960s. In 1968, following the extraordinary successes of Tamara and Irina Press in  
14 the 1960 and 1964 Olympics, who were suspected of being male, female athletes were required to  
15 prove their sex to be eligible to compete as women in international events [3]. Over time,  
16 procedures to determine sex evolved from having female athletes parade naked before a panel of  
17 judges, through gynecological examination of external genitalia, to the use of sex chromatin tests,  
18 and ultimately DNA-based testing [3]. In 2000, the International Olympic Committee (IOC) and  
19 IAAF discontinued routine gender verification in favor of “suspicion-based testing,” reserving the  
20 right to test if officials or competitors raised questions about a female athlete’s sex.  
21

22 In 2011, in the wake of controversy over South African runner Caster Semenya, the IOC’s Medical  
23 Commission recommended hormone-based testing, that is, that individuals recognized in law as  
24 female be eligible to compete in women’s competitions so long as their serum testosterone levels  
25 were “below the male range” or if they had an androgen resistance and derived no competitive  
26 advantage from testosterone levels in the male range [3]. The IAAF adopted hormonal testing and  
27 implemented new policy that routinely tested all female athletes and required those who tested  
28 outside the normal range to undergo treatment to normalize their androgen levels to be eligible to  
29 compete.  
30

31 In March 2019 the United Nations Human Rights Council adopted Resolution 40/5, “Elimination  
32 of discrimination against women and girls in sport,” noting concern that the IAAF/World Athletics  
33 eligibility criteria  
34

35 are not compatible with international human rights norms and standards, including the rights of  
36 women with differences of sex development, and concerned at the absence of legitimate and  
37 justifiable evidence for the regulations to the extent that they may not be reasonable and  
38 objective, and that there is no clear relationship of proportionality between the aim of the  
39 regulations and the proposed measures and their impact [4].  
40

41 The resolution further expressed concern that  
42

43 discriminatory regulations, rules and practices that may require women and girl athletes with  
44 differences of sex development, androgen sensitivity and levels of testosterone to medically  
45 reduce their blood testosterone levels contravene international human rights norms and  
46 standards ... [4]  
47

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

1 to promote a safe and welcoming environment for everyone, consistent with the principles  
2 enshrined in the Olympic Charter; it “acknowledges the central role that eligibility criteria play  
3 in ensuring fairness, particularly in high-level organized sport in the women’s category” [5].  
4

5 With the framework, the IOC recognized “that it is not in a position to issue regulations that define  
6 eligibility for every sport” and explicitly left it “to each sport and its governing body to determine  
7 how an athlete may be at disproportionate advantage to their peers” [5].  
8

9 Also in 2021, the authors of a 2017 study on which World Athletics relied heavily in developing its  
10 eligibility criteria published a correction in response to ongoing critique from independent  
11 statisticians. The correction acknowledged that “there is no confirmatory evidence for causality in  
12 the observed relationships reported” [6]. The authors further noted that the initial research was  
13 “exploratory and not intend[ed] to prove a causal influence and that some statements in the original  
14 publication could have been misleading” [6].  
15

16 World Athletics has not modified its criteria [6], however, and controversy regarding participation  
17 by female athletes with DSD continues.  
18

19 The related controversy concerning participation of transgender athletes in all types of sports has  
20 escalated in recent years. Since 2020, a number of state legislatures have introduced proposals to  
21 prohibit transgender girls from competing in girls’ high school (and in some cases college) sports.  
22 In March 2020, Idaho was the first state to impose a ban on transgender women and girls’  
23 participation in school sports. In 2021, Alabama, Arkansas, Florida, Mississippi, Montana,  
24 Tennessee, and West Virginia passed similar bans, and South Dakota’s governor issued two  
25 Executive Orders which implemented a similar prohibition. At the same time the Connecticut court  
26 case *Soule et al v. CT Association of Schools et al* was in process. In this case the Alliance  
27 Defending Freedom sought to ban two Black, transgender girls from competing in high school  
28 track and field [7].  
29

30 The Idaho ban was blocked by a federal court in August 2020. The AMA, along with the American  
31 Academy of Pediatrics and other health care organizations, submitted an amicus brief with the  
32 Ninth Circuit Court of Appeals noting that the law undermines the accepted approach for treating  
33 gender dysphoria. The brief stated that prohibiting transgender females from participating in  
34 school-sponsored sports in keeping with their gender identity interferes with the treatment of  
35 gender dysphoria by preventing transgender females from living openly in accordance with their  
36 true gender [8].  
37

38 The AMA, together with five other healthcare organizations, also submitted an amicus brief in  
39 *Soule et al v. CT Association of Schools et al*. In it, they emphasize that untreated gender dysphoria  
40 can cause debilitating distress, depression, impairment of function, self-mutilation, other self-  
41 injurious behaviors, and suicide. They also note that transgender individuals are subject to  
42 discrimination in multiple areas of their lives, and this both exacerbates negative health outcomes  
43 and reinforces the stigma associated with being transgender. Being subject to stigmatization is  
44 psychologically harmful and so creates additional negative mental health consequences [9].  
45

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

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

- 4
- 5 • eligibility criteria should be established and implemented fairly and in a manner that does  
6 not systematically exclude athletes from competition based upon their gender identity,  
7 physical appearance and/or sex variations;
- 8 • no athlete should be subject to targeted testing because of, or aimed at determining, their  
9 sex, gender identity and/or sex variations;
- 10 • athletes should not be pressured to undergo medically unnecessary procedures or treatment  
11 to meet eligibility criteria; and
- 12 • criteria to determine eligibility should not include gynecological examinations or other  
13 invasive physical examinations aimed at determining an athlete's gender or sex [5].
- 14

#### 15 FAIRNESS IN SPORT

16  
17 Regulations intended to promote fairness in sport by restricting the participation of individuals  
18 whose genetic characteristics are deemed to give them unfair advantage over competitors raise a  
19 series of questions about what the goals of sport are, what counts as an “unfair” advantage, and  
20 what should be done to “level the playing field.”

#### 21 *Biological Advantage*

22  
23  
24 Policy restricting competition by female athletes who have serum testosterone levels above a  
25 designated “normal” range rests on (at least) two problematic assumptions. The first of those  
26 assumptions is that there is a straightforward relationship between testosterone and athletic  
27 performance that unequivocally gives these athletes significant advantage over female competitors  
28 whose bodies do not produce “excess” endogenous testosterone. The second is that serum  
29 testosterone levels can meaningfully be measured, and that prescribed levels can be safely and  
30 effectively maintained. The specific contribution of testosterone to overall athletic performance  
31 continues to be a subject of debate. Critics of the research on which the IAAF based its regulations  
32 on endogenous testosterone have argued that a key study concluding that women with the highest  
33 testosterone levels significantly and consistently outperformed other female competitors rests on  
34 flawed data [11]. Concerns have also been raised about the rigor of its statistical analysis [12]. The  
35 main author, moreover, was the director for the IAAF Science and Health Department, raising  
36 questions about possible conflict of interest [13]. More importantly, demonstrating a correlation  
37 between testosterone and athletic performance in female athletes falls short of establishing the  
38 unfairness of such advantage [13].

39  
40 However, even if the effect of testosterone on athletic performance was conclusively established,  
41 single point-in-time tests for overall level of serum testosterone cannot provide conclusive  
42 evidence that the individual has or will benefit. It is known that women with androgen insensitivity  
43 disorder physiologically cannot gain benefit from excess endogenous testosterone. Multiple factors  
44 affect serum concentrations of testosterone, including time of day; age- and gender-corrected  
45 normal ranges using a standard assay have not been established; and there is no universally  
46 recognized standard for calibrating testosterone [14].

47  
48 Further, “the relevance of free testosterone vs [sic] the fraction actually available to tissues (the  
49 “bio-testosterone”) is not well understood” [15]. Nor do the IAAF regulations take into account the  
50 existing lack of consensus about “how to use medications safely to lower testosterone levels when

1 used off-label, the side effects of the medications, [or] the difficulties of maintaining the  
2 testosterone levels below the levels requested by IAAF owing to natural fluctuations” [13].

### 3 *Leveling the Playing Field*

4  
5 Assuming, for purposes of analysis, that testosterone does confer a significant competitive  
6 advantage in sport, knowing that does not in itself determine what steps should be taken to “level  
7 the playing field.” The latter decision is a normative matter, not an empirical one.

8  
9 To be defensible, rules and practices intended to ensure that no individual athlete enjoys an unfair  
10 advantage over competitors requires that rules treat all relevantly similar advantage-conferring  
11 attributes in a like manner. Testosterone testing for female athletes who have been singled out on  
12 the basis of their appearance or performance for all practical purposes subjects these individuals to  
13 genetic testing not imposed on their competitors.

14  
15 Fairness would require that sports organizations test for *any* “performance enhancing genes that  
16 predispose [individual athletes] to be athletically superior” [16]. In the present state of knowledge,  
17 this is no more realistic an approach than are current testosterone assays. The influence of genetic  
18 factors on athletic performance is multifactorial and sport specific [17]. Organizations would  
19 further have to regulate all such advantage-conferring attributes consistently.

20  
21 One way to categorize fair versus unfair advantages is by conceptualizing advantages as stable  
22 (fair) or dynamic (unfair) [18]. Fair advantages are those the athlete largely cannot affect, (such as  
23 chronological age, height, genetics, etc.). Unfair advantages are those the athlete can affect (such as  
24 speed, strength, endurance, etc.). On this account, genetic differences in testosterone would be  
25 stable advantages that could be subject to leveling or more fine-grained classification.

26  
27 Thinking specifically about leveling the playing field with respect to inequalities in testosterone  
28 levels, three approaches present themselves [13]. First, sports organizations could require athletes  
29 to lower testosterone levels that exceed a defined threshold to below a predetermined level.  
30 Second, organizations could create separate categories for competition based on the level of  
31 biological variations, allowing all athletes with serum testosterone within a certain range to  
32 compete against one another, regardless of sex or gender identification [13]. Or, third, they could  
33 create categories based on modifying the external conditions of competition instead of intervening  
34 in athletes’ bodies. Handicapped horse racing offers a model [13].

### 35 36 THE ROLE OF PHYSICIANS

37  
38 World Athletics eligibility criteria take the first of these approaches: intervening in the bodies of  
39 transgender athletes and athletes with DSDs. In doing so, they virtually require the participation of  
40 physicians helping athletes achieve and maintain the stipulated levels of serum testosterone. To the  
41 extent that medical interventions to lower testosterone may not be *clinically* indicated, is physician  
42 participation appropriate? Overall, existing policies of the American Medical Association and the  
43 World Medical Association (WMA) argue against physicians cooperating in the implementation of  
44 these regulations.

45  
46 Existing AMA policy in H-470.978, “[Blood Doping](#),” and H-470.976, “[Abuse of Anabolic](#)  
47 [Steroids](#),” prohibit physician participation in blood doping or prescribing anabolic steroids. H-  
48 470.994, “[Non-Therapeutic Use of Pharmacological Agents by Athletes](#),” opposes the use of  
49 interventions to enhance athletic performance but is silent with respect to physicians’ specific  
50 responsibilities.

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

14  
15 Further, Opinion 8.5, “[Disparities in Health Care](#),” states that “differences in treatment that are not  
16 directly related to individual patients' clinical needs or preferences constitute inappropriate  
17 variations in health care.” This can be construed as ruling out unnecessary testing or alteration of  
18 treatment related to gender identity when these are required by third parties for participation in  
19 sports. In Opinion 1.1.2, “[Prospective Patients](#),” physicians are required to refrain from  
20 discrimination on the basis of gender and gender identity, which in accordance with principles of  
21 justice, should extend to declining to participate in (and so refusing to legitimize) discriminatory  
22 practices that violate patients' human rights.

23  
24 In a press release in April 2019, the [World Medical Association](#) demanded that the IAAF  
25 “immediately withdraw” its new eligibility regulations for classifying female athletes and urged  
26 physicians to “take no part” in implementing them. In October 2021 WMA updated “[Declaration](#)  
27 [on Principles of Health Care in Sports Medicine](#)” to oppose World Athletics eligibility regulations  
28 and condemn “medical treatment solely to alter athletic performance,” as “unethical.”

29  
30 These provide strong arguments that, as professionals committed to promoting first and foremost  
31 the well-being of their patients, it is not appropriate for physicians to provide medical interventions  
32 required to fulfill the World Athletics regulations mandating specific testosterone levels for either  
33 athletes with DSDs or transgender athletes. These arguments also suggest it is inappropriate for a  
34 physician to cooperate with any public school or recreational team that requires medical testing  
35 and/or physician confirmation that an athlete is a particular gender in order for them to participate.

## 36 37 RECOMMENDATION

38  
39 In view of these considerations, your AMA recommends that the following recommendations be  
40 adopted in lieu of Resolution 19-A-19 and the remainder of this report be filed:

- 41  
42 1. That our American Medical Association (AMA) oppose mandatory testing, medical treatment  
43 or surgery for transgender athletes and athletes with Differences of Sex Development (DSD),  
44 and affirm that these athletes be permitted to compete in alignment with their identity; (New  
45 HOD Policy)
- 46  
47 2. That our AMA oppose the use of specific hormonal guidelines to determine gender  
48 classification for athletic competitions. (New HOD Policy)

- 1 3. That our AMA oppose physician participation in any practices intended to officially certify or  
2 confirm an athlete's gender for the purposes of satisfying third party requirements. (New HOD  
3 Policy)

Fiscal note: Less than \$500.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 3-I-22

Subject: Delegate Apportionment and Pending Members

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 At June’s Annual Meeting, Board of Trustees Report 20 was considered, with the following  
2 recommendations referred for report at this meeting (to avoid confusion with the original  
3 recommendations, letters are used here to designate the recommendations):  
4

- 5 A. That delegate apportionment for 2023 for constituent societies be based on official 2022 year-  
6 end AMA membership data as recorded by the AMA.
- 7 B. That delegate apportionment for 2024 be based on then current bylaws.
- 8 C. That the Council on Constitution and Bylaws prepare bylaws amendments to implement these  
9 recommendations, with the report to be considered no later than the November 2022 meeting  
10 of the House of Delegates.
- 11 D. That Policy G-600.016, “Data Used to Apportion Delegates,” be rescinded.  
12

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

- 14
- 15 E. That pending members no longer be considered in apportioning delegates in the House of  
16 Delegates.  
17

18 The recommendations labelled A-D above hinged on Recommendation E, which would have  
19 ceased counting pending members for apportionment purposes. By and large Recommendations  
20 A-D could be considered to have been subordinate to or contingent on Recommendation E.  
21

22 PENDING MEMBERS DEFINED

23

24 Essential to dealing with the matter of pending members is the definition. Board Report 1-I-18  
25 defined pending members as individuals who are not current members at the time they pay their  
26 dues for the following calendar year. Two elements are required: the person is not a current  
27 member at the time of dues payment and the person joins for the following calendar year. The  
28 report had been prepared in response to a proposal to count these pending members for delegate  
29 apportionment. To prevent gaming the system, by for example joining only every other year, the  
30 House determined that a pending member would be counted for apportionment purposes the  
31 following year if and only if they had again paid their dues early (i.e., before year end).  
32

33 FOLLOW ON ACTION

34

35 As noted, Recommendation E (originally the first of six recommendations in the Board’s report)  
36 was referred for decision. Acting in September, the Board adopted this recommendation, meaning  
37 pending members will not be counted for apportionment purposes. As a practical matter, once  
38 someone becomes a pending member, the individual must be tracked across time in perpetuity

1 solely for apportionment. Say an individual becomes a pending member in Year 0, meaning they  
2 will be an actual member in Year 1. To be counted for apportionment purposes in Year 2, the  
3 pending member must have paid their dues for Year 2 in Year 1. That will be true for successive  
4 years without end (pay for Year 3 in Year 2, for Year 4 in Year 3, and so on). Note that a current  
5 member (who has never been counted as a pending member) who always pays dues “early” is not a  
6 pending member.

7  
8 If that pending member’s dues payment is delayed to January 1 (or later) of Year 2, they will not  
9 have been counted in apportioning Year 2 delegates but will be counted at the end of Year 2 for  
10 Year 3 as a regular member, NOT as a pending member. At that point, the individual is a regular  
11 member unless their membership lapses and they cycle back into the pending member category. In  
12 other words, the timing of one’s dues payment and one’s membership status at the time of that  
13 payment affect how and whether one is counted for apportionment purposes. These elements  
14 cannot be captured by AMA’s membership accounting system across a potential 40- or 50-year  
15 career in medicine. To track the information would require an estimated quarter million dollar  
16 change to the membership accounting system.

17  
18 Your Board acknowledges the arguments for counting pending members but believes counting  
19 them not only unnecessarily complicates the apportionment process but that it devalues other  
20 benefits of membership and active members themselves:

- 21
- 22 • The notion that pending members gain representation only by being counted for apportionment  
23 purposes belies the fact that delegates represent the needs of not only members but patients,  
24 their sponsoring societies, and the profession, including nonmembers.
  - 25 • Suggestions that being counted toward representation in the House of Delegates is attractive  
26 are speculative at best. Physicians consistently report valuing the advocacy that emerges from  
27 House of Delegates policy, not the House of Delegates per se.
  - 28 • Pending members are in fact NOT members. Individuals who join late in the year wishing to be  
29 counted—a premise that is largely unsupported—could easily join for the current year by  
30 paying half-year dues.
  - 31 • Some have argued that not counting pending members is tantamount to treating them as  
32 second-class members. As just noted, they are not members, at least not initially, but decisions  
33 about apportionment need not be linked to more concrete member benefits, which are a  
34 separate business decision that can and should be addressed as a membership matter.
  - 35 • Finally, no evidence has emerged to suggest that the offer to count pending members for  
36 apportionment purposes has led to membership gains. Virtually all the pending members in the  
37 initial implementation had joined prior to the implementation of the experiment. Few states  
38 gained delegates, meaning few have benefitted if at all.

39  
40 While the makeup of the House is the province of the House, your Board believes that the  
41 longstanding policy of counting actual members for apportionment has served our members well.  
42 Counting pending members can be considered to diminish or discount actual members’ value as  
43 much as it can be seen to enhance representation.

44  
45 **POLICY ADOPTED AT A-22**

46  
47 The following policy was adopted at June’s Annual Meeting and is the subject of Report 1 from the  
48 Council on Constitution and Bylaws at this meeting. The policy was adopted in lieu of a proposal  
49 to extend the delegate freeze into 2023. If implemented—bylaws amendments are required—in  
50 2023 constituent societies will be apportioned delegates using the following formula, whereby each  
51 society will get the greatest of the three calculated numbers:

- 1
- 2 • The number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA
- 3 members;
- 4 • The number of delegates apportioned for 2022 so long as that figure is not greater than 2 more
- 5 than the number apportioned at the rate of 1 per 1000, or fraction thereof, AMA members; or
- 6 • For societies that would lose more than five delegates from their 2022 apportionment, the
- 7 number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members
- 8 plus 5.
- 9

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

#### 15 16 REFERRED ITEMS

17  
18 Turning to the four referred items, each will be dealt with in turn. Recommendation A (as labelled  
19 herein) called for constituent society apportionment in 2023 to be based on "official 2022 year-end  
20 membership data" and simply flowed from the recommendation that preceded it to not count  
21 pending members. That latter recommendation, labelled "E" in this report, has been adopted by  
22 Board action. Existing bylaws or possible amendments at this meeting will suffice. No action is  
23 therefore required on the referred recommendation.

24  
25 Recommendation B calling for delegate apportionment in 2024 to be based on then current bylaws  
26 is unnecessary. Current bylaws are by definition controlling. Moreover, the language does not  
27 affect the ability of the House to amend bylaws, so again, no action is required.

28  
29 The recommendation in Board of Trustees Report 20-A-22 calling for the Council on Constitution  
30 and Bylaws to prepare a report essentially flagged the Council that bylaws amendments might be  
31 necessary. It is more a style for AMA reports than a necessity, as the Council has the authority to  
32 generate and offer reports on its own. The recommendation requires no action.

33  
34 The fourth referred recommendation, labelled D, was simply a housekeeping matter, meant to cull  
35 an unneeded policy from the compendium, which contains 3955 separate policy statements. Policy  
36 G-600.016, "Data Used to Apportion Delegates," reads as follows:

- 37
- 38 1. Our AMA shall issue an annual, mid-year report on or around June 30 to inform each state
- 39 medical society and each national medical specialty society that is in the process of its 5-year
- 40 review of its current AMA membership count.
- 41 2. "Pending members" (defined as individuals who at the time they apply for membership are not
- 42 current in their dues and who pay dues for the following calendar year) will be added to the
- 43 number of active AMA members in the December 31 count for the purposes of AMA delegate
- 44 allocations to state medical societies for the following year and this total will be used to
- 45 determine the number of national medical specialty delegates to maintain parity.
- 46 3. Our AMA will track "pending members" from a given year who are counted towards delegate
- 47 allocation for the following year and these members will not be counted again for delegate
- 48 allocation unless they renew their membership before the end of the following year.
- 49 4. Our AMA Board of Trustees will issue a report to the House of Delegates at the 2022 Annual
- 50 Meeting on the impact of Policy G-600.016 and recommendations regarding continuation of
- 51 this policy.

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

8

9 RECOMMENDATION

10

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

17

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

Fiscal Note: \$150 to update PolicyFinder

REPORT 4 OF THE BOARD OF TRUSTEES (I-22)  
Preserving Access to Reproductive Health Services  
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

At the 2022 American Medical Association (AMA) Annual Meeting, our AMA House of Delegates adopted Policy D-5.999, “Preserving Access to Reproductive Health Services,” which, among other things, instructs the AMA to review the AMA policy compendium and recommend policies to be amended or rescinded. This Board report, therefore, reviews AMA policy related to reproductive health, discusses policies for amendment or rescission, and provides recommendations.

In its review of the policy compendium, the Board identified three duplicative policies and recommends these policies be consolidated into one policy. The report also recommends modifying two policies related to physicians’ personal views on abortion and clinical determinations about the viability of a fetus to conform with new policy adopted at the 2022 Annual Meeting. Finally, the report recommends modifying policy to remove a reference to *Roe v. Wade*.

# REPORT OF THE BOARD OF TRUSTEES

B of T Report 4-I-22

Subject: Preserving Access to Reproductive Health Services

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 INTRODUCTION  
2

3 At the 2022 American Medical Association (AMA) Annual Meeting (2022 Annual Meeting), our AMA  
4 House of Delegates adopted Policy D-5.999, “Preserving Access to Reproductive Health Services,” which  
5 states:  
6

7 That our AMA:

- 8 1. Recognizes that healthcare, including reproductive health services like contraception and  
9 abortion, is a human right;
- 10 2. Opposes limitations on access to evidence-based reproductive health services, including  
11 fertility treatments, contraception, and abortion;
- 12 3. Will work with interested state medical societies and medical specialty societies to vigorously  
13 advocate for broad, equitable access to reproductive health services, including fertility  
14 treatments, contraception, and abortion;
- 15 4. Supports shared decision-making between patients and their physicians regarding  
16 reproductive healthcare;
- 17 5. Opposes any effort to undermine the basic medical principle that clinical assessments, such as  
18 viability of the pregnancy and safety of the pregnant person, are determinations to be made  
19 only by healthcare professionals with their patients;
- 20 6. Opposes the imposition of criminal and civil penalties or other retaliatory efforts against  
21 patients, patient advocates, physicians, other healthcare workers, and health systems for  
22 receiving, assisting in, referring patients to, or providing reproductive health services;
- 23 7. Will advocate for legal protections for patients who cross state lines to receive reproductive  
24 health services, including contraception and abortion, or who receive medications for  
25 contraception and abortion from across state lines, and legal protections for those that  
26 provide, support, or refer patients to these services;
- 27 8. Will review the AMA policy compendium and recommend policies which should be  
28 amended or rescinded to reflect these core values, with report back at I-22.  
29

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

1 AMA POLICY

2  
3 Our AMA has many policies addressing access to abortion and other reproductive health care services.  
4 These policies, including those adopted or amended during the 2022 Annual Meeting, are as follows:

5  
6 *Policy D-5.999, “Preserving Access to Reproductive Health Services”*

7 Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception  
8 and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive  
9 health services, including fertility treatments, contraception, and abortion; (3) will work with  
10 interested state medical societies and medical specialty societies to vigorously advocate for broad,  
11 equitable access to reproductive health services, including fertility treatments, contraception, and  
12 abortion; (4) supports shared decision-making between patients and their physicians regarding  
13 reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical  
14 assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations  
15 to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal  
16 and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other  
17 healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing  
18 reproductive health services; (7) will advocate for legal protections for patients who cross state lines  
19 to receive reproductive health services, including contraception and abortion, or who receive  
20 medications for contraception and abortion from across state lines, and legal protections for those that  
21 provide, support, or refer patients to these services; and (8) will review the AMA policy compendium  
22 and recommend policies which should be amended or rescinded to reflect these core values, with  
23 report back at I-22. (Res. 028, A-22)

24  
25 *Policy H-5.995, “Abortion”*

26 Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly  
27 licensed physician and surgeon in conformance with standards of good medical practice and the  
28 Medical Practice Act of this state; and (2) no physician or other professional personnel shall be  
29 required to perform an act violative of good medical judgment. Neither physician, hospital, nor  
30 hospital personnel shall be required to perform any act violative of personally held moral principles.  
31 In these circumstances, good medical practice requires only that the physician or other professional  
32 withdraw from the case, so long as the withdrawal is consistent with good medical practice.  
33 (Sub. Res. 43, A-73; Reaffirmed: I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed by Sub. Res.  
34 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: CMS Rep. 1, I-00; Reaffirmed: CEJA  
35 Rep. 6, A-10; Reaffirmed: CEJA Rep. 01, A-20)

36  
37 *Policy H-5.993, “Right to Privacy in Termination of Pregnancy”*

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

1 *Policy H-5.983, “Pregnancy Termination”*

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

5  
6 *Policy H-5.990, “Policy on Abortion”*

7 The issue of support of or opposition to abortion is a matter for members of the AMA to decide  
8 individually, based on personal values or beliefs. The AMA will take no action which may be  
9 construed as an attempt to alter or influence the personal views of individual physicians regarding  
10 abortion procedures. (Res. 158, A-90; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep.  
11 26, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Res. 1, A-09; Reaffirmed: CEJA Rep. 03,  
12 A-19)

13  
14 *Policy H-5.988, “Accurate Reporting on AMA Abortion Policy”*

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

21  
22 *Policy H-5.989, “Freedom of Communication Between Physicians and Patients”*

23 It is the policy of the AMA: (1) to strongly condemn any interference by the government or other  
24 third parties that causes a physician to compromise his or her medical judgment as to what  
25 information or treatment is in the best interest of the patient;  
26 (2) working with other organizations as appropriate, to vigorously pursue legislative relief from  
27 regulations or statutes that prevent physicians from freely discussing with or providing information to  
28 patients about medical care and procedures or which interfere with the physician-patient relationship;  
29 (3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on  
30 physician-patient communications; and  
31 (4) to inform the American public as to the dangers inherent in regulations or statutes restricting  
32 communication between physicians and their patients.  
33 (Sub. Res. 213, A-91; Reaffirmed: Sub. Res. 232, I-91; Reaffirmed by Rules & Credentials Cmt., A-  
34 96; Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res. 203 and 707, A-  
35 98; Reaffirmed: Res. 703, A-00; Reaffirmed in lieu of Res. 823, I-07; Reaffirmation I-09;  
36 Reaffirmation: I-12; Reaffirmed in lieu of Res. 5, I-13)

37  
38 *Policy H-100.948, “Supporting Access to Mifepristone (Mifeprex)”*

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

43  
44 *Policy H-140.835, “Political Interference in the Patient-Physician Relationship”*

45 Our AMA opposes any policies that interfere with the patient-physician relationship by giving  
46 probate, inheritance, a social security number, or other legal rights to an undelivered pregnancy, or  
47 imposing legislative barriers to medical decision-making by changes in tax codes or in definitions of  
48 beneficiaries. (Alt. Res. 007, I-17)

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

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

6  
7 *Policy H-425.969, “Support for Access to Preventive and Reproductive Health Services”*

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

12  
13 *Policy H-185.937, “Reproductive Parity”*

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

17  
18 *Policy H-295.923, “Medical Training and Termination of Pregnancy”*

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

33  
34 *Policy H-5.980, “Oppose the Criminalization of Self-Induced Abortion”*

35 Our AMA: (1) opposes the criminalization of self-managed abortion and the criminalization of  
36 patients who access abortions as it increases patients’ medical risks and deters patients from seeking  
37 medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-  
38 managed abortion and the criminalization of patients who access abortions; and (3) will oppose  
39 efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients and  
40 requirements that physicians function as agents of law enforcement—gathering evidence for  
41 prosecution rather than as a provider of treatment. (Res. 007, A-18; Modified: Res. 27, A-22)

42  
43 *Policy H-420.954, “Truth and Transparency in Pregnancy Counseling Centers”*

44 (1) It is AMA’s position that any entity that represents itself as offering health-related services should  
45 uphold the standards of truthfulness, transparency, and confidentiality that govern health care  
46 professionals.  
47 (2) Our AMA urges the development of effective oversight for entities offering pregnancy related  
48 health services and counseling.  
49 (3) Our AMA advocates that any entity offering crisis pregnancy services

1 a. truthfully describes the services they offer or for which they refer—including prenatal care,  
2 family planning, termination, or adoption services—in communications on site and in their  
3 advertising, and before any services are provided to an individual patient; and  
4 b. be transparent with respect to their funding and sponsorship relationships.

5 (4) Our AMA advocates that any entity licensed to provide medical or health services to pregnant  
6 women

7 a. ensure that care is provided by appropriately qualified, licensed personnel; and

8 b. abides by federal health information privacy laws.

9 (5) Our AMA urges that public funding only support programs that provide complete, non-directive,  
10 medically accurate, health information to support patients informed, voluntary decisions.

11 (Res. 7, I-11; Reaffirmed: CEJA Rep. 1, A-21; Modified: BOT Rep. 14, A-22)

12  
13 *Policy H-5.982, “Late-Term Pregnancy Termination Techniques”*

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

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

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

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

40  
41 *Policy H-5.997, “Violence Against Medical Facilities and Health Care Practitioners and Their*  
42 *Families”*

43 The AMA supports the right of access to medical care and opposes (1) violence and all acts of  
44 intimidation directed against physicians and other health care providers and their families and (2)  
45 violence directed against medical facilities, including abortion clinics and family planning centers, as  
46 an infringement of the individual's right of access to the services of such centers.

47 (Res. 82, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Res. 422, A-95; Reaffirmation I-99; Reaffirmed:  
48 CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19)

1 DISCUSSION  
2

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

16  
17 The Board also identified some policies that require updating or amendment for clarification purposes.  
18 Specifically, Policy H-5.993, “Right to Privacy in Termination of Pregnancy,” states that physicians may  
19 withdraw from cases they view as violative of good medical judgment or personally held moral principles  
20 so long as withdrawal is consistent with good medical practice. The Board recommends that this policy  
21 also state that withdrawal due to personally held moral principles must be consistent with ethical  
22 obligations. *AMA Code of Medical Ethics* Opinion 1.1.7, “Physician Exercise of Conscience,” states,  
23 among other things, that “physicians should refer a patient to another physician or institution to provide  
24 treatment the physician declines to offer.”

25  
26 Policy H-5.993, “Right to Privacy in Termination of Pregnancy,” also states that the AMA supports the  
27 position that “the early termination of pregnancy is a medical matter between the patient and the  
28 physician [...]” The Board notes that inclusion of the word “early” has created some confusion. Since  
29 Policy H-5.982, “Late-Term Pregnancy Termination Techniques,” already addresses determinations of  
30 fetal viability and indications for abortion late in pregnancy, the Board recommends deletion of the word  
31 “early.”

32  
33 Policy H-5.993, “Right to Privacy in Termination of Pregnancy,” also states that an abortion should only  
34 be performed by a physician. This policy was adopted when most abortions were surgical; however, by  
35 2020, an estimated 54% of abortions were induced with prescription medication. The Board recommends  
36 this policy be amended to state that abortion is “the practice of medicine and requires the personal  
37 performance or supervision by an appropriately licensed physician.” The amendment will enable the  
38 AMA to advocate for broad, equitable access to abortion care in accordance with Policy D-5.999,  
39 “Preserving Access to Reproductive Health Services,” by building capacity within the physician-led  
40 healthcare teams that provide abortion care, while also advocating for continued physician supervision of  
41 non-physicians who prescribe medication for abortions.

42  
43 Policy H-5.993, “Right to Privacy in Termination of Pregnancy,” also states that abortion “is a medical  
44 matter between the patient and the physician, subject to the physician's clinical judgment, the patient's  
45 informed consent, and the availability of appropriate facilities.” The Board recommends replacing  
46 “availability of appropriate facilities” with “ability to perform the procedure safely.” Because over half of  
47 abortions are now induced with prescription medication, they do not necessarily require care in a facility.  
48 Conditioning AMA support of abortion care on “availability of appropriate facilities” may be used by  
49 some as justification for placing medically unnecessary facility requirements on abortion providers. By  
50 amending the policy to emphasize safety generally, the policy is less likely to be misconstrued.

1 In addition, Policy H-5.990, “Policy on Abortion,” states that support of or opposition to abortion is a  
2 matter for members to decide individually. Since newly adopted policy at the 2022 Annual Meeting,  
3 Policy D-5.999, “Preserving Access to Reproductive Health Services,” supports access to abortion as an  
4 organizational policy matter, the Board recommends that Policy H-5.990, “Policy on Abortion,” be  
5 amended to clarify that the AMA believes members’ *personal* views on abortion should be decided  
6 individually.  
7

8 Additionally, Policy H-5.982, “Late-Term Pregnancy Termination Techniques,” states that the  
9 determination of the viability of a fetus during the second trimester is to be made by a physician. Newly  
10 adopted policy at the 2022 Annual Meeting, Policy D-5.999, “Preserving Access to Reproductive Health  
11 Services,” is broader. Specifically, this new policy protects clinical determinations and assessments  
12 regardless of the stage of pregnancy. The Board, therefore, recommends that Policy H-5.982, “Late-Term  
13 Pregnancy Termination Techniques,” be amended to remove the reference to viability in the second  
14 trimester. Policy H-5.982 also includes a recognition of the constitutional principles articulated by the  
15 Supreme Court in *Roe v. Wade*. In light of the Supreme Court’s decision in *Dobbs v. Jackson Women’s*  
16 *Health Organization*, the Board recommends that Policy H-5.982 be further amended to reflect this legal  
17 activity.  
18

19 Finally, with the completion of this report, the Board recommends that Policy D-5.999, “Preserving  
20 Access to Reproductive Health Services,” be amended to remove the directive to review AMA policy,  
21 recommend policies for amendment or rescission and report back at the 2022 Interim Meeting.  
22

23 In addition to review of policy required by the new policy, the Board notes that Resolution 621-A-22,  
24 Establishing a Task Force to Preserve the Patient-Physician Relationship When Evidence-Based,  
25 Appropriate Care Is Banned or Restricted, instructs our AMA to convene a task force to respond to  
26 restrictions on and criminalization of abortion and other evidence-based care. Importantly, at the time of  
27 the writing of this report (August 2022), the AMA is in the process of developing the task force, with the  
28 task force expected to be formed by the time of the AMA 2022 Interim Meeting in November. It is critical  
29 to further note that activity—in both AMA Advocacy and AMA Office of General Counsel—to protect  
30 the patient-physician relationship is robust and ongoing. The following is a summary of relevant activity  
31 as of early August 2022 when this report was drafted.  
32

33 Since the U.S. Supreme Court decision in *Dobbs v. Jackson Women’s Health Organization* which  
34 overturned *Roe v. Wade* and *Planned Parenthood v. Casey*, the AMA has been pursuing multiple  
35 strategies, at the state level, to address the broad spectrum of issues now facing physicians and patients.  
36 Shortly after the decision was issued, the AMA convened state medical associations to understand state-  
37 by-state dynamics and the concerns of physicians. The AMA has since held multiple meetings with state  
38 medical associations and national medical specialty societies to understand the challenges facing  
39 physicians and plan a coordinated strategy to protect access to care. The AMA Advocacy Resource  
40 Center is working closely with the Federation to protect patients and physicians from legislative  
41 intrusions into and criminalization of the practice of medicine. In many states, it is not clear how broadly  
42 abortion restrictions will be interpreted, and confusion remains about how restrictions impact medically  
43 necessary pregnancy terminations, prescribing of certain medications for reasons unrelated to pregnancy,  
44 and the provision of other types of care. The AMA is working with the Federation and other stakeholders  
45 to seek clarification from policymakers, as well as collecting information, producing resources, and  
46 conducting legislative analyses to help states navigate this new regulatory scheme.  
47

48 One way AMA Advocacy staff is collecting much-needed clinical information for states across the  
49 country is by engaging expert physician members of the Board, Council on Legislation, and Council on  
50 Medical Service. AMA Advocacy staff is also engaging attorneys in the American Society of Medical  
51 Association Counsel to identify answers to legal questions raised in states across the country as legislation

1 and regulation is contemplated and introduced. The AMA Center for Health Equity is collaborating with  
2 the AMA Advocacy team, as well, working to identify impact on historically marginalized and  
3 minoritized communities and strategies related to health equity. Finally, at the 2022 AMA State  
4 Advocacy Roundtable, the AMA hosted an interactive discussion among Federation staff about the  
5 implications of the *Dobbs* decision and because of that discussion is working to create resources for the  
6 Federation. This activity is ongoing.

7  
8 At the federal level, the AMA immediately called for greater digital privacy for patients out of concern  
9 that minimal oversight of data use by digital apps could place women in jeopardy in states seeking to  
10 enforce abortion restrictions. The AMA joined the American College of Obstetricians and Gynecologists  
11 (ACOG) in calling for the U.S. Food and Drug Administration to remove or modify the Risk Evaluation  
12 and Mitigation Strategies (REMS) and Elements to Assure Safe Use (ETASU) requirements for  
13 mifepristone. The Biden Administration also reminded hospitals and health care providers of their  
14 obligation to comply with the provisions of the Emergency Medical Treatment and Labor Act  
15 (EMTALA) that preempt any state laws that restrict access to stabilizing medical treatment, including  
16 abortion procedures and other treatments that may result in the termination of a pregnancy, and reminded  
17 pharmacies of their obligations related to prescription medications for reproductive health under federal  
18 civil rights laws.

19  
20 Finally, in the courts, the AMA has joined ACOG and the Society for Maternal-Fetal Medicine in amicus  
21 briefs around the country seeking to protect access to reproductive care and combat intrusion on the  
22 physician-patient relationship. As of early August, amicus briefs have been filed in Georgia, Kentucky,  
23 Ohio, South Carolina, Utah, and West Virginia. Additional filings are expected in coming months. These  
24 briefs have supported challenges to a range of harmful laws, including bans from the 1800s, trigger laws  
25 intended to ban all abortion following the reversal of *Roe v. Wade*, and criminal penalties that potentially  
26 include felony charges for physicians. In addition, the AMA has worked to support federal guidance and  
27 litigation around access to care in the courts through its amicus efforts. The AMA will continue to work  
28 with the Federation and external stakeholders in the courts and at the state and federal levels to protect the  
29 physician-patient relationship and access to reproductive care.

### 30 31 RECOMMENDATIONS

32  
33 The Board recommends that the following recommendations be adopted and that the remainder of the  
34 report be filed.

- 35  
36 1. That Policy H-5.993, “Right to Privacy in Termination of Pregnancy” be amended by addition  
37 and deletion as follows:

38  
39 The AMA reaffirms existing policy that (1) abortion is the practice of medicine and requires the  
40 personal performance or supervision by an appropriately licensed physician a medical procedure  
41 and should be performed only by a duly licensed physician in conformance with standards of  
42 good medical practice and the laws of the state; and (2) no physician or other professional  
43 personnel shall be required to perform an act violative of good medical judgment or personally  
44 held moral principles. In these circumstances ~~good medical practice requires only that the a~~  
45 physician or other professional may withdraw from the case so long as the withdrawal is  
46 consistent with good medical practice and ethical guidance on the exercise of conscience;- (3)  
47 ~~The~~ AMA further supports the position that the ~~early~~ termination of pregnancy is a medical  
48 matter between the patient and the physician, subject to the physician's clinical judgment, the  
49 patient's informed consent, and the ability to perform the procedure safely-availability of  
50 ~~appropriate facilities.~~ (Modify Current HOD Policy)

1 2. That Policies H-5.995, “Abortion,” and Policy H-5.983, “Pregnancy Termination,” be rescinded.  
2 (Rescind HOD Policy)

3  
4 3. That Policy H-5.990, “Policy on Abortion,” be amended by addition as follows:

5  
6 The issue of personal support of or opposition to abortion is a matter for members of the  
7 AMA to decide individually, based on personal values or beliefs. The AMA will take no  
8 action which may be construed as an attempt to alter or influence the personal views of  
9 individual physicians regarding abortion procedures. (Modify HOD Policy)

10  
11 4. That Policy H-5.982, “Late-Term Pregnancy Termination Techniques,” be amended by addition  
12 and deletion as follows:

13  
14 (1) The term “partial birth abortion” is not a medical term. The AMA will use the term “intact  
15 dilatation and extraction” (or intact D&X) to refer to a specific procedure comprised of the  
16 following elements: deliberate dilatation of the cervix, usually over a sequence of days;  
17 instrumental or manual conversion of the fetus to a footling breech; breech extraction of the body  
18 excepting the head; and partial evacuation of the intracranial contents of the fetus to effect  
19 vaginal delivery of a dead but otherwise intact fetus. This procedure is distinct from dilatation and  
20 evacuation (D&E) procedures more commonly used to induce abortion after the first trimester.  
21 Because 'partial birth abortion' is not a medical term it will not be used by the AMA. (2)  
22 According to the scientific literature, there does not appear to be any identified situation in which  
23 intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been  
24 raised about intact D&X. The AMA recommends that the procedure not be used unless  
25 alternative procedures pose materially greater risk to the woman. The physician must, however,  
26 retain the discretion to make that judgment, acting within standards of good medical practice and  
27 in the best interest of the patient. (3) The viability of the fetus and the time when viability is  
28 achieved may vary with each pregnancy. ~~In the second trimester w~~When viability may be in  
29 question, it is the physician who should determine the viability of a specific fetus, using the latest  
30 available diagnostic technology. (4) ~~In recognition of the constitutional principles regarding the~~  
31 ~~right to an abortion articulated by the Supreme Court in Roe v. Wade, and~~In keeping with the  
32 science and values of medicine, the AMA recommends that abortions not be performed in the  
33 third trimester except in cases of serious fetal anomalies incompatible with life. Although third-  
34 trimester abortions can be performed to preserve the life or health of the mother, they are, in fact,  
35 generally not necessary for those purposes. Except in extraordinary circumstances, maternal  
36 health factors which demand termination of the pregnancy can be accommodated without  
37 sacrifice of the fetus, and the near certainty of the independent viability of the fetus argues for  
38 ending the pregnancy by appropriate delivery. (Modify Current HOD Policy)

39  
40 5. Policy D-5.999, “Preserving Access to Reproductive Health Services,” be amended by deletion as  
41 follows:

42  
43 Our AMA: (1) recognizes that healthcare, including reproductive health services like  
44 contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based  
45 reproductive health services, including fertility treatments, contraception, and abortion; (3) will  
46 work with interested state medical societies and medical specialty societies to vigorously  
47 advocate for broad, equitable access to reproductive health services, including fertility treatments,  
48 contraception, and abortion; (4) supports shared decision-making between patients and their  
49 physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic  
50 medical principle that clinical assessments, such as viability of the pregnancy and safety of the  
51 pregnant person, are determinations to be made only by healthcare professionals with their

1 patients; (6) opposes the imposition of criminal and civil penalties or other retaliatory efforts  
2 against patients, patient advocates, physicians, other healthcare workers, and health systems for  
3 receiving, assisting in, referring patients to, or providing reproductive health services; (7) will  
4 advocate for legal protections for patients who cross state lines to receive reproductive health  
5 services, including contraception and abortion, or who receive medications for contraception and  
6 abortion from across state lines, and legal protections for those that provide, support, or refer  
7 patients to these services; and (8) will review the AMA policy compendium and recommend  
8 policies which should be amended or rescinded to reflect these core values, with report back at  
9 the 2022 Interim Meeting. (Modify Current HOD Policy)

Fiscal Note: Less than \$500.

# REPORT OF THE BOARD OF TRUSTEES

B of T Report 5-I-22

Subject: Towards Diversity and Inclusion: A Global Non-discrimination Policy Statement and Benchmark for our AMA

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

---

## 1 BACKGROUND

2

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

7

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

12

13 Demonstrate its commitment to complying with laws, rules or regulations against  
14 discrimination on the basis of protected characteristics. (Directive to Take Action)

15

16 Reaffirm Policy H-65.988, “Organizations Which Discriminate,” and Policy G-630.040,  
17 “Principles on Corporate Relationships,” in its overarching non-discrimination policy.  
18 (Reaffirm HOD Policy)

19

20 Reaffirm Policy G-600.067, “References to Terms and Language in Policies Adopted to  
21 Protect Populations from Discrimination and Harassment.” (Reaffirm HOD Policy)

22

23 Study the feasibility and need for a comprehensive business conduct standards policy to be  
24 fully integrated with the conflict of interest policy, and report back to the AMA House of  
25 Delegates within 18 months. (Directive to Take Action)

26

27 Provide an update on its comprehensive diversity and inclusion strategy to the AMA House of  
28 Delegates within 24 months. (Directive to Take Action)

29

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

34

35 The reference committee received testimony supportive of the intent of Resolution 602 but noted  
36 there were several amendments proffered to broaden inclusiveness, as well as to strengthen the

1 language contained in existing AMA policy. Still others advocated for referral of this item due to  
2 the complexity of the requests and the need to develop an integrated response.

3  
4 The reference committee supported referral of this item to allow our AMA House of Delegates to  
5 receive a report back that codifies policies and activities and optimizes the language contained in  
6 an overarching non-discrimination policy.

7  
8 This report: 1) describes our AMA's commitment to human rights and health equity that would  
9 support an overarching non-discrimination policy and 2) summarizes our AMA's existing non-  
10 discrimination policies passed by the House of Delegates.

## 11 DISCUSSION

12  
13  
14 The federal landscape related to discrimination is constantly evolving, so any overarching policy  
15 will need to be flexible in its wording and regularly updated.

16  
17 The HOD's policy statements on health topics serve as a cornerstone of our AMA, making clear  
18 what our AMA stands for as an organization, providing information and guidance to physicians and  
19 others about health care issues.

### 20 *AMA's commitment to human rights and health equity*

21  
22  
23 Our AMA Policy H-65.965, "Support of Human Rights and Freedom," provides a clear statement  
24 of our AMA's commitment to supporting and maintaining respect for human rights. It reads as  
25 follows:

26  
27 Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity  
28 of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any  
29 human being of equal rights, privileges and responsibilities commensurate with his or her  
30 individual capabilities and ethical character because of an individual's sex, sexual orientation,  
31 gender, gender identity or transgender status, race, religion, disability, ethnic origin, national  
32 origin or age; (3) opposes any discrimination based on an individual's sex, sexual orientation,  
33 gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and  
34 any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat  
35 to the public health and social welfare of the citizens of the United States, urges expedient  
36 passage for appropriate hate crimes prevention legislation in accordance with our AMA's  
37 policy through letters to members of Congress; and registers support for hate crimes prevention  
38 legislation, via letter, to the President of the United States.

39  
40 The policy provides a key foundation in fostering equity and inclusion both within the organization  
41 and externally.

42  
43 Additionally, our AMA has [made a commitment](#) to "actively work to dismantle racist and  
44 discriminatory policies and practices across all of health care." Furthermore, "our AMA recognizes  
45 that racism in its systemic, structural, institutional, and interpersonal forms as a serious threat to  
46 public health, the advancement of health equity, and a barrier to appropriate medical care" and  
47 "supports the development of policy to combat racism and its effects" (Policy H-65.952, "Racism  
48 as a Public Health Threat").

49  
50 By establishing the AMA Center for Health Equity, our AMA has demonstrated its intention and  
51 commitment to [embed health equity into the DNA of the organization](#) and its work. As part of the

1 “Plan for Continued Progress Toward Health Equity” (Policy D-180.981) our AMA has made the  
2 pursuit of diversity, equity, and inclusion a key strategy to operationalize health equity. This  
3 pursuit includes a commitment to anti-racism/anti-discrimination/anti-harassment policies. Our  
4 AMA has continued to expand on our diversity and inclusion strategy as outlined in Board Report  
5 10-A-22 about 2021 progress on the AMA’s Organizational Strategic Plan to Embed Racial Justice  
6 and Advance Health Equity.

7  
8 *Existing AMA HOD non-discrimination policies*

9  
10 A policy scan of our AMA’s HOD non-discrimination policies identified 88 non-discrimination  
11 policies. This summary only includes policies currently published in our AMA’s PolicyFinder.  
12 Policies that were rescinded are not included. The policies are grouped below based on the nature  
13 of the protections covered by the policies. The number of policies matched to each grouping is  
14 listed below (Please see Appendix A for details):

- 15  
16 • Non-discrimination policies – AMA (3)  
17 • Non-discrimination policies – Constitution and Bylaws (3)  
18 • Non-discrimination policies listed under AMA governance (3)  
19 • General non-discrimination policies that protect all individuals (11)  
20 • Non-discrimination policies that apply to specific populations (17)  
21 • Non-discrimination policies that protect physicians and/or their practices (23)  
22 • Non-discrimination policies that protect international medical graduates (IMGs) (4)  
23 • Non-discrimination policies that protect residents (5)  
24 • Non-discrimination policies that protect medical students (4)  
25 • Non-discrimination policies that protect patients (14)  
26 • Non-discrimination related to terrorism (1)

27  
28 Within HOD policies, H-65.965, “Support of Human Rights and Freedom,” modified in 2022,  
29 provides the most comprehensive list of protected groups. Policy G-600.067, “References to Terms  
30 and Language in Policies Adopted to Protect Populations from Discrimination and Harassment,”  
31 mentioned in the original resolution, was rescinded and replaced [via Board Report 5-N-21](#) by  
32 Policy H-65.950 stating that our AMA recommends preferred terminology for protected personal  
33 characteristics to be used in AMA policies and position statements. Board Report 5-N-21 provides  
34 a summary of categories or characteristics cited by AMA policy and a sampling from other  
35 organizations.

36  
37 Policy H-65.951, “Healthcare and Organizational Policies and Cultural Changes to Prevent and  
38 Address Racism, Discrimination, Bias and Microaggressions,” provides guidelines for effective  
39 non-discrimination policy for healthcare, including implementation considerations.

40  
41 Eight other HOD policies provide a similar list of protections, 17 policies target discrimination of  
42 very specific groups (e.g., victims of domestic violence), and seven policies used the word  
43 “discrimination” in the title of the policy but not within the body of the policy statement.

44  
45 Policy H-140.837, “Policy on Conduct at AMA Meetings,” sets forth our AMA’s policy of zero  
46 tolerance for any type of harassing conduct by physicians and others attending AMA functions or  
47 meetings and defines prohibited behaviors. The policy also provides multiple reporting options  
48 available to both the targets of any harassment and witnesses to prohibited conduct, including an  
49 option to register complaints confidentially to an external vendor online or via a toll-free hotline.

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

8  
9 Policy H-65.988, "Organizations Which Discriminate," also listed as a relevant AMA policy in  
10 Resolution 602, provides the organization with guidance encouraging, but not mandating, that  
11 meetings or other gatherings be held in organizational facilities that do not discriminate on the  
12 basis of race, religion, or gender and encourages its constituent societies to adopt a similar policy.  
13

#### 14 RECOMMENDATIONS

15  
16 Based on a review of internal policies, the Board of Trustees recommends that the following  
17 recommendations be adopted in lieu of Resolution 602-N-20, and the remainder of this report be  
18 filed.  
19

- 20 • That our AMA reaffirm its commitment to complying with all applicable laws, rules or  
21 regulations against discrimination on the basis of protected characteristics, including Title  
22 VII of the Civil Rights Act, The Age Discrimination in Employment Act, and the  
23 Americans with Disabilities Act, among other federal, state and local laws. (New HOD  
24 Policy)
- 25 • That our AMA reaffirm Policy H-65.965, "Support of Human Rights and Freedom," as an  
26 overarching non-discrimination policy for the Association. (Reaffirm HOD Policy)
- 27 • That our AMA reaffirm Policy H-65.988, "Organizations Which Discriminate," Policy G-  
28 630.040, "Principles on Corporate Relationships," and Policy H-65.950, "Terms and  
29 Language in Policies Adopted to Protect Populations from Discrimination and  
30 Harassment." (Reaffirm HOD Policy)
- 31 • That our AMA provide updates on its comprehensive diversity and inclusion strategy as  
32 part of the annual Board report to the AMA House of Delegates on health equity.  
33 (Directive to Take Action)

Fiscal Note: Within current budget

APPENDIX A: 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](#)

# REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-I-22

Subject: Terms and Language in Policies Adopted to Protect Populations from  
Discrimination and Harassment

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

---

## 1 BACKGROUND

2

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

5

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

8

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

15

## 16 DISCUSSION

17

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

29

30 Language and identity often go together and are critical within health equity. Both are fluid and  
31 most importantly, social constructs, meaning they are derived from humans and can change as time  
32 progresses. For example, the acronym BIPOC is used to collectively refer to those who identify as  
33 Black, Indigenous, and People of Color; it was created within the last decade. Some view it as a  
34 shift away from using other terms such as “marginalized” and “minority” and is another term used  
35 to unify and amplify communities that have long been shunned and/or ignored. However, there are  
36 others that have differing opinions. Jonathan Rosa, sociocultural and linguistic anthropologist, and  
37 associate professor at Stanford University explains that BIPOC “presupposes a kind of solidarity

1 and a shared positionality that doesn't play out in practice for a lot of people, and in fact obscures  
2 more than it reveals from some perspectives." It can also have an impact on research. Some  
3 scholars have argued that aggregating data can mask critical in-group differences and disparities,  
4 limiting efforts to specifically target resources. AMA has acknowledged this in recent years  
5 through the adoption of Policy D-350.979 at the 2021 Interim Meeting directing the organization to  
6 add "Middle Eastern/North African (MENA)" as a separate racial category on all AMA  
7 demographics forms; (2) advocate for the use of "Middle Eastern/North African (MENA)" as a  
8 separate race category in all uses of demographic data including but not limited to medical records,  
9 government data collection and research, and within medical education. Therefore, the acronym  
10 can be used in certain circumstances, but should not be used in quantitative reporting to  
11 unnecessarily aggregate groups; instead, disaggregated data should be used to depict the  
12 experiences of groups (see AMA AAPI Data [Report](#)).  
13

14 Additional key terms to consider such as sex and gender are often mistakenly used interchangeably.  
15 Within medicine, sex or "sex assigned at birth" is a label typically given by a physician based on  
16 the genitals a person is born with, but over time that very label may not align with how they  
17 identify. According to *The Oxford Handbook of Gender and Politics*, gender, refers to the social,  
18 psychological, and emotional traits, attitudes, norms and behaviors, often influenced by society's  
19 expectations, that classify someone as man, woman, both, or neither. The American Academy of  
20 Pediatrics defines gender identity as "one's internal sense of who one is, which results from a  
21 multifaceted interaction of biological traits, developmental influences, and environmental  
22 conditions. It may be male, female, ... a combination of both, or neither (i.e., not conforming to a  
23 binary conceptualization of gender)."  
24

25 Language usage is critical. At a time when so many are working to not only diversify medicine, but  
26 promote antiracism, the terms and phrases that are amplified can have lasting impacts that can  
27 cause harm for both physicians and patients.  
28

29 Board Report 5-N-21 notes: "Federal, state, and local law establish a baseline, identifying the  
30 minimum constellation of characteristics with respect to which discrimination should not be  
31 tolerated, based on the history of discrimination in the U.S." The landscape related to protected  
32 personal characteristics is constantly evolving (e.g., update to Title IX), so any recommendation on  
33 terminology will need to be flexible in its wording and regularly updated to remain in compliance.  
34

35 Board of Trustees Report 5-N-21 also found protected personal characteristics mentioned in  
36 existing policy of the AMA and other organizations at frequencies detailed in Appendix A, with  
37 minor adjustments made accounting for additional policy adopted by the AMA since the report was  
38 adopted (e.g., Policy H-350.960, Underrepresented Student Access to US Medical Schools).  
39

40 Finally, while not policy, the Strategic Plan and the Narrative Guide offer language (see  
41 Appendices B and C). The Strategic Plan at various points (see pages 11-16) mentions: "race,  
42 ethnicity, gender, sexual orientation, ability and country of origin (i.e., International Medical  
43 Graduates)," "gender, gender identity, sexual orientation, disability, age, class/socioeconomic  
44 status, citizenship status and language," "marginalized (women, LGBTQ+, people with disabilities,  
45 International Medical Graduates) and minoritized (Black, Indigenous, Latinx, Asian) physicians,"  
46 "race/ethnicity, gender, sexual identity, immigration status, country of origin, language and  
47 disability status," and "race/ethnicity, gender, socioeconomic status, ability status, LGBTQ+  
48 identity, literacy." The Narrative Guide at various points (see pages 9-15) mentions: "formerly  
49 incarcerated/returning citizen/persons with a history of incarceration," "sex assigned at birth," and  
50 "ethnicity, nationality, class, or other status/identities." The Narrative Guide stresses the  
51 importance of avoiding "dehumanizing language" and instead "offering equity-based, equity

1 explicit, and person-first alternatives” and advises us to “describe people as having a condition or  
2 circumstance, not being a condition” and “humanize those you are referring to by using people or  
3 persons.” Person-first or people-first formulations include: “people with...,” “people  
4 experiencing...,” and “people identifying as...” However, the Narrative Guide notes that  
5 “different communities and individuals have different standards and preferences” regarding person-  
6 first language.

7  
8 RECOMMENDATION

9  
10 Based on a review of internal policies, the Strategic Plan and Narrative Guide, the Board of  
11 Trustees recommends that the following be adopted, and the remainder of this report be filed:

- 12  
13 1. That our AMA amend Policy H-65.950 by addition and deletion to read as follows:

14  
15 Our AMA recognizes broad and evolving protected personal characteristics spanning  
16 identity, origin, and status that include those outlined by regulatory authorities overlapping  
17 with those prioritized by AMA. To prevent misunderstandings and facilitate collaboration  
18 to move medicine forward, AMA recommends acknowledges preferred terminology for  
19 protected personal characteristics outlined in the actual sources used in the 2021 AMA  
20 Strategic Plan to Embed Racial Justice and Advance Health Equity and the AMA-AAMC  
21 Advancing Health Equity such as the CDC’s Health Equity Guiding Principles for  
22 Inclusive Communication ~~to~~ that may be used in AMA policies and position statements.  
23 (Modify Current HOD Policy)

Fiscal Note: Less than \$500

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

<b>Characteristic</b>	<b>Federal Agencies (DOE, EEOC, HHS)</b>	<b>AMA Policy</b>	<b>Other Professional Societies (Convenience Sample)</b>	<b>Schools (Convenience Sample)</b>
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

	<b>Definitions</b>	<b>Notes</b>
<b>Racism</b>	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.
<b>Structural Racism</b>	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."	
<b>Institutional Racism</b>	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.
<b>Interpersonal Racism</b>	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.
<b>Internalized Racism</b>	Acceptance by members of stigmatized races of negative messages about their own abilities and intrinsic worth.	
<b>Prejudice</b>	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.

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

	Definitions	Notes
<b>Bias</b>	<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 biases<sup>20</sup> discussed in scholarly research and in medicine<sup>21,22</sup> that inhibit progress towards multiculturalism and equity in our society:</p> <ol style="list-style-type: none"> <li>1. <b>Explicit or Conscious bias</b>—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.</li> <li>2. <b>Implicit or Unconscious bias</b>—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.</li> </ol>	<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><b>Avoid use of adjectives such as vulnerable, marginalized and high-risk.</b> 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"> <li>• Vulnerable groups</li> <li>• Marginalized communities</li> <li>• Hard-to-reach communities</li> <li>• Underserved communities</li> <li>• Underprivileged communities</li> <li>• Disadvantaged groups</li> <li>• High-risk groups</li> <li>• At-risk groups</li> <li>• High-burden groups</li> </ul>	<ul style="list-style-type: none"> <li>• Groups that have been economically/ socially marginalized</li> <li>• Groups that have been historically marginalized or made vulnerable; <i>historically</i> marginalized</li> <li>• Groups that are struggling against economic marginalization</li> <li>• Communities that are underserved by/with limited access to (specific service/resource)</li> <li>• Under-resourced communities</li> <li>• Groups experiencing disadvantage because of (reason)</li> <li>• Groups placed at increased risk/put at increased risk of (outcome)</li> <li>• Groups with higher risk of (outcome)</li> <li>• For scientific publications:                             <ul style="list-style-type: none"> <li>– Disproportionately affected groups</li> <li>– Groups experiencing disproportionate prevalence/rates of (condition)</li> </ul> </li> </ul>
<p><b>Avoid dehumanizing language. Use person-first language instead.</b> Describe <b>people</b> 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. <b>Humanize those you are referring to by using people or persons.</b></p>	<ul style="list-style-type: none"> <li>• The obese or the morbidly obese</li> <li>• COVID-19 cases</li> <li>• The homeless</li> <li>• Disabled person</li> <li>• Handicapped</li> <li>• Inmates</li> <li>• Victims</li> <li>• Cases or subjects (when referring to affected persons)</li> <li>• Individuals</li> </ul>	<ul style="list-style-type: none"> <li>• People experiencing (health outcome or life circumstance)</li> <li>• People with obesity; people with severe obesity</li> <li>• Patients or persons with COVID-19</li> <li>• People who are experiencing (condition or disability type)</li> <li>• Person with mobility disability</li> <li>• Person with vision impairments</li> <li>• People who are experiencing homelessness</li> <li>• Survivors</li> </ul>
<p><b>Remember that there are many types of subpopulations.</b> 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"> <li>• Minorities</li> <li>• Minority</li> <li>• Ethnic groups</li> <li>• Racial groups</li> </ul>	<ul style="list-style-type: none"> <li>• Specify the type of subpopulation:                             <ul style="list-style-type: none"> <li>– (People from) racial and ethnic groups</li> <li>– (People from) racial and ethnic minority groups</li> <li>– (People from) sexual/gender /linguistic/religious minority groups</li> <li>– (People with/living with) mobility/ cognitive/vision/hearing/independent living/self-care disabilities</li> </ul> </li> </ul>
<p><b>Avoid saying target, tackle, combat or other terms with violent connotation when referring to people, groups or communities.</b> These terms should also be avoided, in general, when communicating about public health activities.</p>	<ul style="list-style-type: none"> <li>• Target communities for interventions</li> <li>• Target population</li> <li>• Tackle issues within the community</li> <li>• Aimed at communities</li> <li>• Combat (disease)</li> <li>• War against (disease)</li> </ul>	<ul style="list-style-type: none"> <li>• Engage/prioritize/collaborate with/serve (population of focus)</li> <li>• Consider the needs of/Tailor to the needs of (population of focus)</li> <li>• Communities/populations of focus</li> <li>• Intended audience</li> <li>• Eliminate (issue/disease)</li> </ul>
<p><b>Avoid unintentional blaming.</b> 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"> <li>• Workers who do not use PPE</li> <li>• People who do not seek healthcare</li> </ul>	<ul style="list-style-type: none"> <li>• People with limited access to (specific service/resource)</li> <li>• Workers under-resourced with (specific service/resource)</li> </ul>

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

# REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-I-22

Subject: Updated Bylaws: Delegate Apportionment and Pending Members

Presented by: Kevin C. Reilly, Sr., MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 At the 2022 Annual Meeting, the House adopted Recommendation 3 of BOT Report 20, “Delegate  
2 Apportionment and Pending Members,” in lieu of Resolution 618. This recommendation directs  
3 “That delegates be apportioned to constituent societies for 2023 with each society getting the  
4 greatest of the following numbers:

- 5
- 6 - The number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA  
7 members;
- 8 - The number of delegates apportioned for 2022 so long as that figure is not greater than 2  
9 more than the number apportioned at the rate of 1 per 1000, or fraction thereof, AMA  
10 members; or
- 11 - For societies that would lose more than 5 delegates from their 2022 apportionment, the  
12 number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA  
13 members plus 5.”
- 14

15 Existing bylaw language on apportionment will sunset as of the close of business of the 2022  
16 Interim Meeting; thus, the Council puts forth amended language consistent with the adopted  
17 recommendation of BOT Report 20-A-22. In doing so, the Council acknowledges that the Board’s  
18 actions on the other five referred recommendations in Board Report 20 may impact the House’s  
19 action on apportionment, if not for 2023 but for future years. The Board’s report on the referred  
20 items is also before the House at this meeting.

## 21 22 RECOMMENDATIONS

23  
24 The Council on Constitution and Bylaws recommends that the following amendments to the AMA  
25 Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative  
26 vote of two-thirds of the members of the House of Delegates present and voting.

27  
28 **2.1 Constituent Associations.** Each recognized constituent association granted representation  
29 in the House of Delegates is entitled to delegate representation based on the number of  
30 seats allocated to it by apportionment, and such additional delegate seats as may be  
31 provided under Bylaw 2.1.4-2. Only one constituent association from each U.S. state,  
32 commonwealth, territory, or possession shall be granted representation in the House of  
33 Delegates.

34  
35 **2.1.1 Apportionment.** The apportionment of delegates from each constituent  
36 association is one delegate for each 1,000, or fraction thereof, active constituent  
37 and active direct members of the AMA within the jurisdiction of each constituent  
38 association, as recorded by the AMA as of December 31 of each year.

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**2.1.1.1** ~~The December 31 count will include pending members for purposes of apportionment; however, pending members shall not be recounted the following year absent membership renewal. For 2023 only, the apportionment shall include the greatest of the following numbers: the number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members consistent with Bylaw 2.1.1; 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 5 delegates from their 2022 apportionment, the number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members plus 5. Bylaw 2.1.1.1 will sunset as of December 31, 2023 the close of business of the 2022 Interim Meeting unless the House of Delegates acts to retain it.~~

**2.1.1.2 Effective Date.** Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

**2.1.1.2.1 Retention of Delegate.** If the membership information as recorded by the AMA as of December 31 warrants a decrease in the number of delegates representing a constituent association, the constituent association shall be permitted to retain the same number of delegates, without decrease, for one additional year, if it promptly files with the AMA a written plan of intensified AMA membership development activities among its members. At the end of the one year grace period, any applicable decrease will be implemented.

**2.1.1.2.1.1** ~~A constituent association that shows a membership loss for 2020 and/or 2021 shall be granted an additional one year grace period beyond the one year grace period set forth in 2.1.1.2.1 without a decrease in the number of delegates. This Bylaw will sunset at the close of the 2022 Interim Meeting. A constituent society may not benefit from both this provision and 2.1.1.1. Bylaw 2.1.1.2.1.1 will sunset as of December 31, 2023.~~

\*\*\*

**2.2 National Medical Specialty Societies.** The number of delegates representing national medical specialty societies shall equal the number of delegates representing the constituent societies. Each national medical specialty society granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment, and such additional delegate seat as may be provided under Bylaw 2.2.2. The total number of delegates apportioned to national medical specialty societies under Bylaw 2.2.1 shall be adjusted to be equal to the total number of delegates apportioned to constituent societies under sections 2.1.1 and 2.1.1.1-2.1 using methods specified in AMA policy.

(Modify Bylaws)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 1-I-22

Subject: Amendment to Opinion 4.2.7, “Abortion”

Presented by: Peter A Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Current guidance on abortion in Opinion 4.2.7 of the AMA *Code of Medical Ethics* was issued in  
2 1977 in the context of the U.S. Supreme Court decision in *Roe v. Wade*,<sup>1</sup> which recognized a  
3 constitutional right to abortion. The Court’s recent decision in *Dobbs v. Jackson Women’s Health*  
4 *Organization*<sup>2</sup> overturning *Roe* and returning debate about abortion to the states has significantly  
5 altered the landscape for patients and their physicians.

6  
7 As the American Medical Association immediately [noted](#), *Dobbs*:  
8  
9 overturn[s] nearly a half century of precedent protecting patients’ right to critical reproductive  
10 health care—representing an egregious allowance of government intrusion into the medical  
11 examination room, a direct attack on the practice of medicine and the patient-physician  
12 relationship, and a brazen violation of patients’ rights to evidence-based reproductive health  
13 services.

14  
15 The AMA joined the American College of Obstetricians and Gynecologists and more than 70 other  
16 professional medical associations in [condemning](#) the unacceptable effects *Dobbs* will have on  
17 access to safe, accepted, essential reproductive health services; the privacy and integrity of patient-  
18 physician relationships; and indeed, the safety of patients and physicians.

19  
20 Guidance throughout the *Code* underscores physicians’ duty of fidelity to patients and to promote  
21 access to care, as well as responsibility to support informed decision making in keeping with  
22 patients’ individual goals and preferences as autonomous moral agents. The *Code* likewise  
23 prohibits physicians acting as agents of government entities in conflict with their duties to patients.  
24 At the same time, the *Code* acknowledges that physicians too are moral agents as individuals,  
25 whose deeply held personal beliefs may at times conflict with the expectations held of them as  
26 medical professionals, and offers guidance to help physicians navigate an ethically acceptable path  
27 forward in the face of diverging commitments.

28  
29 Finally, the *Code* [acknowledges](#) that although deeply intertwined, law and the ethical commitments  
30 of the profession do not always align:

31  
32 In some cases, the law mandates conduct that is ethically unacceptable. When physicians  
33 believe a law violates ethical values or is unjust they should work to change in law. In  
34 exceptional circumstances of unjust laws, ethical responsibilities should supersede legal duties.

35  
36 When the letter of the law would foreclose urgently needed care physicians must have latitude to  
37 act in accord with their best professional judgement.

1 RECOMMENDATION

2

3 With all of the foregoing considerations in mind, the Council on Ethical and Judicial Affairs  
4 recommends that Opinion 4.2.7, "Abortion," be amended as follows and the remainder of this  
5 report be filed:

6

7 Abortion is a safe and common medical procedure, about which thoughtful individuals hold  
8 diverging, yet equally deeply held and well-considered perspectives. Like all health care  
9 decisions, a decision to terminate a pregnancy should be made privately within the relationship  
10 of trust between patient and physician in keeping with the patient's unique values and needs  
11 and the physician's best professional judgment.

12

13 ~~The *Principles of Medical Ethics* of the AMA do not prohibit a physician from performing an~~  
14 ~~abortion permit physicians to perform abortions in keeping with good medical practice under~~  
15 ~~circumstances that do not violate the law.~~

16

(Modify HOD/CEJA Policy)

Fiscal Note: Less than \$500

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<sup>1</sup> *Roe v. Wade*, 410 U. S. 113 (1973).

<sup>2</sup> *Dobbs v. Jackson Women's Health Organization*, 142 S.Ct. 2228.

# REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS\*

CEJA Report 2-I-22

Subject: Amendment to Opinion 10.8, “Collaborative Care”

Presented by: Peter A. Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Recent years have seen the rise of nonphysician practitioners (e.g., nurse practitioners, physician  
2 assistants, midwives) as a growing share of health care providers in the United States. Moreover,  
3 nonphysician practitioners have gained increasing autonomy, authorized by state governments  
4 (e.g., legislatures and licensing boards) in response to the lobbying from professional associations,  
5 as part of an effort to ameliorate provider shortages, and in response to rising health care costs.  
6 Expanded autonomy has increased the interactions of independent nonphysician practitioners and  
7 physicians in care of patients. Increasingly nonphysician practitioners are seeking advanced  
8 training that results in a doctorate degree, such as “Doctor of Nursing.” Such terminology  
9 sometimes results in misconception or confusion for both patients and physicians about the  
10 practitioner’s skillset, training, and experience.

11  
12 The following is an analysis of the ethical concerns centering on issues of transparency and  
13 misconception. In recognition of the growing relevance of the issue, the Council brings this  
14 analysis on its own initiative, offering an amendment to the AMA *Code of Medical Ethics* Opinion  
15 10.8 Collaborative Care.

## 16 17 DESCRIPTION OF NONPHYSICIAN PRACTITIONERS

18  
19 The term “nonphysician practitioners” denotes a broad range of professionals including nurse  
20 practitioners, physician assistants, midwives, doulas, pharmacists, and physical therapists. There  
21 are “multiple pathways” for one to become a nonphysician practitioner, the most common is a  
22 nurse earning a “master’s degree or doctoral degree in nursing” after initial completion of a  
23 bachelor’s degree [1]. However, the skill sets and experience of nonphysician practitioners are not  
24 the same as those of physicians. Hence, when a nonphysician practitioner identifies themselves as  
25 “Doctor” consistent with the degree they received, it may create confusion and be misleading to  
26 patients and other practitioners.

## 27 28 PATIENT CONFUSION AND MISCONCEPTION

29  
30 Patient confusion and misconception about provider credentials is a significant concern. Data  
31 suggest that many patients are not sure who is and who is not a physician. For example, 47% of  
32 respondents in one survey indicated they believed optometrists were physicians (10% were unsure),  
33 while some 15% believed ophthalmologists are *not* (with 12% being unsure) [2]. Nineteen percent

---

\* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

1 of respondents to the same survey believed nurse practitioners (NPs) to be physicians, although  
2 74% identified them as nonphysicians.

3  
4 Meanwhile, the range of professional titles of various NPs is wide and the issue is compounded by  
5 the fact that many NPs hold doctorate degrees [3]. While the PhD in nursing degree is the oldest  
6 and most traditional doctorate in the nursing profession, having its roots in the 1960s and 70s [4],  
7 Al-Agba and Bernard note how in “recent years, an explosion of doctorates in various medical  
8 professions has made the label of ‘doctor’ far less clear”, a common example being that of the of  
9 the “Doctor of Nursing Practice” (DNP) [3]. The DNP, a professional practice doctorate (distinct  
10 from the research-oriented PhD), was first granted in the U.S. in 2001. As of 2020, there are now  
11 348 DNP programs in the U.S. [3]. Critics argue that the rise of DNP programs is not about  
12 providing better patient care, but is rather a “political maneuver, designed to appropriate the title of  
13 ‘doctor’ and create a false sense of equivalence between nurse practitioners and physicians in the  
14 minds of the public” [3].

15  
16 The problem of identification has been recognized by some states where NPs with a doctorate are  
17 only allowed to be “addressed as ‘doctor’ if the DNP clarifies that he or she is actually an NP” and  
18 some jurisdictions require NPs without a doctorate to have special identification that  
19 “unambiguously identifies them” [5]. From an ethical standpoint, NPs have a duty as do all health  
20 care practitioners, including physicians, to be forthright with patients about their skill sets,  
21 education, or training, and to not allow any situation where a misconception is possible.  
22 Ambiguous representation of credentials is unethical, because it interferes with the patient’s  
23 autonomy, as the patient is not able to execute valid informed consent if they misconstrue the  
24 provider. For example, a patient may only want a certain procedure done by a physician and then  
25 assent to an NP performing the procedure, under the mistaken belief that the NP is a physician.  
26 However, such an assent to the medical procedure is neither a valid *consent* nor an adequately  
27 informed *assent*, as the patient’s decision is founded on a flawed basis of key information, i.e., the  
28 nature and extent of the practitioner’s skill set, education, and experience.

## 30 GUIDANCE IN AMA POLICY AND CODE OF MEDICAL ETHICS

31  
32 AMA House Policy and the AMA *Code of Medical Ethics* respond to and recognize issues of  
33 transparency of credentials and professional identification. However, the *Code* could be modestly  
34 amended to offer specific guidance regarding transparency in the context of team-based care  
35 involving nonphysician practitioners.

### 37 *House Policy*

38  
39 [H-405.992](#) – “Doctor as Title,” states:

40  
41 The AMA encourages state medical societies to oppose any state legislation or regulation that  
42 might alter or limit the title ““Doctor,”” which persons holding the academic degrees of Doctor  
43 of Medicine or Doctor of Osteopathy are entitled to employ.

44  
45 [D-405.991](#) – “Clarification of the Title “Doctor” in the Hospital Environment,” states:

46  
47 Our AMA Commissioners will, for the purpose of patient safety, request that The Joint  
48 Commission develop and implement standards for an identification system for all hospital  
49 facility staff who have direct contact with patients which would require that an identification  
50 badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD,

1 DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a  
2 Doctorate, and those with other types of credentials.

3  
4 [H-405.969](#) – “Definition of a Physician”, states:

5  
6 ... a physician is an individual who has received a “Doctor of Medicine” or a “Doctor of  
7 Osteopathic Medicine” degree or an equivalent degree following successful completion of a  
8 prescribed course of study from a school of medicine or osteopathic medicine.

9  
10 AMA policy requires anyone in a hospital environment who has direct contact with a patient  
11 who presents himself or herself to the patient as a "doctor,” and who is not a “physician”  
12 according to the AMA definition above, must specifically and simultaneously declare  
13 themselves a “nonphysician” and define the nature of their doctorate degree.

14  
15 *Code of Medical Ethics*

16  
17 The Code already addresses transparency in context of residents and fellows. [Opinion 9.2.2](#),  
18 “Resident & Fellow Physicians’ Involvement in Patient Care,” possesses some language regarding  
19 transparency and identification where it states:

20  
21 When they are involved in patient care, residents and fellows should:

22  
23 (a) Interact honestly with patients, including clearly identifying themselves as members of a  
24 team that is supervised by the attending physician and clarifying the role they will play in  
25 patient care.

26  
27 In the context of a team-based collaborative care involving nonphysician practitioners, [Opinion](#)  
28 [10.8](#), “Collaborative Care” is the most relevant *Code* opinion. It gives guidance on the  
29 collaborative team-based setting, where a mix of health professionals provide care. However,  
30 Opinion 10.8 lacks guidance on the transparency of identification and credentials, ultimately  
31 leaving the *Code* silent on the issue of transparency in the context of team-based collaborative care.  
32 Hence, amendment to Opinion 10.8 is warranted.

33  
34 RECOMMENDATION

35  
36 In light of the foregoing, the Council on Ethical and Judicial Affairs recommends that Opinion  
37 10.8, “Collaborative Care,” be amended as follows and the remainder of this report be filed:

38  
39 In health care, teams that collaborate effectively can enhance the quality of care for individual  
40 patients. By being prudent stewards and delivering care efficiently, teams also have the  
41 potential to expand access to care for populations of patients. Such teams are defined by their  
42 dedication to providing patient-centered care, ~~protecting the integrity of the patient-physician~~  
43 ~~relationship~~, sharing mutual respect and trust, communicating effectively, sharing  
44 accountability and responsibility, and upholding common ethical values as team members.

45  
46 Health care teams often include members of multiple health professions, including physicians,  
47 nurse practitioners, physician assistants, pharmacists, physical therapists, and care managers  
48 among others. To foster the trust essential to healing relationships between patients and  
49 physicians or nonphysician practitioners, all members of the team should be candid about their  
50 professional credentials, their experience, and the role they will play in the patient’s care.

1 An effective team requires the vision and direction of an effective leader. In medicine, this  
2 means having a clinical leader who will ensure that the team as a whole functions effectively  
3 and facilitates decision-making. Physicians are uniquely situated to serve as clinical leaders. By  
4 virtue of their thorough and diverse training, experience, and knowledge, physicians have a  
5 distinctive appreciation of the breadth of health issues and treatments that enables them to  
6 synthesize the diverse professional perspectives and recommendations of the team into an  
7 appropriate, coherent plan of care for the patient.

8  
9 As clinical leaders within health care teams, physicians individually should:

10  
11 (a) Model ethical leadership by:

- 12  
13 (i) Understanding the range of their own and other team members' skills and expertise and  
14 roles in the patient's care  
15 (ii) Clearly articulating individual responsibilities and accountability  
16 (iii) Encouraging insights from other members and being open to adopting them and  
17 (iv) Mastering broad teamwork skills  
18

19 (b) Promote core team values of honesty, discipline, creativity, humility and curiosity and  
20 commitment to continuous improvement.

21  
22 (c) Help clarify expectations to support systematic, transparent decision making.

23  
24 (d) Encourage open discussion of ethical and clinical concerns and foster a team culture in  
25 which each member's opinion is heard and considered and team members share  
26 accountability for decisions and outcomes.

27  
28 (e) Communicate appropriately with the patient and family, ~~and~~ respecting their unique  
29 relationship of patient and family as members of the team.

30  
31 (f) Assure that all team members are describing their profession and role.

32  
33 As leaders within health care institutions, physicians individually and collectively should:

34  
35 (~~g~~) Advocate for the resources and support health care teams need to collaborate effectively in  
36 providing high-quality care for the patients they serve, including education about the  
37 principles of effective teamwork and training to build teamwork skills.

38  
39 (~~gh~~) Encourage their institutions to identify and constructively address barriers to effective  
40 collaboration.

41  
42 (~~hi~~) Promote the development and use of institutional policies and procedures, such as an  
43 institutional ethics committee or similar resource, to address constructively conflicts within  
44 teams that adversely affect patient care.

45  
46 (j) Promote a culture of respect, collegiality and transparency among all health care personnel.

47  
48 (Modify HOD/CEJA Policy)

Fiscal Note: Less than \$500

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Subject: Pandemic Ethics and the Duty of Care

Presented by: Peter A. Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Policy D-130.960, “Pandemic Ethics and the Duty of Care,” adopted by the American Medical  
2 Association (AMA) House of Delegates in June 2021, asks the Council on Ethical and Judicial  
3 Affairs (CEJA) to “reconsider its guidance on pandemics, disaster response and preparedness in  
4 terms of the limits of professional duty of individual physicians, especially in light of the unique  
5 dangers posed to physicians, their families and colleagues during the COVID-19 global pandemic.”  
6

7 At the 2022 Annual Meeting, the Council’s informational report on this matter, CEJA Report 5-A-  
8 22, was extracted and referred to Reference Committee on Amendments to Constitution and  
9 Bylaws. Testimony acknowledged that the Council has disseminated interpretive materials to help  
10 users apply guidance from multiple Opinions in the AMA *Code of Medical Ethics* relating to the  
11 duty to treat in crisis situations but felt that additional guidance was nonetheless needed in the  
12 *Code* itself. The present report proposes amendments to Opinion 8.3, “Physician Responsibility in  
13 Disaster Response and Preparedness.”  
14

#### 15 A CONTESTED DUTY

16  
17 As several scholars have noted, the idea that physicians have a professional duty to treat has waxed  
18 and waned historically, at least in the context of infectious disease [1,2,3]. Many physicians fled  
19 the Black Death; those who remained did so out of religious devotion, or because they were enticed  
20 by remuneration from civic leaders [1]. Even in the early years of the AIDS epidemic, physicians  
21 contested whether they had a responsibility to put themselves at risk for what was then a lethal and  
22 poorly understood disease [3]. Yet the inaugural edition of the AMA *Code of Medical Ethics* in  
23 1847 codified a clear expectation that physicians would accept risk:  
24

25       When pestilence prevails, it is [physicians’] duty to face the danger, and to continue their  
26       labors for the alleviation of suffering, even at the jeopardy of their own lives [[1847 Code](#), p.  
27       105].  
28

29 That same sensibility informs AMA’s [Declaration of Professional Responsibility](#) when it calls on  
30 physicians to “apply our knowledge and skills when needed, though it may put us at risk.” And it is  
31 embedded in current guidance in the *Code*. Based on physicians’ commitment of fidelity to  
32 patients, [Opinion 8.3](#), “Physicians’ Responsibilities in Disaster Response and Preparedness,”  
33 enjoins a duty to treat. This opinion provides that “individual physicians have an obligation to  
34 provide urgent medical care during disasters . . . even in the face of greater than usual risks to

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\* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

1 physicians' own safety, health, or life." The *Code* is clear that this obligation isn't absolute,  
2 however. Opinion 8.3 qualifies the responsibility when it notes that "physicians also have an  
3 obligation to evaluate the risks of providing care to individual patients versus the need to be  
4 available to provide care in the future."

5  
6 From the perspective of the *Code*, then, the question isn't whether physicians have a duty to treat  
7 but how to think about the relative strength of that duty in varying circumstances.

## 8 9 INTERPRETING ETHICS GUIDANCE

10  
11 Over the course of the COVID-19 pandemic, AMA has drawn on the *Code* to explore this question  
12 in reflections posted to its COVID-19 Resource Center on whether physicians may decline to treat  
13 [unvaccinated patients](#) and under what conditions medical students may ethically be permitted to  
14 [graduate early](#) to join the physician workforce.

15  
16 Drawing particularly on guidance in [Opinion 1.1.2](#), "Prospective Patients," and—in keeping with  
17 Opinion 8.3, taking physicians' expertise and availability as itself a health care resource—[Opinion](#)  
18 [11.1.3](#), "Allocating Limited Health Care Resources," as well as [Opinion 8.7](#), "Routine Universal  
19 Immunization of Physicians," these analyses offer key criteria for assessing the strength of the duty  
20 to treat:

- 21
- 22 • urgency of medical need
- 23 • risk to other patients or staff in a physician's practice
- 24 • risk to the physician
- 25 • likelihood of occurrence and magnitude of risk
- 26

27 To these criteria should be added likelihood of benefit—that is, physicians should not be obligated  
28 to put themselves at significant risk when patients are not likely to benefit from care [2]. Although  
29 the *Code* does not link the question specifically to situations of infectious disease or risk to  
30 physicians, it supports this position. [Opinion 5.5](#), "Medically Ineffective Interventions," provides  
31 that physicians are not obligated to provide care that, in their considered professional judgment,  
32 will not provide the intended clinical benefit or achieve the patient's goals for care.

33  
34 Similarly, to the extent that the *Code* articulates a general responsibility on the part of physicians to  
35 protect the well-being of patients and staff, it supports consideration of risk to others in assessing  
36 the relative strength of a duty to treat. Thus, while Opinion 1.1.2 explicitly prohibits physicians  
37 from declining a patient based solely on the individual's disease status, it permits them to decline to  
38 provide care to patients who threaten the well-being of other patients or staff. In the context of a  
39 serious, highly transmissible disease this responsibility to minimize risk to others in professional  
40 settings may constrain the presumption of a duty to treat.

41  
42 Yet the *Code* is also silent on important matters that have been noted in the literature. For example,  
43 it doesn't address whether the duty to treat applies uniformly across all medical specialties. Some  
44 scholars argue that the obligation should be understood as conditioned by physicians' expertise,  
45 training, and role in the health care institution [4,5,6]. In essence, the argument is that the more  
46 relevant a physician's clinical expertise is to the needs of the moment, the more reasonable it is to  
47 expect physicians to accept greater personal risk than clinicians who do not have the same  
48 expertise. The point is well taken. Guidance that addresses the duty to treat "as if it were the  
49 exclusive province of any individual health profession" [2], risks undercutting its own value to  
50 offer insight into that duty.

1 Moreover, for the most part the *Code* restricts its analysis of physicians’ responsibilities to the  
 2 context of their professional lives, addressing their duties to patients, and to a lesser degree, to their  
 3 immediate colleagues in health care settings. In this, guidance overlooks the implications of  
 4 responsibilities physicians hold in their *nonprofessional* lives—as members of families, as friends,  
 5 as participants in community outside the professional domain. Thus, it is argued, a physician whose  
 6 household includes a particularly vulnerable individual—e.g., someone who has chronic underlying  
 7 medical condition or is immune compromised and thus at high risk for severe disease—has a less  
 8 stringent duty to treat than does a physician whose personal situation is different.

9  
 10 Although the *Code* acknowledges that physicians indeed have lives as moral agents outside  
 11 medicine ([Opinion 1.1.7](#), “Physician Exercise of Conscience”), it does not reflect as deeply as it  
 12 might about the nature of competing personal obligations or how to balance the professional and  
 13 the personal. In much the same way as understanding the duty to treat as the responsibility of a  
 14 single profession, restricting analysis to a tension between altruism and physicians’ individual self-  
 15 interests “fails to capture the real moral dilemmas faced by health care workers in an infectious  
 16 epidemic” [7].

## 17 18 SUPPORTING THE HEALTH CARE WORKFORCE

19  
 20 As adopted in 1847, the *Code* addressed physicians’ ethical obligations in the broader framework  
 21 of reciprocal obligations among medical professionals, patients, and society. Over time, the *Code*  
 22 came to focus primarily on physician conduct.

23  
 24 Pandemic disease doesn’t respect conceptual boundaries between the professional and the personal,  
 25 the individual and the institutional. Nor does it respect the borders of communities or catchment  
 26 areas. In situations of pandemic disease, “the question is one of a social distribution of a  
 27 biologically given risk within the workplace and society at large” [7].

### 28 29 *Health Care Institutions*

30  
 31 Under such conditions, it is argued, the duty to treat “is not to be borne solely by the altruism and  
 32 heroism of individual health care workers” [7]. Moreover, as has been noted,

33  
 34 ... organizations, as well as individuals, can be virtuous. A virtuous organization encourages  
 35 and nurtures the virtuous behavior of the individuals within it. At the very least, the virtuous  
 36 institution avoids creating unnecessary barriers to the virtuous behavior of individuals [2].

37  
 38 The *Code* is not entirely insensitive to the ethics of health care institutions. It touches on  
 39 institutions’ responsibility to the communities they serve ([Opinion 11.2.6](#), “Mergers between  
 40 Secular and Religiously Affiliated Health Care Institutions”) and the needs of physicians and other  
 41 health care personnel who staff them ([Opinions 11.1.2](#), “Physician Stewardship of Health Care  
 42 Resources,” and [11.2.1](#), “Professionalism in Health Care Systems). Health care facilities and  
 43 institutions are the locus within which the practice of today’s complex health care takes place. As  
 44 such, institutions—notably nonprofit institutions—too have duties,

45  
 46 ... fidelity to patients, service to patients, ensuring that the care is high quality and provided “in  
 47 an effective and ethically appropriate manner”; service to the community the hospital serves,  
 48 deploying hospital resources “in ways that enhance the health and quality of life” of the  
 49 community; and institutional stewardship [[CEJA 2-A-18](#)].

1 Analyses posted to the AMA’s COVID-19 Resource Center look to this guidance to examine  
2 institutional obligations to [protect health care personnel](#) and to respect physicians who voice  
3 concern when institutional [policies and practices](#) impinge on clinicians’ ability to fulfill their  
4 ethical duties as health care professionals.

5  
6 Although existing guidance does not explicitly set out institutional responsibility to provide  
7 appropriate resources and strategies to mitigate risk for health care personnel, it does support such  
8 a duty. The obligation to be responsible stewards of resources falls on health care institutions as  
9 well as individuals. To the extent that health care professionals themselves are an essential and  
10 irreplaceable resource for meeting patient and community needs, institutions have an ethical duty  
11 to protect the workforce (independent of occupational health and safety regulation). On this view,  
12 institutions discharge their obligations to the workforce when, for example, they:

- 13
- 14 • support robust patient safety and infection control practices
- 15 • make immunization readily available to health care personnel
- 16 • provide adequate supplies of appropriate personal protective equipment (PPE)
- 17 • ensure that staffing patterns take into account the toll that patient care can exact on  
18 frontline clinicians
- 19 • distribute burdens equitably among providers in situations when individual physicians or  
20 other health care personnel *should not* put themselves at risk
- 21 • have in place fair and transparent mechanisms for responding to individuals who decline to  
22 treat on the basis of risk. (Compare Opinion 8.7, “Routine Universal Immunization of  
23 Physicians.”)
- 24

25 Equally, institutions support staff by gratefully acknowledging the contributions all personnel make  
26 to the operation of the institution and providing psychosocial support for staff.

### 27 *Professional Organizations*

28  
29  
30 So too physicians and other health care professionals should be able to rely on their professional  
31 organizations to advocate for appropriate support of the health care workforce, as in fact several  
32 [organizations](#) have done over the course of the COVID-19 pandemic. In March 2020, the American  
33 Medical Association, American Hospital Association, and American Nurses Association, for  
34 example, jointly argued vigorously for and helped secure use of the Defense Production Act (DPA)  
35 to [provide PPE](#). The [American College of Physicians](#) similarly urged use of the DPA to address the  
36 shortage of PPE. [Physicians for Human Rights](#) led a coalition of organizations that called on the  
37 National Governors Association to urge governors to implement mandatory standards for  
38 protecting health workers during the pandemic.

39  
40 The AMA further advocated for opening [visa processing](#) for international physicians to help  
41 address workforce issues, and secured [financial support](#) for physician practices under the Provider  
42 Relief Fund of the American Rescue Plan Act.

### 43 *Public Policy*

44  
45  
46 As noted, the *Code* originally delineated reciprocal obligations among physicians, patients, and  
47 society. Such obligations on the part of communities and public policymakers should be  
48 acknowledged as among the main factors that “contour the duty to treat” [1]. More specifically, it  
49 is argued,

1 in preparation for epidemics communities should: 1) take all reasonable precautions to prevent  
2 illness among health care workers and their families; 2) provide for the care of those who do  
3 become ill; 3) reduce or eliminate malpractice threats for those working in high-risk emergency  
4 situations; and 4) provide reliable compensation for the families of those who die while  
5 fulfilling this duty [1].  
6

7 In the face of the failure on the part of health care institutions and public agencies to ensure that  
8 essential resources have been in place to reduce risk and lessen the burdens for individuals of  
9 taking on the inevitable risk that remains, it is understandable that physicians and other health care  
10 professionals may resent the expectation that they will unhesitatingly put themselves at risk. At  
11 least one scholar has forcefully argued that, in the case of COVID-19, celebrations of medical  
12 heroism were overwhelmingly insensitive to the fact such heroism was the “direct, avoidable  
13 consequence” of institutional and public policy decisions that left the health care system  
14 unprepared and transferred the burden of responding to the pandemic to individual health care  
15 professionals [8].  
16

#### 17 ACKNOWLEDGING THE DUTY TO TREAT: SOLIDARITY

18

19 In the end, seeing the duty to treat as simply a matter of physicians’ altruistic dedication to patients  
20 forecloses considerations that can rightly condition the duty in individual circumstances. As  
21 Opinion 8.3 observes, providing care for individual patients in immediate need is not physicians’  
22 only obligation in a public health crisis. They equally have an obligation to be part of ensuring that  
23 care can be provided in the future. Equating duty to treat with altruism “makes invisible moral  
24 conflicts between the various parties to whom a person may owe care and interferes with the need  
25 of healthcare professionals to understand that they must take all possible measures consistent with  
26 the social need for a functioning healthcare system to protect themselves in an epidemic” [7].  
27

28 Further, such a view not only elides institutional and societal obligations but misrepresents how the  
29 duty actually plays out in contemporary health care settings. The risks posed by pandemic disease  
30 are distributed across the health care workforce, not uniquely borne by individuals, let alone by  
31 individual physicians. Ultimately, the risk refused by one will be borne by someone else, someone  
32 who is more often than not a colleague [2,7]. From this perspective, accepting the duty to treat is an  
33 obligation physicians owe to fellow health care personnel as much as to patients or to society.  
34

#### 35 AN ENDURING PROFESSIONAL RESPONSIBILITY

36

37 Taken together, the foregoing considerations argue that physicians indeed *should* recognize the  
38 duty to treat as a fundamental obligation of professional ethics. This is not to argue that the duty is  
39 absolute and unconditional. However, as the Preface to Opinions of the Council on Ethical and  
40 Judicial Affairs observes, recognizing when circumstances argue against adhering to the letter of  
41 one’s ethical obligations  
42

43 ... requires physicians to use skills of ethical discernment and reflection. Physicians are  
44 expected to have compelling reasons to deviate from guidance when, in their best judgment,  
45 they determine it is ethically appropriate or even necessary to do so.  
46

47 Decisions to decline a duty to treat during a public health crisis carry consequences well beyond  
48 the immediate needs of individual patients. In exercising the required discernment and ethical  
49 reflection, physicians should take into account:

- 50 • the urgency of patients’ medical need and likelihood of benefit  
51

- 1 • the nature and magnitude of risks to the physician and others to whom the physician also
- 2 owes duties of care
- 3 • the resources available or reasonably attainable to mitigate risk to patients, themselves and
- 4 others
- 5 • other strategies that could reasonably be implemented to reduce risk, especially for those
- 6 who are most vulnerable
- 7 • the burden declining to treat will impose on fellow health care workers

8  
9 Physicians who themselves have underlying medical conditions that put them at high risk for  
10 severe disease that cannot reasonably be mitigated, or whose practices routinely treat patients at  
11 high risk, have a responsibility to protect themselves as well as their patients. But protecting  
12 oneself and one's patients carries with it a responsibility to identify and act on opportunities to  
13 support colleagues who take on the risk of providing frontline care.

14  
15 Physicians and other health care workers *should* be able to rely on the institutions within which  
16 they work to uphold the organization's responsibility to promote conditions that enable caregivers  
17 to meet the ethical requirements of their professions. So too, physicians and other health care  
18 workers *should* be able to trust that public policymakers will make and enforce well-considered  
19 decisions to support public health and the health care workforce. When those expectations are not  
20 met, physicians have a responsibility to advocate for change [[Principles III, IX](#)].

21  
22 Yet, the failure of institutions or society does not in itself absolve physicians of their duty of  
23 fidelity to patients and the professional obligation to treat.

## 24 25 RECOMMENDATION

26  
27 In light of these considerations, the Council on Ethical and Judicial Affairs recommends that  
28 Opinion 8.3, "Physician Responsibility in Disaster Response and Preparedness," be amended by  
29 addition and deletion as follows and the remainder of this report be filed:

### 30 31 8.3 Physician Responsibility in Disaster Response and Preparedness

32  
33 Whether at the national, regional, or local level, responses to disasters require extensive  
34 involvement from physicians individually and collectively. Because of their commitment to  
35 care for the sick and injured, individual physicians have an obligation to provide urgent  
36 medical care during disasters. This obligation holds even in the face of greater than usual risks  
37 to physicians' own safety, health, or life.

38  
39 ~~However, the physician workforce is not an unlimited resource. Therefore, when providing~~  
40 ~~care in a disaster with its inherent dangers, physicians also have an obligation to evaluate the~~  
41 ~~risks of providing care to individual patients versus the need to be available to provide care in~~  
42 ~~the future.~~

43  
44 The duty to treat is foundational to the profession of medicine but is not absolute. The health  
45 care work force is not an unlimited resource and must be preserved to ensure that care is  
46 available in the future. For their part, physicians have a responsibility to protect themselves, as  
47 well as a duty of solidarity to colleagues to share risks and burdens in a public health crisis. So  
48 too, health care institutions have responsibilities to support and protect health care  
49 professionals and to apportion the risks and benefits of providing care as equitably as possible.

1 Many physicians owe competing duties of care as medical professionals and as individuals  
2 outside their professional roles. In a public health crisis, institutions should provide support to  
3 enable physicians to meet compelling personal obligations without undermining the  
4 fundamental obligation to patient welfare. In exceptional circumstances, when arrangements to  
5 allow the physician to honor both obligations are not feasible, it may be ethically acceptable for  
6 a physician to limit participating in care, provided that the institution has made available  
7 another mechanism for meeting patients' needs. Institutions should strive to be flexible in  
8 supporting physicians in efforts to address such conflicts. The more immediately relevant a  
9 physician's clinical expertise is to the urgent needs of the moment and the less that alternative  
10 care mechanisms are available, the stronger the professional obligation to provide care despite  
11 competing obligations.

12

13 With respect to disaster, whether natural or manmade, individual physicians should:

14

15 (a) Take appropriate advance measures, including acquiring and maintaining appropriate  
16 knowledge and skills to ensure they are able to provide medical services when needed.

17

18 Collectively, physicians should:

19

20 (b) Provide medical expertise and work with others to develop public health policies that:

21

22 (i) Are designed to improve the effectiveness and availability of medical services during a  
23 disaster

24

(ii) Are based on sound science

25

(iii) Are based on respect for patients

26

27 (c) Advocate for and participate in ethically sound research to inform policy decisions.

28

(Modify HOD/CEJA Policy)

Fiscal Note: Less than \$500

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002  
(1-22)

Introduced by: Resident and Fellow Section

Subject: Assessing the Humanitarian Impact of Sanctions

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, The Office of Foreign Assets Control (“OFAC”) of the US Treasury Department  
2 administers and enforces financial, economic, and trade sanctions against foreign individuals,  
3 organizations, and entire countries, based on US foreign policy and national security goals<sup>1</sup>; and  
4

5 Whereas, Primary sanctions prohibit U.S.-based individuals and entities from economic  
6 transactions with the target nation, while secondary sanctions prohibit non-U.S. entities from  
7 conducting any financial transaction that requires routing through U.S.-based institutions, such  
8 as currency exchange<sup>2</sup>; and  
9

10 Whereas, As of April 2022, the US had active, comprehensive economic sanctions against  
11 seven nations (North Korea, Cuba, Iran, Syria, Venezuela, Afghanistan, and Russia) and  
12 against individuals in nineteen other nations and territories (Bangladesh, Belarus, Central  
13 African Republic, China, Democratic Republic of the Congo, Eritrea, Hong Kong, Iraq, Lebanon,  
14 Liberia, Mali, Myanmar, Nicaragua, Somalia, South Sudan, Turkey, Ukraine, Yemen, and  
15 Zimbabwe)<sup>3</sup>; and  
16

17 Whereas, Research shows that while arms embargoes may reduce violence in armed conflicts,  
18 economic sanctions fail to do so, and instead contribute to military escalation and increased  
19 violence<sup>4,5</sup>; and  
20

21 Whereas, Economic sanctions are estimated to succeed in only 4-34% of cases, with the two  
22 most notable successes being the fall of the apartheid regime in South Africa (after three  
23 decades of economic sanctions and arms embargoes), and the fall of the government of  
24 Rhodesia after over ten years of sanctions and civil war<sup>6</sup>; and  
25

26 Whereas, Comprehensive economic sanctions have been compared to medieval siege warfare,  
27 imposing suffering on innocent civilians within the targeted nations in order to force a surrender  
28 by the ruling class<sup>7</sup>; and  
29

30 Whereas, A study of economic sanctions in 98 countries over 35 years found that US-imposed  
31 sanctions reduced life expectancy by 0.4-0.5 years in target nations, with a greater impact on  
32 women, caused by an increase in child mortality and in deaths due to cholera<sup>8</sup>; and  
33

34 Whereas, Nations targeted by US economic sanctions experience a higher poverty rate of 3.8%  
35 compared to non-sanctioned nations, with the impact lasting for 21 years<sup>9</sup>; and  
36

37 Whereas, Rates of HIV infection in children were 2.5% higher in 71 countries targeted by  
38 sanctions between 1990 and 2012, and AIDS-related death rates were 1% higher, illustrating  
39 the disproportionate impact of sanctions on marginalized populations<sup>10</sup>; and

1 Whereas, Despite the use of humanitarian carve-outs, foreign firms are reluctant to engage in  
2 any trade with sanctioned nations for fear of triggering secondary sanctions, which place the  
3 onus of compliance on these foreign firms, thus impairing access to food and medicines in  
4 target nations<sup>11,12</sup>; and

5  
6 Whereas, Unilateral US-imposed economic sanctions have been shown to slow economic  
7 growth in target nations and decrease their GDP per capita by 13.4%<sup>13</sup>; and

8  
9 Whereas, An economic embargo imposed on Haiti between 1991 and 1994 contributed to a  
10 decline in income, a rise in unemployment, poorer nutrition status, and a rise in mortality among  
11 children aged 1-4 years old<sup>14</sup>; and

12  
13 Whereas, An Oxfam report found that US-imposed sanctions on Cuba had restricted access to  
14 basic medical supplies including syringes and masks, medicines, vaccines, and food<sup>15</sup>; and

15  
16 Whereas, In 2019, Human Rights Watch documented shortages of antiepileptic drugs and  
17 chemotherapy medications in Iran and concluded that due to US economic sanctions, “Iranians’  
18 access to essential medicine and their right to health is being negatively impacted, threatening  
19 the health of millions of Iranians”<sup>12,16</sup>; and

20  
21 Whereas, Journals including *JAMA* and the *New England Journal of Medicine* continued to  
22 publish papers authored by Iranian scientists, while overcompliance with US-imposed sanctions  
23 led the editors of several other journals to reject them, with one stating that “US owned journals  
24 are unable to handle scientific manuscripts which are authored by Iranian scientists, employed  
25 by the Government of Iran”<sup>17</sup>; and

26  
27 Whereas, A 2018 systematic review of 55 papers found that US-led economic sanctions on Iran  
28 led to an increase in inflation and unemployment, a devaluation of the nation’s currency, scarcity  
29 of lifesaving medicines, with impacts disproportionately affecting Iranians who were poor, ill,  
30 women, and children and found no positive effect from existing “humanitarian exemptions”<sup>18</sup>;  
31 and

32  
33 Whereas, Comprehensive economic sanctions on Syria, first imposed in 1985 and strengthened  
34 in the past decade, have contributed to a breakdown in its healthcare system, including  
35 shutdowns of MRI, CT, and dialysis machines as healthcare facilities are unable to import spare  
36 parts to maintain these machines or license software to run them<sup>19</sup>; and

37  
38 Whereas, Economic sanctions also drive up healthcare costs, as hospitals must assemble multi-  
39 national legal teams to navigate EU and US sanctions exemption applications<sup>19</sup>; and

40  
41 Whereas, US and EU-led economic sanctions on Syria have contributed to devaluation of the  
42 Syrian currency, shortages of fuel, electricity, medicines, and water, a drop in agricultural and  
43 pharmaceutical output, along with an inability to test, track, treat, or vaccinate against  
44 COVID-19<sup>20</sup>; and

45  
46 Whereas, Twenty-three million Afghans face famine in 2022, with aid efforts hampered by US  
47 sanctions imposed after the fall of the Afghan government in 2021<sup>21</sup>; and

48  
49 Whereas, Thirteen thousand Afghan children died of malnutrition in the first ten weeks of 2022,  
50 as sanctions caused a collapse of the banking sector and foreign banks are reluctant to transfer  
51 aid money into the country for fear of triggering secondary sanctions<sup>22</sup>; and

1 Whereas, In February 2022, the Biden administration announced it would relax some sanctions  
2 on Afghanistan, including allowing half of the Afghan Central Bank’s assets in the US to be used  
3 to pay for humanitarian purchases such as food and medicine, while continuing to freeze the  
4 other half, in a move that was described as “aiming to make it harder to blame the US  
5 government’s sanctions for the unfolding economic disaster in Afghanistan”<sup>23</sup>; and  
6

7 Whereas, Freezing the Afghan Central Bank’s reserves has contributed to a crash in the Afghan  
8 currency’s value, leading to a rise in food prices over 40% since the previous year<sup>24</sup>; and  
9

10 Whereas, In its 2019 report, Human Rights Watch recommended that Congress request a study  
11 on the humanitarian impact of economic sanctions<sup>12</sup>; and  
12

13 Whereas, The United Nation’s (UN) Committee on Economic, Social, and Cultural Rights states  
14 that nations that impose economic sanctions must take steps to respond to any disproportionate  
15 suffering experienced by vulnerable groups within the targeted country<sup>25</sup>; and  
16

17 Whereas, The UN’s Office of the High Commissioner for Human Rights has found that unilateral  
18 economic sanctions disproportionately harm women, children, and marginalized groups, and  
19 that US-imposed sanctions are hindering reconstruction in war-torn nations, calling for lifting or  
20 minimizing these sanctions<sup>26,27</sup>; and  
21

22 Whereas, The World Medical Association “urges national medical associations to ensure that  
23 Governments employing economic sanctions against other States respect the agreed  
24 exemptions for medicines, medical supplies, and basic food items”<sup>28</sup>; and  
25

26 Whereas, Lawmakers in the US have called for a report on the humanitarian impact of  
27 sanctions, most recently through a February 2022 letter signed by over twenty members of  
28 Congress<sup>29,30</sup>; and  
29

30 Whereas, Our AMA supports medical access in countries in turmoil (H-65.994), and broadly  
31 urges all parties to minimize the health costs of war on civilian populations (D-65.993), it does  
32 not have policy discussing the harmful health costs of economic sanctions; therefore be it  
33

34 RESOLVED, That our American Medical Association recognize that economic sanctions can  
35 negatively impact health and exacerbate humanitarian crises (New HOD Policy); and be it  
36 further  
37

38 RESOLVED, That our AMA support efforts to study the humanitarian impact of economic  
39 sanctions imposed by the United States. (New HOD Policy)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 09/14/22

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## **RELEVANT AMA POLICY**

### **Medical Care in Countries in Turmoil H-65.994**

The AMA (1) supports the provision of food, medicine and medical equipment to noncombatants threatened by natural disaster or military conflict within their country through appropriate relief organizations; (2) expresses its concern about the disappearance of physicians, medical students and other health care professionals, with resulting inadequate care to the sick and injured of countries in turmoil; (3) urges appropriate organizations to transmit these concerns to the affected country's government; and (4) asks appropriate international health organizations to monitor the status of medical care, medical education and treatment of medical personnel in these countries, to inform the world health community of their findings, and to encourage efforts to ameliorate these problems.

Citation: Sub. Res. 133, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CLRPD Rep. 1, A-05; Reaffirmed: CEJA Rep. 5, A-15

### **War Crimes as a Threat to Physicians' Humanitarian Responsibilities D-65.993**

Our American Medical Association will (1) implore all parties at all times to understand and minimize the health costs of war on civilian populations generally and the adverse effects of physician persecution in particular, (2) support the efforts of physicians around the world to practice medicine ethically in any and all circumstances, including during wartime or episodes of civil strife, and condemn the military targeting of health care facilities and personnel and using denial of medical services as a weapon of war, by any party, wherever and whenever it occurs, and (3) advocate for the protection of physicians' rights to provide ethical care without fear of persecution.

Citation: BOT Action in response to referred for decision Res. 620, A-09; Modified: BOT Rep. 09, A-19

### **Promoting Equitable Resource Distribution Globally in Response to the COVID-19 Pandemic D-440.917**

1. Our AMA will, in an effort to improve public health and national stability, explore possible assistance through the COVID-19 Vaccines Global Access (COVAX) initiative co-led by the World Health Organization, Gavi, and the Coalition for Epidemic Preparedness Innovations, as well as all other relevant organizations, for residents of countries with limited financial or technological resources.

2. Our AMA will work with governmental and appropriate regulatory bodies to encourage prioritization of equity when providing COVID-19 pandemic-related resources, such as diagnostics, low cost or free medications, therapeutics, vaccines, raw materials for vaccine production, personal protective equipment, and/or financial support.

3. Our AMA recognizes the extraordinary efforts of many dedicated physicians, physician and ethnic organizations assisting in this humanitarian COVID-19 pandemic crisis.

4. Our AMA will support World Health Organization (WHO) efforts and initiatives to increase production and distribution of therapeutics and vaccines necessary to combat COVID-19 and future pandemics in order to provide vaccine doses to low- and middle-income countries with limited access, including: (a) a temporary waiver of the Trade Related Aspects of Intellectual Property (TRIPS) agreement and other relevant intellectual property protections; (b) technological transfers relevant for vaccine production; (c) other support, financial and otherwise, necessary to scale up global vaccine manufacturing; and (d) measures that ensure the safety and efficacy of products manufactured by such means.

Citation: Res. 608, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003  
(I-22)

Introduced by: Medical Student Section

Subject: Indigenous Data Sovereignty

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, There is a history of research misconduct against American Indian and Alaska Native  
2 (AI/AN) Tribes and Villages<sup>1</sup>; and  
3  
4 Whereas, One notable example of this misconduct was a psychiatric biomarkers study on  
5 members of the Havasupai Indian Tribe conducted by researchers at Arizona State University  
6 without prior, informed and free consent<sup>2,3</sup>; and  
7  
8 Whereas, Havasupai Indian Tribe v. Arizona State University resulted in a punitive settlement  
9 against Arizona State University and indirectly led to moratorium on all genetic research on  
10 members of the neighboring Navajo Nation<sup>4</sup>; and  
11  
12 Whereas, The Indian Health Service and Tribal leaders developed frameworks and guidelines  
13 for Tribal Institutional Review Boards (IRB)<sup>5</sup>; and  
14  
15 Whereas, All research conducted on an American Indian and Alaska Native reservation requires  
16 the approval of the Indian Health Service Area IRB or respective Tribal IRB<sup>5</sup>; and  
17  
18 Whereas, A Tribal IRB assumes responsibility for the ethical review and oversight of all  
19 research occurring on Tribal land, including the protection of human subjects, the Tribe, Tribal  
20 communities, and Tribal resources (including environmental, animal, plant and cultural  
21 resources)<sup>6</sup>; and  
22  
23 Whereas, A Tribal IRB differs from an Academic IRB by allowing for community members and  
24 Tribal leadership to provide input into research design and conduct and the prioritization of  
25 research linked to community priorities<sup>5,7</sup>; and  
26  
27 Whereas, A Tribal IRB ensures that the principles of Indigenous Data Sovereignty, defined as  
28 the right of each American Indian and Alaska Native Tribe and Villages to control the collection,  
29 ownership, and application of their own data are upheld<sup>8,9</sup>; and  
30  
31 Whereas, While federal research protections for American Indian and Alaska Native Tribes and  
32 Villages are enforceable on Tribal lands and properties, there are complex jurisdictional issues  
33 preventing their timely enforcement off of Tribal lands and properties<sup>10</sup>; and  
34  
35 Whereas, Federal programs such as the NIH All of Us Research Program have sought to  
36 address these challenges by incorporating best practices and maximizing American Indian and  
37 Alaska Native participation in policy and program design<sup>11</sup>; and

1 Whereas, An example of a best practice used by All of Us includes ensuring “that research  
2 using the program’s biospecimens and data from [T]ribal members is done in a way that is  
3 respectful of applicable [T]ribal customs, culture, and laws”<sup>12</sup>; and  
4

5 Whereas, Existing best practices for working with American Indian and Alaska Native Tribes  
6 and Villages include the the use of data-sharing agreements, which also specify rules for data  
7 sharing and ownership<sup>13</sup>; and  
8

9 Whereas, Tribal government officials, liaisons, and elected leaders are recommended to have  
10 shared decision-making and oversight over research affairs specific to their members<sup>5</sup>; and  
11 therefore be it  
12

13 RESOLVED, That our American Medical Association recognize that American Indian and  
14 Alaska Native (AI/AN) Tribes and Villages are sovereign governments that should be consulted  
15 before the conduct of research specific to their members, lands, and properties (New HOD  
16 Policy); and be it further  
17

18 RESOLVED, That our AMA support that AI/AN Tribes and Villages’ Institutional Review Boards  
19 (IRBs) and research departments retain the right to oversee and regulate the collection,  
20 ownership, and management of research data generated by their members, and that individual  
21 members of AI/AN Tribes and Villages retain their autonomy and privacy regarding research  
22 data shared with researchers, AI/AN Tribes and Villages, and governments, consistent with  
23 existing protections under 45 CFR 46 (New HOD Policy); and it be further  
24

25 RESOLVED, That our AMA encourage the use and regular review of data-sharing agreements  
26 for all studies between academic medical centers and AI/AN Tribes and Villages (New HOD  
27 Policy); and be it further  
28

29 RESOLVED, That our AMA encourage the National Institutes of Health and other stakeholders  
30 to provide flexible funding to AI/AN Tribes and Villages for research efforts, including the  
31 creation and maintenance of IRBs. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 09/20/22

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## RELEVANT AMA POLICY

### E-7.3.7 Safeguards in the Use of DNA Databanks

DNA databanks facilitate population-based research into the genetic components of complex diseases. These databanks derive their power from integrating genetic and clinical data, as well as data on health, lifestyle, and environment about large samples of individuals. However, the use of DNA databanks in genomic research also raises the possibility of harm to individual participants, their families, and even populations.

Breach of confidentiality of information contained in DNA databanks may result in discrimination or stigmatization and may carry implications for important personal choices, such as reproductive choices. Human participants who contribute to research involving DNA databanks have a right to be informed about the nature and scope of the research and to make decisions about how their information may be used.

In addition to having adequate training to be able to discuss genomic research and related ethical issues with patients or prospective research participants, physician-researchers who are involved in genomic research using DNA databanks should:

#### *Research involving individuals*

- (a) Obtain informed consent from participants in genomic research, in keeping with ethics guidance. In addition, physicians should put special emphasis in the consent process on disclosing:
  - (i) the specific privacy standards to which the study will adhere, including whether the information or biological sample will be encrypted and remain identifiable to the researcher or will be completely de-identified;
  - (ii) whether participants whose data will be encrypted rather than de-identified can expect to be contacted in the future about findings or be invited to participate in additional research, either related to the current protocol or for other research purposes;
  - (iii) whether researchers or participants stand to gain financially from research findings, and any conflicts of interest researchers may have in regard to the research, in keeping with ethics guidance;
  - (iv) when, if ever, archived information or samples will be discarded;
  - (v) participants' freedom to refuse use of their biological materials without penalty.

#### *Research involving identifiable communities*

- (b) When research is to be conducted within a defined subset of the general population, physicians should:
  - (i) consult with the community in advance to design a study that is sensitive to community concerns and that will minimize harm for the community, as well as for individual participants. Physicians should not carry out a study when there is substantial opposition to the research within the community of interest;
  - (ii) protect confidentiality by encrypting any demographic or identifying information that is not required for the study's purpose.

[AMA Principles of Medical Ethics: I,IV,V,VII](#)

Issued: 2016

### Racial and Ethnic Disparities in Health Care H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a

position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

2. The AMA emphasizes three approaches that it believes should be given high priority:

A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

CLRPD Rep. 3, I-98, Appended and Reaffirmed: CSA Rep.1, I-02, Reaffirmed: BOT Rep. 4, A-03, Reaffirmed in lieu of Res. 106, A-12, Appended: Res. 952, I-17, Reaffirmed: CMS Rep. 10, A-19, Reaffirmed: CMS Rep. 3, A-21, Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21

### **Improving Health Care of American Indians H-350.976**

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.

(2) The federal government provide sufficient funds to support needed health services for American Indians.

(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.

(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.

(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.

(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.

(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.

(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.

(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.

(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.

(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

CLRPD Rep. 3, I-98, Reaffirmed: Res. 221, A-07, Reaffirmation A-12, Reaffirmed: Res. 233, A-13

### **Indian Health Service H-350.977**

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

CLRPD Rep. 3, I-98, Reaffirmed: CLRPD Rep. 1, A-08, Reaffirmation A-12, Reaffirmed: Res. 233, A-13

### **Support for Institutional Review Boards H-460.921**

Our AMA: (1) commends the thousands of Institutional Review Board (IRB) members who each have volunteered hundreds of hours annually; (2) urges medical schools and teaching hospitals to provide IRBs with adequate personnel and other resources to accomplish their mission to safeguard the rights

and welfare of human research subjects; and (3) encourages the National Institutes of Health to develop a program that provides flexible funding to institutions, including support directed at IRBs. Res. 317, I-98, Reaffirmed: Res. 528, A-00, Modified: CSAPH Rep. 1, A-10, Reaffirmed: CSAPH Rep. 01, A-20

### **Health Information Technology Principles H-478.981**

Our AMA will promote the development of effective electronic health records (EHRs) in accordance with the following health information technology (HIT) principles. Effective HIT should:

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

Our AMA will utilize HIT principles to:

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

Our AMA policy is that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules.

BOT Rep. 19, A-18, Reaffirmation: A-19

### **Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987**

1. Our AMA will strongly advocate that all of the facilities that serve Native Americans under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers.
2. Our AMA will ask Congress to take all necessary action to immediately restore full and adequate funding to the Indian Health Service.
3. Our AMA adopts as new policy that the Indian Health Service not be treated more adversely than other health plans in the application of any across the board federal funding reduction.
4. In the event of federal inaction to restore full and adequate funding to the Indian Health Service, our AMA will consider the option of joining in legal action seeking to require the federal government to honor existing treaties, obligations, and previously established laws regarding funding of the Indian Health Service.
5. Our AMA will request that Congress: (A) amend the Indian Health Care Improvement Act to authorize Advanced Appropriations; (B) include our recommendation for the Indian Health Service (IHS) Advanced Appropriations in the Budget Resolution; and (C) include in the enacted appropriations bill IHS Advanced Appropriations.

Res. 233, A-13, Appended: Res. 229, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005  
(I-22)

Introduced by: Medical Student Section

Subject: Strengthening Interview Guidelines for American Indian and Alaska Native  
Medical School, Residency, and Fellowship Applicants

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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- 1 Whereas, The Association of Native American Medical Students has communicated to the  
2 AMA-MSS Committee on American Indian Affairs, Association of American Medical Colleges,  
3 National Residency Matching Program, and Accreditation Council for Graduate Medical  
4 Education that they have received reports of residency interviewers asking American Indian and  
5 Alaska Native applicants inappropriate interview questions about blood quantum<sup>1</sup>; and  
6  
7 Whereas, Mathematical blood quantum was implemented by the federal government, requiring  
8 the Bureau of Indian Affairs (BIA) to issue a Certificate Degree of Indian Blood (CDIB) that  
9 provided evidence of descent from pureblood (full-fraction) Tribal members<sup>2,3</sup>; and  
10  
11 Whereas, The role of blood quantum in the identity of Indigenous Peoples is a topic of  
12 controversy, with foundations in colonization and disenfranchisement<sup>2,4</sup>; and  
13  
14 Whereas, There is no practical or biological basis for blood quantum and its persistence in these  
15 communities is a relic of external governmental influences<sup>4</sup>; and  
16  
17 Whereas, Many Tribes have foregone blood quantum as a determinant in favor of direct lineage,  
18 while the Tribes that continue to evaluate lineage by blood quantum have no absolute  
19 minimum<sup>4</sup>; and  
20  
21 Whereas, Of the racial groups defined in the United States Census, American Indians and  
22 Alaskan Natives are the only group that have identity associated with fractions of blood (blood  
23 quantum), which may introduce significant potential for discrimination<sup>4</sup>; and  
24  
25 Whereas, Multiple evidence-based studies detailed the complexities of Indigenous identity  
26 formation and the specific barriers that cause exclusion of Indigenous learners that lead to  
27 continued underrepresentation of Indigenous students in all stages of medical training<sup>5,6</sup>; and  
28  
29 Whereas, It is recognized that current admissions and interview practices, whether intentionally  
30 or unintentionally, may be racially biased; studies suggest that creating a culturally safe  
31 environment in interviews can successfully reduce racial biases<sup>5</sup>; and  
32  
33 Whereas, Compared to other residency interview methods, 64% of unstructured interviews were  
34 found to include inappropriate questions about applicant marital status, family planning,  
35 ethnicity, and religion, despite the presence of anti-discrimination laws, which greatly increases  
36 bias and applicant stereotyping<sup>7</sup>; and

1 Whereas, The AAMC's Best Practice Guidelines for Residency Program Interviews encourage  
2 the use of standardized interview content, clearly defined criteria, scoring guidelines, and  
3 interview training to decrease bias and applicant stereotyping<sup>8</sup>; and  
4

5 Whereas, Addressing structural, interpersonal, and individual bias in residency selection has  
6 been shown to increase the percentage of entering underrepresented minority interns<sup>9</sup>;  
7

8 Whereas, American Indian and Alaskan Native applicants subjected to questioning about their  
9 blood quantum may discourage applicants from advancing their education, further exacerbating  
10 the shortage of American Indian medical trainees<sup>10</sup>; and  
11

12 Whereas, Our AMA supports the inclusion of American Indians in established medical training  
13 programs in numbers adequate to meet their needs (H-350.981); and  
14

15 Whereas, Our AMA opposes questions regarding applicant race during the medical school,  
16 residency, and fellowship application process (H-310.919), but questioning based on American  
17 Indian and Alaska Native "blood quantum" is not based on race<sup>11</sup>; therefore be it  
18

19 RESOLVED, That our American Medical Association work with the Accreditation Council for  
20 Graduate Medical Education, the National Residency Matching Program, the Association of  
21 American Medical Colleges, and other interested parties to eliminate questioning about or  
22 discrimination based on American Indian and Alaska Native blood quantum during the medical  
23 school, residency, and fellowship application process. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 09/20/22

**References:**

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**RELEVANT AMA POLICY**

**Residents and Fellows' Bill of Rights H-310.912**

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of

training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.

2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.

3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.

4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.

5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.

6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.

7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.

8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:

**RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS**

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any

organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.

10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).

11. The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.

12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles.

CME Rep. 8, A-11, Appended: Res. 303, A-14, Reaffirmed: Res. 915, I-15, [Appended: CME Rep. 04, A-16](#), [Modified: CME Rep. 06, I-18](#), Appended: Res. 324, A-19, Modified: Res. 304, A-21, Modified: Res. 305, A-21, Modified: BOT Rep. 18, I-21, Reaffirmation: A-22

### **Indian Health Service H-350.977**

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

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(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

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(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

CLRPD Rep. 3, I-98, Reaffirmed: CLRPD Rep. 1, A-08, Reaffirmation A-12, Reaffirmed: Res. 233, A-13

### **Residency Interview Costs H-310.966**

1. It is the policy of the AMA to pursue changes to federal legislation or regulation, specifically to the Higher Education Act, to include an allowance for residency interview costs for fourth-year medical students in the cost of attendance definition for medical education.

2. Our AMA will work with appropriate stakeholders, such as the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, in consideration of the following strategies to address the high cost of interviewing for residency/fellowship: a) establish a method of collecting data on interviewing costs for medical students and resident physicians of all specialties for study, and b) support further study of residency/fellowship interview strategies aimed at mitigating costs associated with such interviews.

Res. 265, A-90, Reaffirmed: Sunset Report, I-00, Modified: CME Rep. 2, A-10, Appended: Res. 308, A-15

### **Medical Student Involvement and Validation of the Standardized Video Interview Implementation D-310.949**

Our AMA: (1) will work with the Association of American Medical Colleges and its partners to advocate for medical students and residents to be recognized as equal stakeholders in any changes to the residency application process, including any future working groups related to the residency application process; (2) will advocate for delaying expansion of the Standardized Video Interview until data demonstrates the Association of American Medical Colleges' stated goal of predicting resident performance, and make timely recommendations

regarding the efficacy and implications of the Standardized Video Interview as a mandatory residency application requirement; and (3) will, in collaboration with the Association of American Medical Colleges, study the potential implications and repercussions of expanding the Standardized Video Interview to all residency applicants.

Res. 960, I-17

#### **Educating Competent and Caring Health Professionals H-295.975**

(1) Programs of health professions education should foster educational strategies that encourage students to be independent learners and problem-solvers. Faculty of programs of education for the health professions should ensure that the mission statements of the institutions in which they teach include as an objective the education of practitioners who are both competent and compassionate.

(2) Admission to a program of health professions education should be based on more than grade point average and performance on admissions tests. Interviews, applicant essays, and references should continue to be part of the application process in spite of difficulties inherent in evaluating them. Admissions committees should review applicants' extra-curricular activities and employment records for indications of suitability for health professions education. Admissions committees should be carefully prepared for their responsibilities, and efforts should be made to standardize interview procedures and to evaluate the information gathered during interviews. Research should continue to focus on improving admissions procedures. Particular attention should be paid to improving evaluations of subjective personal qualities.

(3) Faculty of programs of education for the health professions must continue to emphasize that they have in the past on educating practitioners who are skilled in communications, interviewing and listening techniques, and who are compassionate and technically competent. Faculty of health professions education should be attentive to the environment in which education is provided; students should learn in a setting where respect and concern are demonstrated. The faculty and administration of programs of health professions education must ensure that students are provided with appropriate role models; whether a faculty member serves as an appropriate role model should be considered when review for promotion or tenure occurs. Efforts should be made by the faculty to evaluate the attitudes of students toward patients. Where these attitudes are found lacking, students should be counseled. Provisions for dismissing students who clearly indicate personality characteristics inappropriate to practice should be enforced.

(4) In spite of the high degree of specialization in health care, faculty of programs of education for the health professions must prepare students to provide integrated patient care; programs of education should promote an interdisciplinary experience for their students.

BOT Rep. NN, A-87, Modified: Sunset Report, I-97, Reaffirmed: CME Rep. 2, A-07, Reaffirmed: CME Rep. 01, A-17

#### **Residency Interview Schedules H-310.998**

1. Our AMA encourages residency and fellowship programs to incorporate in their interview dates increased flexibility, whenever possible, to accommodate applicants' schedules. Our AMA encourages the ACGME and other accrediting bodies to require programs to provide, by electronic or other means, representative contracts to applicants prior to the interview. Our AMA encourages residency and fellowship programs to inform applicants in a timely manner confirming receipt of application and ongoing changes in the status of consideration of the application.

2. Our AMA will: (a) oppose changes to residency and fellowship application requirements unless (i) those changes have been evaluated by working groups which have students and residents as representatives, (ii) there are data which demonstrates that the proposed application components contribute to an accurate representation of the candidate, (iii) there are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of bias that affects medical students and residents from underrepresented minority backgrounds, and (iv) the costs to medical students and residents are mitigated; and (b) continue to work with specialty societies, the Association of American Medical Colleges, the National Resident Matching Program and other relevant stakeholders to improve the application process in an effort to accomplish these requirements.

Res. 93, I-79, Reaffirmed: CLRPD Rep. B, I-89, Appended: Res. 302 and Res. 313, I-97, Reaffirmed: CME Rep. 2, A-07, Modified: Res. 302, A-14, Appended: Res. 314, A-19

#### **Gender-Based Questioning in Residency Interviews H-310.976**

The AMA (1) opposes gender-based questioning during residency interviews in both public and private institutions for the purpose of sexual discrimination; (2) supports inclusion in the AMA Fellowship and Residency Interactive Database Access (FREIDA) system information on residency Family and Medical Leave policies; and (3) supports monitoring the Accreditation Council for Graduate Medical Education as it proposes

changes to the "Common Requirements" and the "Institutional Requirements" of the "Essentials of Accredited Residencies," to ensure that there is no gender-based bias.

Res. 125, I-88, Reaffirmed: Sunset Report, I-98, Modified and Reaffirmed: CME Rep. 2, A-08, Reaffirmed: CCB/CLRPD Rep. 4, A-13

#### **Housestaff Input During the ACGME Review Process H-310.952**

The AMA asks its representatives to the Accreditation Council for Graduate Medical Education to support a requirement that site visitors to both residency training programs and institutions conduct interviews with residents, including peer-selected residents, as well as with administrators and faculty.

Res. 314, I-92, Reaffirmed: CME Rep. 2, A-03, Reaffirmed: CME Rep. 2, A-13

#### **Improving Health Care of American Indians H-350.976**

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.

(2) The federal government provide sufficient funds to support needed health services for American Indians.

(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.

(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.

(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.

(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.

(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.

(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.

(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.

(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.

(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

CLRPD Rep. 3, I-98, Reaffirmed: Res. 221, A-07, Reaffirmation A-12, Reaffirmed: Res. 233, A-13

#### **Continued Support for Diversity in Medical Education D-295.963**

Our AMA will: (1) publicly state and reaffirm its stance on diversity in medical education; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; and (5) work with appropriate stakeholders to study reforms to mitigate demographic and socioeconomic inequities in the residency and fellowship selection process, including but not limited to the selection and reporting of honor society membership and the use of standardized tools to rank applicants, with report back to the House of Delegates.

Res. 325, A-03, Appended: CME Rep. 6, A-11, [Modified: CME Rep. 3, A-13](#), [Appended: CME Rep. 5, A-21](#)

#### **AMA Support of American Indian Health Career Opportunities H-350.981**

AMA policy on American Indian health career opportunities is as follows: (1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.

(2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals.

(3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for additional health professionals to work among the American Indian population.

(4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations.

CLRPD Rep. 3, I-98, Reaffirmed: Res. 221, A-07, Reaffirmation A-12, Reaffirmed: CME Rep. 1, A-22

#### **Competency-Based Portfolio Assessment of Medical Students D-295.318**

1. Our AMA will work with the Association of American Medical Colleges, the American Osteopathic Association and the Accreditation Council for Graduate Medical Education, and other organizations to examine new and emerging approaches to medical student evaluation, including competency-based portfolio assessment.

2. Our AMA will work with the NRMP, ACGME and the 11 schools in the AMA's Accelerating Change in Medical Education consortium to develop pilot projects to study the impact of competency-based frameworks on student graduation, the residency match process and off-cycle entry into residency programs.

Res. 314, A-10, Appended: Res. 311, A-14

#### **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**

Our AMA: 1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion; 2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process; 3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants; 4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and 5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.

Res. 307, A-09 Appended: Res. 955, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006  
(1-22)

Introduced by: Medical Student Section

Subject: Assessing the Humanitarian Impact of Sanctions

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, The Office of Foreign Assets Control (“OFAC”) of the US Treasury Department  
2 administers and enforces financial, economic, and trade sanctions against foreign individuals,  
3 organizations, and entire countries, based on US foreign policy and national security goals<sup>1</sup>;  
4 and

5  
6 Whereas, Primary sanctions prohibit US-based individuals and entities from economic  
7 transactions with the target nation, while secondary sanctions prohibit non-US entities from  
8 conducting any financial transaction that requires routing through US-based institutions, such as  
9 currency exchange<sup>2</sup>; and

10  
11 Whereas, As of April 2022, the US had active, comprehensive economic sanctions against  
12 seven nations (North Korea, Cuba, Iran, Syria, Venezuela, Afghanistan, and Russia) and  
13 against individuals in 19 other nations and territories (Bangladesh, Belarus, Central African  
14 Republic, China, Democratic Republic of the Congo, Eritrea, Hong Kong, Iraq, Lebanon, Liberia,  
15 Mali, Myanmar, Nicaragua, Somalia, South Sudan, Turkey, Ukraine, Yemen, and Zimbabwe)<sup>3</sup>;  
16 and

17  
18 Whereas, Research shows that while arms embargoes may reduce violence in armed conflicts,  
19 economic sanctions fail to do so, and instead contribute to military escalation and increased  
20 violence<sup>4,5</sup>; and

21  
22 Whereas, Economic sanctions are estimated to succeed in only 4-34% of cases, with the two  
23 most notable successes being the fall of the apartheid regime in South Africa (after three  
24 decades of economic sanctions and arms embargoes), and the fall of the government of  
25 Rhodesia after over ten years of sanctions and civil war<sup>6</sup>; and

26  
27 Whereas, Comprehensive economic sanctions have been compared to medieval siege warfare,  
28 imposing suffering on innocent civilians within the targeted nations in order to force a surrender  
29 by the ruling class<sup>7</sup>; and

30  
31 Whereas, A study of economic sanctions in 98 countries over 35 years found that US-imposed  
32 sanctions reduced life expectancy by 0.4-0.5 years in target nations, with a greater impact on  
33 women, caused by an increase in child mortality and in deaths due to cholera<sup>8</sup>; and

34  
35 Whereas, Nations targeted by US economic sanctions experience a higher poverty rate of 3.8%  
36 compared to non-sanctioned nations, with the impact lasting for 21 years<sup>9</sup>; and

37  
38 Whereas, Rates of HIV infection in children were 2.5% higher in 71 countries targeted by  
39 sanctions between 1990 and 2012, and AIDS-related death rates were 1% higher, illustrating  
40 the disproportionate impact of sanctions on marginalized populations<sup>10</sup>; and

1 Whereas, Despite the use of humanitarian carve-outs, foreign firms are reluctant to engage in  
2 any trade with sanctioned nations for fear of triggering secondary sanctions, which place the  
3 onus of compliance on these foreign firms, thus impairing access to food and medicines in  
4 target nations<sup>11,12</sup>; and

5  
6 Whereas, Unilateral US-imposed economic sanctions have been shown to slow economic  
7 growth in target nations and decrease their GDP per capita by 13.4%<sup>13</sup>; and

8  
9 Whereas, An economic embargo imposed on Haiti between 1991 and 1994 contributed to a  
10 decline in income, a rise in unemployment, poorer nutrition status, and a rise in mortality among  
11 children aged 1-4 years old<sup>14</sup>; and

12  
13 Whereas, An Oxfam report found that US-imposed sanctions on Cuba had restricted access to  
14 basic medical supplies including syringes and masks, medicines, vaccines, and food<sup>15</sup>; and

15  
16 Whereas, In 2019, Human Rights Watch documented shortages of antiepileptic drugs and  
17 chemotherapy medications in Iran and concluded that due to US economic sanctions, “Iranians’  
18 access to essential medicine and their right to health is being negatively impacted, threatening  
19 the health of millions of Iranians”<sup>12,16</sup>; and

20  
21 Whereas, Journals including *JAMA* and the *New England Journal of Medicine* continued to  
22 publish papers authored by Iranian scientists, while overcompliance with US-imposed sanctions  
23 led the editors of several other journals to reject them, with one stating that “US owned journals  
24 are unable to handle scientific manuscripts which are authored by Iranian scientists, employed  
25 by the Government of Iran”<sup>17</sup>; and

26  
27 Whereas, A 2018 systematic review of 55 papers found that US-led economic sanctions on Iran  
28 led to an increase in inflation and unemployment, a devaluation of the nation’s currency, scarcity  
29 of lifesaving medicines, with impacts disproportionately affecting Iranians who were poor, ill,  
30 women, and children and found no positive effect from existing “humanitarian exemptions”<sup>18</sup>;  
31 and

32  
33 Whereas, Comprehensive economic sanctions on Syria, first imposed in 1985 and strengthened  
34 in the past decade, have contributed to a breakdown in its healthcare system, including  
35 shutdowns of MRI, CT, and dialysis machines as healthcare facilities are unable to import spare  
36 parts to maintain these machines or license software to run them<sup>19</sup>; and

37  
38 Whereas, Economic sanctions also drive up healthcare costs, as hospitals must assemble multi-  
39 national legal teams to navigate EU and US sanctions exemption applications<sup>19</sup>; and

40  
41 Whereas, US- and EU-led economic sanctions on Syria have contributed to devaluation of the  
42 Syrian currency, shortages of fuel, electricity, and medicines, water, a drop in agricultural and  
43 pharmaceutical output, along with an inability to test, track, treat, or vaccinate against COVID-  
44 19<sup>20</sup>; and

45  
46 Whereas, Twenty-three million Afghans face famine in 2022, with aid efforts hampered by US  
47 sanctions imposed after the fall of the Afghan government in 2021<sup>21</sup>; and

48  
49 Whereas, Thirteen thousand Afghan children died of malnutrition in the first ten weeks of 2022,  
50 as sanctions caused a collapse of the banking sector and foreign banks are reluctant to transfer  
51 aid money into the country for fear of triggering secondary sanctions<sup>22</sup>; and

1 Whereas, In February 2022, the Biden administration announced it would relax some sanctions  
2 on Afghanistan, including allowing half of the Afghan Central Bank’s assets in the US to be used  
3 to pay for humanitarian purchases such as food and medicine, while continuing to freeze the  
4 other half, in a move that was described as “aiming to make it harder to blame the US  
5 government’s sanctions for the unfolding economic disaster in Afghanistan”<sup>23</sup>; and  
6

7 Whereas, Freezing the Afghan Central Bank’s reserves has contributed to a crash in the Afghan  
8 currency’s value, leading to a rise in food prices over 40% since the previous year<sup>24</sup>; and  
9

10 Whereas, In its 2019 report, Human Rights Watch recommended that Congress request a study  
11 on the humanitarian impact of economic sanctions<sup>12</sup>; and  
12

13 Whereas, The United Nation’s (UN) Committee on Economic, Social, and Cultural Rights states  
14 that nations that impose economic sanctions must take steps to respond to any disproportionate  
15 suffering experienced by vulnerable groups within the targeted country<sup>25</sup>; and  
16

17 Whereas, The UN’s Office of the High Commissioner for Human Rights has found that unilateral  
18 economic sanctions disproportionately harm women, children, and marginalized groups, and  
19 that US-imposed sanctions are hindering reconstruction in war-torn nations, calling for lifting or  
20 minimizing these sanctions<sup>26,27</sup>; and  
21

22 Whereas, The World Medical Association “urges national medical associations to ensure that  
23 Governments employing economic sanctions against other States respect the agreed  
24 exemptions for medicines, medical supplies, and basic food items”<sup>28</sup>; and  
25

26 Whereas, Lawmakers in the US have called for a report on the humanitarian impact of  
27 sanctions, most recently through a February 2022 letter signed by over twenty members of  
28 Congress<sup>29,30</sup>; and  
29

30 Whereas, Our AMA supports medical access in countries in turmoil (H-65.994), and broadly  
31 urges all parties to minimize the health costs of war on civilian populations (D-65.993), it does  
32 not have policy discussing the harmful health costs of economic sanctions; therefore be it  
33

34 RESOLVED, That our American Medical Association recognize that economic sanctions can  
35 negatively impact health and exacerbate humanitarian crises (New HOD Policy); and be it  
36 further  
37

38 RESOLVED, That our AMA support legislative and regulatory efforts to study the humanitarian  
39 impact of economic sanctions imposed by the United States. (New HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 09/20/22

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## RELEVANT AMA POLICY

### Medical Care in Countries in Turmoil H-65.994

The AMA (1) supports the provision of food, medicine and medical equipment to noncombatants threatened by natural disaster or military conflict within their country through appropriate relief organizations; (2) expresses its concern about the disappearance of physicians, medical students and other health care professionals, with resulting inadequate care to the sick and injured of countries in turmoil; (3) urges appropriate organizations to transmit these concerns to the affected country's government; and (4) asks appropriate international health organizations to monitor the status of medical care, medical education and treatment of medical personnel in

these countries, to inform the world health community of their findings, and to encourage efforts to ameliorate these problems.

Sub. Res. 133, A-83, Reaffirmed: CLRPD Rep. 1, I-93, Reaffirmed: CLRPD Rep. 1, A-05, Reaffirmed: CEJA Rep. 5, A-15

**War Crimes as a Threat to Physicians' Humanitarian Responsibilities D-65.993**

Our American Medical Association will (1) implore all parties at all times to understand and minimize the health costs of war on civilian populations generally and the adverse effects of physician persecution in particular, (2) support the efforts of physicians around the world to practice medicine ethically in any and all circumstances, including during wartime or episodes of civil strife, and condemn the military targeting of health care facilities and personnel and using denial of medical services as a weapon of war, by any party, wherever and whenever it occurs, and (3) advocate for the protection of physicians' rights to provide ethical care without fear of persecution.

BOT Action in response to referred for decision Res. 620, A-09, Modified: BOT Rep. 09, A-19

**Promoting Equitable Resource Distribution Globally in Response to the COVID-19 Pandemic D-440.917**

1. Our AMA will, in an effort to improve public health and national stability, explore possible assistance through the COVID-19 Vaccines Global Access (COVAX) initiative co-led by the World Health Organization, Gavi, and the Coalition for Epidemic Preparedness Innovations, as well as all other relevant organizations, for residents of countries with limited financial or technological resources.

2. Our AMA will work with governmental and appropriate regulatory bodies to encourage prioritization of equity when providing COVID-19 pandemic-related resources, such as diagnostics, low cost or free medications, therapeutics, vaccines, raw materials for vaccine production, personal protective equipment, and/or financial support.

3. Our AMA recognizes the extraordinary efforts of many dedicated physicians, physician and ethnic organizations assisting in this humanitarian COVID-19 pandemic crisis.

4. Our AMA will support World Health Organization (WHO) efforts and initiatives to increase production and distribution of therapeutics and vaccines necessary to combat COVID-19 and future pandemics in order to provide vaccine doses to low- and middle-income countries with limited access, including: (a) a temporary waiver of the Trade Related Aspects of Intellectual Property (TRIPS) agreement and other relevant intellectual property protections; (b) technological transfers relevant for vaccine production; (c) other support, financial and otherwise, necessary to scale up global vaccine manufacturing; and (d) measures that ensure the safety and efficacy of products manufactured by such means.

Res. 608, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007  
(1-22)

Introduced by: International Medical Graduates Section

Subject: Consent for Sexual and Reproductive Healthcare

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, The ability of minors to provide consent for health care services including sexual and  
2 reproductive health care, mental health care has expanded over the past decades; and  
3  
4 Whereas, Involving parents or guardians in the decision of children and adolescent health care  
5 is desirable, many young people will not seek important services if they are forced to involve  
6 their parents/guardian. The sexual and reproductive health care services is one of those  
7 services; and  
8  
9 Whereas, Twenty-three states and the District of Columbia have laws that explicitly give minors  
10 the authority to consent to contraceptive services. Nineteen states allow only certain categories  
11 of people younger than eighteen to consent to contraceptive services; and  
12  
13 Whereas, Twenty-seven states and the District of Columbia specifically allow pregnant minors  
14 to obtain prenatal care and delivery services without parental consent or notification; and  
15  
16 Whereas, There are some states which allow specific minors such as those who are married,  
17 pregnant, or already parents, and high school graduates to consent for oral contraception;  
18 therefore be it  
19  
20 RESOLVED, That our American Medical Association work with state and county medical  
21 societies to advocate for legislation and legal protections: 1) allowing minors (age 12 or above)  
22 to consent for sexual and reproductive health care; 2) allowing minors to consent for prenatal  
23 care and delivery services; and 3) protecting physician autonomy to provide sexual and  
24 reproductive health care with minor consent, without parental consent. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 09/27/22

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## **RELEVANT AMA POLICY**

### **Health Care Rights of Pregnant Minors H-60.907**

Our AMA will: (1) work with appropriate stakeholders to support legislation allowing pregnant minors to consent to related tests and procedures from the prenatal stage through postpartum care; and (2) oppose any law or policy that prohibits a pregnant minor from consenting to prenatal and other pregnancy related care, including, but not limited to, prenatal genetic testing, epidural block, pain management, Cesarean section, diagnostic imaging, procedures, and emergency care. (Resolution 008, A-18)

### **Opinion 2.2.2 Confidential Health Care for Minors**

Physicians who treat minors have an ethical duty to promote the developing autonomy of minor patients by involving children in making decisions about their health care to a degree commensurate with the child's abilities. A minor's decision-making capacity depends on many factors, including not only chronological age, but also emotional maturity and the individual's medical experience. Physicians also have a responsibility to protect the confidentiality of minor patients, within certain limits.

In some jurisdictions, the law permits minors who are not emancipated to request and receive confidential services relating to contraception, or to pregnancy testing, prenatal care, and delivery services. Similarly, jurisdictions may permit unemancipated minors to request and receive confidential care to prevent, diagnose, or treat sexually transmitted disease, substance use disorders, or mental illness.

When an unemancipated minor requests confidential care and the law does not grant the minor decisionmaking authority for that care, physicians should:

(a) Inform the patient (and parent or guardian, if present) about circumstances in which the physician is obligated to inform the minor's parent/guardian, including situations when:

(i) involving the patient's parent/guardian is necessary to avert life- or health- threatening harm to the patient;

(ii) involving the patient's parent/guardian is necessary to avert serious harm to others;

(iii) the threat to the patient's health is significant and the physician has no reason to believe that parental involvement will be detrimental to the patient's well- being.

(b) Explore the minor patient's reasons for not involving his or her parents (or guardian) and try to correct misconceptions that may be motivating the patient's reluctance to involve parents.

(c) Encourage the minor patient to involve his or her parents and offer to facilitate conversation between the patient and the parents.

(d) Inform the patient that despite the physician's respect for confidentiality the minor patient's parents/guardians may learn about the request for treatment or testing through other means (e.g., insurance statements).

(e) Protect the confidentiality of information disclosed by the patient during an exam or interview or in counseling unless the patient consents to disclosure or disclosure is required to protect the interests of others, in keeping with ethical and legal guidelines.

(f) Take steps to facilitate a minor patient's decision about health care services when the patient remains unwilling to involve parents or guardians, so long as the patient has appropriate decision-making capacity in the specific circumstances and the physician believes the decision is in the patient's best interest. Physicians should be aware that states provide mechanisms for unemancipated minors to receive care without parental involvement under conditions that vary from state to state.

(g) Consult experts when the patient's decision-making capacity is uncertain.

(h) Inform or refer the patient to alternative confidential services when available if the physician is unwilling to provide services without parental involvement.

AMA Principles of Medical Ethics: IV

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008  
(I-22)

Introduced by: Colorado

Subject: Support for Physicians Practicing Evidence-Based Medicine in a  
Post Dobbs Era

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, In some states, physicians may face criminal penalties for providing medical  
2 treatments that are the standard of care according to multiple professional organizations; and  
3

4 Whereas, The failure to provide standard of care when requested by a patient and agreed to by  
5 the physician violates professional legal obligations as well as primary principles of medical  
6 ethics including beneficence, non-maleficence and patient autonomy; and  
7

8 Whereas, Being precluded from providing quality care due to fear of legal prosecution creates  
9 moral injury to the physician who would otherwise offer that care; and  
10

11 Whereas, Some state laws are putting physicians in the untenable position wherein withholding  
12 appropriate care that results in harm to a patient puts physicians at risk for civil liability, while  
13 providing that care may expose them to state criminal sanctions; and  
14

15 Whereas, The AMA Code of Ethics states that “In some cases, the law mandates conduct that  
16 is ethically unacceptable. When physicians believe a law violates ethical values or is unjust,  
17 they should work to change the law. In exceptional circumstances of unjust laws, ethical  
18 responsibilities should supersede legal duties.”; and  
19

20 Whereas, Recent commentary has encouraged professional civil disobedience reflecting “a  
21 professional group’s deciding together, after frank and rational debate, to support disobedience  
22 of an unjust law [which] might eventually reinforce social cohesion, elevate trust in the  
23 profession, and help communities avoid tragic errors.”<sup>1</sup>; and  
24

25 Whereas, The US Supreme Court overturned Roe v Wade in June 2022, and now each state’s  
26 legislature will decide if and when its citizens will have legal access to abortion care and if and  
27 when its physicians will be criminalized for providing what is considered to be the standard of  
28 care by multiple health-related organizations. This extraordinary change in the medico-legal  
29 landscape requires reevaluation of health profession codes of ethics related to clinician  
30 conscience. These codes must now be expanded to address affirmative protection for  
31 “conscientious provision” in hostile environments on par with protection of conscientious  
32 refusal.<sup>2</sup>; therefore be it  
33

34 RESOLVED, That our American Medical Association Task Force developed under HOD Policy  
35 G-605.009, “Establishing A Task Force to Preserve the Patient-Physician Relationship When  
36 Evidence-Based, Appropriate Care Is Banned or Restricted,” provide policy and strategies to  
37 support physicians individually and through their medical organizations when they are required  
38 by medical and ethical standards of care to act against state and federal laws (Directive to Take  
39 Action); and be it further

1 RESOLVED, That our AMA work to provide support, including legal support through the AMA  
2 Litigation Center, as may be appropriate, to physicians that are targeted for practicing in  
3 accordance with accepted standards of medical care and medical ethics in the face of legal  
4 constraint or any other disciplinary action (Directive to Take Action); and be it further  
5

6 RESOLVED, That our AMA advocate for affirmative protections for “conscientious provision” of  
7 care in accordance with accepted standards of medical care and medical ethics in hostile  
8 environments on par with protection of “conscientious objection.” (Directive to Take Action)

Fiscal Note: Estimated cost of \$58,000 to implement this resolution.

Received: 09/30/22

1. Wynia, MK, Professional Civil Disobedience — Medical-Society Responsibilities after Dobbs, NEJM, 387;11, 9/15/2022, pp 955-961.
2. Ryan, I et al., Why the Post-Roe Era Requires Protecting Conscientious Provision as We Protect Conscientious Refusal in Health Care, AMA Journal of Ethics®, September 2022, Volume 24, Number 9: E906-912

### RELEVANT AMA POLICY

#### **Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted G-605.009**

1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine’s response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
  - a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;
  - b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
  - c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;
  - d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;
  - e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;
  - f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and
  - g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.

Citation: Res. 621, A-22

## Reference Committee B

### Resolution(s)

- 201 Physician Reimbursement for Interpreter Services
- 202 Advocating for State GME Funding
- 203 International Medical Graduate Employment
- 205 Waiver of Due Process Clauses
- 206 The Shortage of Bedside Nurses and Intersection with Concerns in Nurse Practitioner Training
- 207 Preserving Physician Leadership in Patient Care
- 208 Comparing Student Debt, Earnings, Work Hours, and Career Satisfaction Metrics in Physicians v. Other Health Professionals
- 209 Comprehensive Solutions for Medical School Graduates Who Are Unmatched or Did Not Complete Training
- 211 Illicit Drug Use Harm Reduction Strategies
- 213 Hazard Pay During a Disaster Emergency
- 214 Universal Good Samaritan Statute
- 215 Eliminating Practice Barriers for Immigrant Physicians During Public Health Emergencies

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201  
(I-22)

Introduced by: American Association of Clinical Urologists, American Urological Association

Subject: Physician Reimbursement for Interpreter Services

Referred to: Reference Committee B

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1 Whereas, CMS Report 07, JUN 21, reaffirms Policy D-385.957 which advocates for legislative  
2 and/or regulatory changes to require that payers including Medicaid programs and Medicaid  
3 managed care plans cover interpreter services and directly pay interpreters for such services;  
4 and

5  
6 Whereas, Antidiscrimination provisions in federal law require health programs and clinicians  
7 receiving federal financial assistance to take reasonable steps to provide meaningful access to  
8 individuals with limited English proficiency (LEP) who are likely to be encountered in their  
9 medical practice; and

10  
11 Whereas, The cost of interpreter services can be considerable ranging up to \$150.00/hour  
12 which often is charged to the physician without any reimbursement; and

13  
14 Whereas, Many physicians serve communities with patients who have LEP; and

15  
16 Whereas, The use of qualified interpreters has shown to result in better and more efficient  
17 patient care for those patients with LEP; therefore be it

18  
19 RESOLVED, That our American Medical Association prioritize physician reimbursement for  
20 interpreter services and advocate for legislative and/or regulatory changes to federal health care  
21 programs such as Medicare, Medicare Advantage plans, Tricare, Veterans Administration, etc.,  
22 for payment for such services (Directive to Take Action); and be it further

23  
24 RESOLVED, That our AMA develop model state legislation for physician reimbursement for  
25 interpreter services for commercial health plans, worker compensation plans, Medicaid,  
26 Medicaid managed care plans, etc., for payment for such services. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 08/04/22

Reference:  
Jacobs,B. et.al, (Ann Fam Med, 2018 Jan; 16(1): 70-76). Medical Interpreters in Outpatient Practice.

## **RELEVANT AMA POLICY**

### **Certified Translation and Interpreter Services D-385.957**

Our AMA will: (1) work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act; and (2) advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates.

Citation: Res. 703, A-17; Reaffirmed: CMS Rep. 7, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202  
(1-22)

Introduced by: Young Physicians Section  
Subject: Advocating for State GME Funding  
Referred to: Reference Committee B

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1 Whereas, “The number of Medicare-funded graduate medical education (GME) positions has  
2 been capped at 1996 levels, and there is little political will for increasing Medicare’s contribution  
3 to GME”;<sup>1</sup> and  
4

5 Whereas, Our “AMA has long been an advocate for preservation and expansion of GME funding  
6 to mitigate projected physician shortages and ensure that positions are available for medical  
7 school graduates applying to residency programs”;<sup>2,3</sup> and  
8

9 Whereas, In some states, state legislatures have funded several graduate medical education  
10 positions; and  
11

12 Whereas, For example, the Commonwealth of Virginia has been funding 25 new residency slots  
13 (the “majority of which must be in primary care,” and “encouraging applications from programs  
14 that offer the opportunity to train in underserved areas”) since 2018;<sup>4-5</sup> and  
15

16 Whereas, Information about these state-funded GME positions<sup>6-9</sup> is not easy to find online; and  
17

18 Whereas, There have been some news reports about how some state budgets are flush with  
19 cash these days;<sup>10</sup> therefore be it  
20

21 **RESOLVED**, That our American Medical Association publicize best practice examples of state-  
22 funded Graduate Medical Education positions and develop model state legislation where  
23 appropriate. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 08/19/22

References:

1. AMA Council on Medical Education Report 1 (I-15) on “Sources of Funding for Graduate Medical Education,” at <<https://www.ama-assn.org/system/files/2021-06/i15-cme-01.pdf>>. Accessed 30 April 2022.
2. AMA Council on Medical Education Report 6-I-19 on “Veterans Health Administration Funding of Graduate Medical Education,” at <<https://www.ama-assn.org/system/files/2020-04/cme-report-6-i19-annotated.pdf>>. Accessed 30 April 2022.
3. Heisler EJ, Mendez BHP, Mitchell A, Panangala SV, Villagrana MA. 2018. Federal Support for Graduate Medical Education: An Overview. (CRS Report No. R44376) Retrieved from Congressional Research Service website: <https://crsreports.congress.gov/product/pdf/R/R44376>. Accessed 30 April 2022.
4. “Virginia med students, residents help open 25 more GME spots,” 5/24/17 at <<https://www.ama-assn.org/education/gme-funding/virginia-med-students-residents-help-open-25-more-gme-spots>>
5. “Graduate Medical Education” at the Virginia Medicaid Dept of Medical Assistance Services (DMAS), at <<https://www.dmas.virginia.gov/for-providers/rates-and-rate-setting/graduate-medical-education/>>
6. 303#31s (DMAS) Graduate Medical Education Residency Slots. SB30 - Member Request (virginia.gov), at <<https://budget.lis.virginia.gov/amendment/2018/1/SB30/Introduced/MR/303/31s/>>
7. 303#14h (DMAS) Allow Supplemental Funding for UVA Medical Center and VCU Health System. HB30 - Committee Approved (virginia.gov), at <<https://budget.lis.virginia.gov/amendment/2018/1/HB30/Introduced/CA/303/14h/>>
8. 303#14s (DMAS) Graduate Medical Education Residency Slots. SB30 - Committee Approved (virginia.gov), at <<https://budget.lis.virginia.gov/amendment/2018/1/SB30/Introduced/CA/303/14s/>>

9. 313#21c (DMAS) Fully Fund Medicaid Graduate Medical Education Residency Slots. HB30 - Conference Report (virginia.gov), at <https://budget.lis.virginia.gov/amendment/2020/1/HB30/Introduced/CR/313/21c/>
10. California's budget surplus has exploded to \$68B - POLITICO, at <https://www.politico.com/news/2022/04/28/californias-budget-surplus-has-exploded-to-68b-00028680>
11. [savegme.org](http://savegme.org)

## RELEVANT AMA POLICY

### **The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967**

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.

15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten

years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

Citation: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep. 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended: CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18; Modified: Res. 233, A-19; Modified: BOT Rep. 25, A-19; Reaffirmed: CME Rep. 3, A-21

### **Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929**

1. It is AMA policy that:

- A. Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.
- B. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved.
- C. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.
- D. Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.
- E. All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.
- F. Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage.
- G. Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.
- H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.

1. New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.
  2. Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce distribution; and (d) Service to the local community and the public at large.
  3. Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.
  4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publically report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.
  5. Our AMA supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty.
- Citation: CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmed: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmed: CME Rep. 15, A-10; Reaffirmation A-11; Reaffirmation A-13; Reaffirmed: CME Rep. 5, A-13; Appended: CME 05, A-16; Appended: Res. 319, A-16; Reaffirmation A-16

#### **US Physician Shortage H-200.954**

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.
- Citation: Res. 807, I-03; Reaffirmation I-06; Reaffirmed: CME Rep. 7, A-08; Appended: CME Rep. 4, A-10; Appended: CME Rep. 16, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 922, I-13; Modified: CME Rep. 7, A-14; Reaffirmed: CME Rep. 03, A-16; Appended: Res. 323, A-19; Appended: CME Rep. 3, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203  
(I-22)

Introduced by: Missouri

Subject: International Medical Graduate Employment

Referred to: Reference Committee B

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- 1 Whereas, International Medical Graduates (IMGs) play a vital role in Missouri's health care  
2 system; and  
3  
4 Whereas, IMGs provide medical care to a disproportionately higher number of patients in  
5 underserved communities; and  
6  
7 Whereas, IMGs provide medical care to a disproportionately higher number of patients using  
8 Medicaid (including those dually eligible for Medicare and Medicaid) or SCHIP as their primary  
9 payment source; and  
10  
11 Whereas, Patients of IMGs are more likely to live in lower median income and incomes below  
12 federal poverty level neighborhoods; and  
13  
14 Whereas, The number of IMGs serving in medically underserved areas has declined during the  
15 last decade; and  
16  
17 Whereas, The process to recruit IMGs on visas is too onerous, especially for small independent  
18 physician practices; therefore be it  
19  
20 RESOLVED, That our American Medical Association support federal legislation that reduces the  
21 paperwork burden on hiring of International Medical Graduates in rural communities. (New HOD  
22 Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 09/07/22

The topic of this resolution is currently under study by the Council on Medical Education.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205  
(I-22)

Introduced by: Missouri  
Subject: Waiver of Due Process Clauses  
Referred to: Reference Committee B

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1 Whereas, Due process is a fundamental right of employment and due process protections are  
2 essential to allow healthcare workers to act in the best interest of their patients and co-workers;  
3 and  
4  
5 Whereas, When due process is waived by an employee, that employee’s power to advocate for  
6 their patients and co-workers is constrained by a reasonable fear of loss of employment; and  
7  
8 Whereas, Some healthcare employers insert “Waiver of Due Process” clauses into the  
9 employment contracts; and  
10  
11 Whereas, It is in the interest of society for healthcare workers to be able to freely raise patient  
12 and healthcare worker safety concerns; and  
13  
14 Whereas, Federal legislation proposing to ban “Waiver of Due Process” provisions in health  
15 care worker employment contracts was introduced in the 116<sup>th</sup> Congress of the United States of  
16 America, the “ER Hero and Patient Safety Act”, also known as HR 6910; therefore be it  
17  
18 RESOLVED, That our American Medical Association support legislation that bans the use of  
19 “Waiver of Due Process” provisions within employment contracts and declares such current  
20 provisions to be declared void. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 09/07/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206  
(1-22)

Introduced by: Resident and Fellow Section

Subject: The Shortage of Bedside Nurses and Intersection with Concerns in Nurse Practitioner Training

Referred to: Reference Committee B

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- 1 Whereas, There are nearly three million registered nurses (RNs) in the United States, making  
2 up three times the number of doctors in healthcare<sup>1</sup>; and  
3  
4 Whereas, The shortage of bedside nurses is not a new phenomenon. Over the last century, the  
5 nursing student supply has transitioned from ample to scarce<sup>2</sup>; and  
6  
7 Whereas, The COVID-19 pandemic exacerbated the issue and resulted in many RNs retiring or  
8 quitting, moving into non-direct care roles, returning to school for advanced degrees, or leaving  
9 the profession to pursue other career paths. Major motivating factors were insufficient staffing,  
10 unmanageable workloads, and emotional toll<sup>3</sup>; and  
11  
12 Whereas, Despite efforts for improvement, the shortage has persisted, and with it have come  
13 consequences for nurses and their patients; therefore be it  
14  
15 RESOLVED, That our American Medical Association study, and encourage relevant advocacy  
16 organizations to study, the links between the bedside nursing shortage, expansion of nurse  
17 practitioner programs, and the impact of this connection on patient health outcomes (Directive to  
18 Take Action); and be it further  
19  
20 RESOLVED, That our AMA reaffirm existing policies H-160.947, "Physician Assistants and  
21 Nurse Practitioners," and H-35.996, "Status and Utilization of New or Expanding Health  
22 Professionals in Hospitals." (Reaffirm HOD Policy)

Fiscal Note: Estimated cost of 53K to implement resolution.

Received: 09/14/22

**REFERENCES:**

1. Bakhamis L, Paul DP 3rd, Smith H, Coustasse A. Still an Epidemic: The Burnout Syndrome in Hospital Registered Nurses. *Health Care Manag (Frederick)*. 2019 Jan/Mar;38(1):3-10.
2. Abdellah FG. The nursing shortage: dynamics and solutions. *Reflections on a recurring theme. Nurs Clin North Am*. 1990 Sep;25(3):509-16.
3. Hansen A, Tuttas C. Professional Choice 2020-2021: Travel Nursing Turns the Tide. *Nurse Lead*. 2022 Feb 9. doi: 10.1016/j.mnl.2021.12.018. Epub ahead of print.

**RELEVANT AMA POLICY**

**Physician Assistants and Nurse Practitioners H-160.947**

Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):

- (1) The physician is responsible for managing the health care of patients in all settings.
- (2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
- (3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
- (4) The physician is responsible for the supervision of the physician assistant in all settings.
- (5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
- (6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.
- (7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.
- (8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
- (9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
- (10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care.

Citation: BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13

#### **Status and Utilization of New or Expanding Health Professionals in Hospitals H-35.996**

(1) The services of certain new health professionals, as well as those professionals assuming an expanded medical service role, may be made available for patient care within the limits of their skills and the scope of their authorized practice. The occupations concerned are those whose patient care activities involve medical diagnosis and treatment to such an extent that they meet the three criteria specified below: (a) As authorized by the medical staff, they function in a newly expanded medical support role to the physician in the provision of patient care. (b) They participate in the management of patients under the direct supervision or direction of a member of the medical staff who is responsible for the patient's care. (c) They make entries on patients' records, including progress notes, only to the extent established by the medical staff. Thus this statement covers regulation of such categories as the new physician-support occupations generically termed physician assistants, nurse practitioners, and those allied health professionals functioning in an expanded medical support role.

(2) The hospital governing authority should depend primarily on the medical staff to recommend the extent of functions which may be delegated to, and services which may be provided by, members of these emerging or expanding health professions. To carry out this obligation, the following procedures should be established in medical staff bylaws: (a) Application for use of such professionals by medical staff members must be processed through the credentials committee or other medical staff channels in the same manner as applications for medical staff membership and privileges. (b) The functions delegated to and the services provided by such personnel should be considered and specified by the medical staff in each instance, and should be based upon the individual's professional training, experience, and demonstrated competency, and upon the physician's capability and competence to supervise such an assistant. (c) In those cases involving use by the physician of established health professionals functioning in an expanded medical support role, the organized medical staff should work closely with members of the appropriate discipline now employed in an administrative capacity by the hospital (for example, the director of nursing services) in delineating such functions.

Citation: BOT Rep. G, A-73 Reaffirmed: CLRPD Rep. C, A-89 Reaffirmed: Sunset Report, A-00 Modified: CMS Rep. 6, A-10 Reaffirmation A-12 Reaffirmed: CMS Rep. 1, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207  
(I-22)

Introduced by: Resident and Fellow Section

Subject: Preserving Physician Leadership in Patient Care

Referred to: Reference Committee B

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1 Whereas, The term “provider” has become a nationally accepted term; however, its origins and  
2 impact are rarely discussed; and  
3

4 Whereas, What began as a word to distinguish physicians quickly broadened into a term  
5 describing a wide variety of healthcare workers, from medical doctors to clinical social workers,  
6 and such a broad term can be misleading and confusing to patients since the term gives no  
7 identifying information regarding role or training level; and  
8

9 Whereas, As the roles of midlevel providers continue to grow, it is more important than ever to  
10 distinguish physicians from other “providers” and protect the physician-patient relationship; and  
11

12 Whereas, The AMA, AAFP, and other physician advocacy groups have policy explicitly rejecting  
13 the use of an overarching term such as “provider” that equates the training of physicians with  
14 that of non-physician clinicians;<sup>1</sup> therefore be it  
15

16 RESOLVED, That our American Medical Association create a national targeted ad campaign to  
17 educate the public about the training pathway of physicians compared to non-physician  
18 providers (Directive to Take Action); and be it further  
19

20 RESOLVED, That our AMA reaffirm our opposition to physicians being referred to as “providers”  
21 in healthcare settings (New HOD Policy); and be it further  
22

23 RESOLVED, That our AMA conduct a review of the AMA policy compendium and replace  
24 conflicting policies referring to physicians as “providers” with the term “physician” when  
25 appropriate and report back at the 2023 Annual Meeting. (Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is \$255,000

Received: 09/14/22

**REFERENCES**

1. American Academy of Family Physicians. "NON-PHYSICIAN PROVIDERS (NPPs) Guidelines on the Supervision of Certified Nurse Midwives, Nurse Practitioners and Physician Assistants." 2000-2001 AAFP Policies on Health Issues.

## **RELEVANT AMA POLICY**

### **Clarification of the Term "Provider" in Advertising, Contracts and Other Communications H-405.968**

1. Our AMA supports requiring that health care entities, when using the term "provider" in contracts, advertising and other communications, specify the type of provider being referred to by using the provider's recognized title which details education, training, license status and other recognized qualifications; and supports this concept in state and federal health system reform.

2. Our AMA: (a) considers the generic terms "health care providers" or "providers" as inadequate to describe the extensive education and qualifications of physicians licensed to practice medicine in all its branches; (b) will institute an editorial policy prohibiting the use of the term "provider" in lieu of "physician" or other health professionals for all AMA publications not otherwise covered by the existing JAMA Editorial Governance Plan, which protects editorial independence of the Editor in Chief of JAMA and The JAMA Network journals; and (c) will forward to the editorial board of JAMA the recommendation that the term "physician" be used in lieu of "provider" when referring to MDs and DOs.

Citation: Sub. Res. 712, I-94; Reaffirmed: Res. 226, I-98; Reaffirmation I-99; Res. 605, A-09; Reaffirmed: CLRPD Rep. 1, A-09; Modified: Speakers Rep., A-15; Reaffirmed: BOT Rep. 09, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208  
(I-22)

Introduced by: Resident and Fellow Section

Subject: Comparing Student Debt, Earnings, Work Hours, and Career Satisfaction Metrics in Physicians v. Other Health Professionals

Referred to: Reference Committee B

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1 Whereas, Our healthcare system has had a steady increase in the amount of physician  
2 assistants (PAs) and nurse practitioners (NPs) assuming physician duties and responsibilities;  
3 and  
4  
5 Whereas, PAs and NPs have also advocated successfully for increased pay as evidenced in  
6 multiple state legislatures and even federal legislation; and  
7  
8 Whereas, Student debt of physicians is notoriously some of the highest in American education;  
9 and  
10  
11 Whereas, PAs and NPs have access to the same programs as physicians which include public  
12 service loan forgiveness, national health service corps, Indian health services loan repayment  
13 program, armed forces, income-driven repayment, etc.<sup>1,2</sup>; and  
14  
15 Whereas, A recent report on resident salary and debt found that 57% of resident physicians  
16 were dissatisfied with their compensation, 81% felt that their compensation did not adequately  
17 reflect the number of hours they worked, and 77% felt that their compensation was not  
18 comparable to what physician's assistants, nurses, and other medical staff were paid<sup>3</sup>; and  
19  
20 Whereas, Today, burnout among physicians in training such as medical students and trainees  
21 ranges from 50-70%; and  
22  
23 Whereas, Within nursing, burnout is discussed in terms of turnover rate at hospitals, as  
24 registered nurses (RN) turnover rate ranges between 20-30%<sup>4</sup>; and  
25  
26 Whereas, Among nurse practitioners, 25% of those in primary care environments have  
27 experienced burnout<sup>5</sup>; and  
28  
29 Whereas, Current research on burnout indirectly being used to measure work-life balance does  
30 not account for differences among individuals, especially those with varying socioeconomic,  
31 racial and/or sexual minoritized backgrounds; therefore be it  
32  
33 RESOLVED, That our American Medical Association's advocacy efforts be informed by the fact  
34 that student debt burden is higher for physicians when compared to physician assistants and  
35 nurse practitioners (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA work with relevant stakeholders to study: (a) how total career  
2 earnings of physicians compare to those physician assistants and nurse practitioners in order to  
3 specifically discern if there is a financial disincentive to becoming a physician, considering the  
4 relatively high student debt burden and work hours of physicians; (b) if resident physicians  
5 provide a net financial benefit for hospitals and healthcare institutions; (c) best practices for  
6 increasing resident physician compensation so that their services may be more equitably  
7 reflected in their earnings; and (d) burnout metrics using a standardized system to compare  
8 differences among physicians, physician assistants and nurse practitioners (Directive to Take  
9 Action); and be it further  
10  
11 RESOLVED, That our AMA recognize that burnout-centered metrics do not fully characterize  
12 work-life balance, particularly for individuals with varying socioeconomic, racial and/or sexual  
13 minoritized backgrounds (New HOD Policy); and be it further  
14  
15 RESOLVED, That our AMA seek to publish its findings in a peer-reviewed medical journal.  
16 (Directive to Take Action)

Fiscal Note: Estimated cost of \$306K to implement this resolution.

Received: 09/14/22

#### REFERENCES

1. <https://students-residents.aamc.org/financial-aid-resources/postponing-loan-repayment-during-residency>
2. <https://www.aamc.org/news-insights/7-ways-reduce-medical-school-debt#:~:text=According%20to%20a%20recent%20AAMC,debt%20was%20%24200%2C000%20in%202019>
3. <https://www.medscape.com/slideshow/2021-residents-salary-debt-report-6014074#:~:text=As%20in%20previous%20years%2C%20average,making%20about%20the%20same%20salary>.
4. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2775923>
5. <https://pubmed.ncbi.nlm.nih.gov/34519700/>

## RELEVANT AMA POLICY

### Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new policies and novel approaches to prevent debt from influencing specialty and subspecialty choice.

23. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.

Citation: CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of: Res. 311, A-21; Modified: CME Rep. 4, I-21; Reaffirmation: A-22

### **Competency Based Medical Education Across the Continuum of Education and Practice D-295.317**

1. Our AMA Council on Medical Education will continue to study and identify challenges and opportunities and critical stakeholders in achieving a competency-based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients. 2. Our AMA Council on Medical Education will work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, andragogy and assessment implementation. 3. Our AMA will continue to explore, with the Accelerating Change in Medical Education initiative and with other stakeholder organizations, the implications of shifting from time-based to competency-based medical education on residents' compensation and lifetime earnings.

Citation: CME Rep. 3, A-14; Appended: CME Rep. 04, A-16

### **Resident/Fellow Clinical and Educational Work Hours H-310.907**

Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training: 1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as "duty hours"). 2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents. 3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice. 4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities. 5. Our AMA encourages the ACGME to: a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation. b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits. c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules. d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours. 6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to: a) Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards. b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor. c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home. d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue. 7. Our AMA supports the following statements related to clinical and educational work hours: a) Total clinical and educational work hours must not exceed 80 hours per week, averaged

over a four-week period (Note: "Total clinical and educational work hours" includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients). b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time. c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks. d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period." f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated. g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty. h) Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians. i) Scheduled time providing patient care services of limited or no educational value should be minimized. j) Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics. k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians. l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy. m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program. n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system. o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations. 8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety. 9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

Citation: CME Rep. 5, A-14; Modified: CME Rep. 06, I-18; Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209  
(I-22)

Introduced by: Resident and Fellow Section

Subject: Comprehensive Solutions for Medical School Graduates Who Are Unmatched or Did Not Complete Training

Referred to: Reference Committee B

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- 1 Whereas, Fully trained physicians are in shortage now and forecasted to be in shortage in the  
2 future<sup>1</sup>; and  
3  
4 Whereas, This shortage does not extend to all specialties and several specialties such as  
5 Emergency Medicine<sup>2</sup> and Radiation Oncology<sup>3</sup> are projected to be in oversupply; and  
6  
7 Whereas, No current body with direct regulatory oversight over residencies can act to allocate  
8 and re-allocate funding and positions from fields projected to be in oversupply to fields in greater  
9 shortage due to antitrust restrictions; and  
10  
11 Whereas, Almost all other countries allocate residency positions based to some extent on the  
12 future workforce needs of the nation, instead of local factors; and  
13  
14 Whereas, The United States population could benefit greatly from available governmental  
15 funding for first year categorical positions being allocated in ratio to the projected physician  
16 workforce needs of the nation; and  
17  
18 Whereas, Many US allopathic and osteopathic medical school graduates cannot make the time  
19 or location commitment to a residency program due to personal, financial, or other  
20 commitments; therefore be it  
21  
22 RESOLVED, That our American Medical Association work with US Centers for Medicare and  
23 Medicaid Services and other relevant stakeholders to create a commission to estimate future  
24 physician workforce needs and suggest re-allocation of available residency funding and  
25 available first-year positions accordingly (Directive to Take Action); and be it further  
26  
27 RESOLVED, That our AMA work with relevant stakeholders to study the possibility of alternative  
28 pathways to ACGME certification of training, ABMS board certification, and medical practice for  
29 unmatched medical school graduates. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 09/14/22

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**RELEVANT AMA POLICY**

**Securing Funding for Graduate Medical Education H-310.917**

Our American Medical Association: (1) continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); (2) continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation; (3) encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs; and (4) encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.

Citation: CME Rep. 3, I-09; Modified: CME Rep. 15, A-10; Reaffirmed in lieu of Res. 324, A-12; Reaffirmed: CME Rep. 5, A-13; Appended: CME Rep. 1, I-15

**Proposed Revisions to AMA Policy on the Financing of Medical Education Programs D-305.973**

Our AMA will work with:

- (1) the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes:
  - (a) ensure adequate Medicaid and Medicare funding for graduate medical education;
  - (b) ensure adequate Disproportionate Share Hospital funding;
  - (c) make the Medicare direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions;
  - (d) revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings;
  - (e) stabilize funding for pediatric residency training in children's hospitals;
  - (f) explore the possibility of extending full direct medical education per-resident payment beyond the time of first board eligibility for specialties/subspecialties in shortage/defined need;
  - (g) identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties; and
  - (h) act on existing policy by seeking federal legislation requiring all health insurers to support graduate medical education through an all-payer trust fund created for this purpose; and
- (2) other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions.

Citation: (CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: Res. 921, I-12; Reaffirmation A-13; Reaffirmed: CME Rep. 5, A-13)

**The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967**

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).

4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and

other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.

20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.

21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.

22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.

23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.

24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.

25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.

28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.

29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.

30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary

care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

Citation: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep. 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended: CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18; Modified: Res. 233, A-19; Modified: BOT Rep. 25, A-19; Reaffirmed: CME Rep. 3, A-21

### **National Resident Matching Program Reform D-310.977**

Our AMA:

- (1) will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies;
- (2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
- (3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
- (4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match;
- (5) will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
- (6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
- (7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
- (8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants;
- (9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
- (10) will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;
- (11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;
- (12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
- (13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;

(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;

(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;

(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies;

(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine;

(18) encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency; and

(19) will work with appropriate stakeholders to study options for improving transparency in the resident application process.

Citation: CME Rep. 4, A-05; Appended: Res. 330, A-11; Appended: Res. 920, I-11; Appended: Res. 311, A-14; Appended: Res. 312, A-14; Appended: Res. 304, A-15; Appended: CME Rep. 03, A-16; Reaffirmation: A-16; Appended: CME Rep. 06, A-17; Appended: Res. 306, A-17; Modified: Speakers Rep. 01, A-17; Appended: CME Rep. 3, A-21; Modified: CME Rep. 1, A-22; Appended: Res. 328, A-22

#### **Preliminary Year Program Placement H-310.910**

1. Our AMA encourages the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, and other involved organizations to strongly encourage residency programs that now require a preliminary year to match residents for their specialty and then arrange with another department or another medical center for the preliminary year of training unless the applicant chooses to pursue preliminary year training separately.

2. Our AMA encourages appropriate stakeholders to explore options to decrease the burden upon medical students who must apply to separate preliminary PGY-1 and categorical PGY-2 positions.

3. Our AMA will work with the Accreditation Council for Graduate Medical Education to encourage programs with PGY-2 positions in the National Resident Matching Program (NRMP) with insufficient availability of local PGY-1 positions to create local PGY-1 positions that will enable coordinated applications and interviews for medical students.

4. Our AMA encourages the NRMP, the San Francisco Match, the American Urological Association, the Electronic Residency Application Service, and other stakeholders to reduce barriers for medical students, residents, and physicians applying to match into training programs, including barriers to “couples matching,” and to ensure that all applicants have access to robust, informative statistics to assist in decision-making.

5. Our AMA encourages the NRMP, San Francisco Match, American Urological Association, Electronic Residency Application Service, and other stakeholders to collect and publish data on a) the impact of separate matches on the personal and professional lives of medical students and b) the impact on medical students who are unable to successfully “couples match” with their significant others due to staggered entry into residency, utilization of unlinked match services, or other causes.

Citation: Res. 306, A-12; Appended: CME Rep. 03, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211  
(I-22)

Introduced by: Resident and Fellow Section

Subject: Illicit Drug Use Harm Reduction Strategies

Referred to: Reference Committee B

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- 1 Whereas, 2021 was the worst year on record for opioid overdoses in the US, with over 75,000  
2 reported<sup>1</sup>; and  
3  
4 Whereas, The involvement of synthetic opioids, including fentanyl, in drug overdoses across  
5 America is rising drastically year after year, and was 11-fold higher in 2019 than 2013<sup>2,3</sup>; and  
6  
7 Whereas, Fentanyl test strips are a point-of-care test that identifies fentanyl contamination in a  
8 drug supply with a specificity of 87.5% and a sensitivity of 95.2%<sup>4</sup>; and  
9  
10 Whereas, Fentanyl test strips are readily available and as inexpensive as \$1 per test<sup>5</sup>; and  
11  
12 Whereas, In a survey of young adults who use drugs, 95% reported that they were willing to use  
13 fentanyl test strips to identify fentanyl in their drug supply<sup>6</sup>; and  
14  
15 Whereas, A positive test with a fentanyl test strip has been shown to lead to modification of  
16 behaviors in order to reduce risk of overdose<sup>7,8</sup>; and  
17  
18 Whereas, Possession of fentanyl test strips is explicitly legal in only 22 states<sup>9</sup>; and  
19  
20 Whereas, Our AMA sent a federal correspondence denouncing laws that allow possessors of  
21 fentanyl test strips to be subject to civil and/or criminal penalties; and  
22  
23 Whereas, Drug checking services can also serve as a point of contact with users of recreational  
24 drugs for other harm reduction services and advice, and that accessibility to these resources  
25 through drug checking services is overwhelmingly supported by the target market<sup>10</sup>; therefore  
26 be it

1 RESOLVED, That our American Medical Association amend current policy D-95.987,  
2 "Prevention of Drug-Related Overdose," by addition to read as follows:

3  
4 4. Our AMA will advocate for and encourage state and county medical societies  
5 to advocate for harm reduction policies that provide civil and criminal immunity  
6 for the possession, distribution, and use of "drug paraphernalia" designed for  
7 harm reduction from drug use, including but not limited to drug contamination  
8 testing and injection drug preparation, use, and disposal supplies.

9  
10 5. Our AMA will implement an education program for patients with substance use  
11 disorder and their family/caregivers to increase understanding of the increased  
12 risk of adverse outcomes associated with having a substance use disorder and a  
13 serious respiratory illness such as COVID-19.

14  
15 6. Our AMA supports efforts to increase access to fentanyl test strips and other  
16 drug checking supplies for purposes of harm reduction. (Modify Current HOD  
17 Policy)

Fiscal Note: Minimal – less than \$1,000

Received: 09/14/22

**REFERENCES:**

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**RELEVANT AMA POLICY**

**Prevention of Drug-Related Overdose D-95.987**

1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.

3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
  4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use of "drug paraphernalia" designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.
  5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.
- Citation: Res. 526, A-06 Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18; Modified: Res. 506, I-21; Appended: Res. 513, A-22

#### **Increasing Availability of Naloxone H-95.932**

1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
  2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
  3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
  4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
  5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
  6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
  7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
  8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
  9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription.
- Citation: BOT Rep. 22, A-16; Modified: Res. 231, A-17; Modified: Speakers Rep. 01, A-17; Appended: Res. 909, I-17; Reaffirmed: BOT Rep. 17, A-18; Modified: Res. 524, A-19; Reaffirmed: BOT 09, I-19; Reaffirmed: Res. 219, A-21

#### **Pilot Implementation of Supervised Injection Facilities H-95.925**

Our AMA supports the development and implementation of pilot supervised injection facilities (SIFs) in the United States that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use.

Citation: Res. 513, A-17

#### **Harmful Drug Use in the United States - Strategies for Prevention H-95.978**

Our AMA: (1) Urges the Substance Abuse and Mental Health Administration to support research into special risks and vulnerabilities, behavioral and biochemical assessments and intervention methodologies most useful in identifying persons at special risk and the behavioral and biochemical strategies that are most effective in ameliorating risk factors.

(2) Urges the Center for Substance Abuse Prevention to continue to support community-based prevention strategies which include: (a) Special attention to children and adolescents, particularly in schools, beginning at the pre-kindergarten level. (b) Changes in the social climate (i.e., attitudes of community leaders and the public), to reflect support of harmful drug and alcohol use prevention and treatment, eliminating past imbalances in allocation of resources to supply and demand reduction. (c) Development of innovative programs that train and involve parents, educators, physicians, and other community leaders in "state of the art" prevention approaches and skills.

(3) Urges major media programming and advertising agencies to encourage the development of more accurate and prevention-oriented messages about the effects of harmful drug and alcohol use.

- (4) Supports the development of advanced educational programs to produce qualified prevention specialists, particularly those who relate well to the needs of economically disadvantaged, ethnic, racial, and other special populations.
- (5) Supports investigating the feasibility of developing a knowledge base of comprehensive, timely and accurate concepts and information as the "core curriculum" in support of prevention activities.
- (6) Urges federal, state, and local government agencies and private sector organizations to accelerate their collaborative efforts to develop a national consensus on prevention and eradication of harmful alcohol and drug use.

Citation: Res. 910, I-12

**Reduction of Medical and Public Health Consequences of Drug Abuse: Update D-95.999**

Our AMA encourages state medical societies to advocate for the expansion of and increased funding for needle and syringe-exchange programs and methadone maintenance and other opioid treatment services and programs in their states.

Citation: CSA Rep. 12, A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213  
(I-22)

Introduced by: New York

Subject: Hazard Pay During a Disaster Emergency

Referred to: Reference Committee B

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1 Whereas, The US Labor Department defines Hazard Pay as “additional pay for performing a  
2 hazardous duty or work involving physical hardship”; and  
3

4 Whereas, A 25 percent hazard bonus is authorized for federal employees working directly with  
5 or close to substances “of micro-organic nature which when introduced into the body are likely  
6 to cause serious disease or fatality and for which protective devices do not afford complete  
7 protection”; and  
8

9 Whereas, This definition reflects the situation of physicians’ working in emergency departments,  
10 intensive care units, and COVID wards; therefore be it  
11

12 RESOLVED, That our American Medical Association work with the federation of medicine to  
13 advocate for state or federal programs that would provide hazard pay bonuses to physicians  
14 and other healthcare staff delivering care during a state or federal disaster emergency.  
15 (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 09/20/22

**RELEVANT AMA POLICY**

**AMA Leadership in the Medical Response to Terrorism and Other Disasters H-130.946**

Our AMA: (1) Condemns terrorism in all its forms and provide leadership in coordinating efforts to improve the medical and public health response to terrorism and other disasters.

(2) Will work collaboratively with the Federation in the development, dissemination, and evaluation of a national education and training initiative, called the National Disaster Life Support Program, to provide physicians, medical students, other health professionals, and other emergency responders with a fundamental understanding and working knowledge of their integrated roles and responsibilities in disaster management and response efforts.

(3) Will join in working with the Department of Homeland Security, the Department of Health and Human Services, the Department of Defense, the Federal Emergency Management Agency, and other appropriate federal agencies; state, local, and medical specialty societies; other health care associations; and private foundations to (a) ensure adequate resources, supplies, and training to enhance the medical and public health response to terrorism and other disasters; (b) develop a comprehensive strategy to assure surge capacity to address mass casualty care; (c) implement communications strategies to inform health care professionals and the public about a terrorist attack or other major disaster, including local information on available medical and mental health services; (d) convene local and regional workshops to share "best practices" and "lessons learned" from disaster planning and response activities; (e) organize annual symposia to share new scientific knowledge and information for enhancing the medical and public health response to terrorism and other disasters; and (f) develop joint educational programs to enhance clinical collaboration and increase physician knowledge of the diagnosis and treatment of depression, anxiety, and post traumatic stress disorders associated with exposure to disaster, tragedy, and trauma.

(4) Believes all physicians should (a) be alert to the occurrence of unexplained illness and death in the

community; (b) be knowledgeable of disease surveillance and control capabilities for responding to unusual clusters of diseases, symptoms, or presentations; (c) be knowledgeable of procedures used to collect patient information for surveillance as well as the rationale and procedures for reporting patients and patient information; (d) be familiar with the clinical manifestations, diagnostic techniques, isolation precautions, decontamination protocols, and chemotherapy/prophylaxis of chemical, biological, and radioactive agents likely to be used in a terrorist attack; (e) utilize appropriate procedures to prevent exposure to themselves and others; (f) prescribe treatment plans that may include management of psychological and physical trauma; (g) understand the essentials of risk communication so that they can communicate clearly and nonthreateningly with patients, their families, and the media about issues such as exposure risks and potential preventive measures (e.g., smallpox vaccination); and (h) understand the role of the public health, emergency medical services, emergency management, and incident management systems in disaster response and the individual health professional's role in these systems.

(5) Believes that physicians and other health professionals who have direct involvement in a mass casualty event should be knowledgeable of public health interventions that must be considered following the onset of a disaster including: (a) quarantine and other movement restriction options; (b) mass immunization/chemoprophylaxis; (c) mass triage; (d) public education about preventing or reducing exposures; (e) environmental decontamination and sanitation; (f) public health laws; and (g) state and federal resources that contribute to emergency management and response at the local level.

(6) Believes that physicians and other health professionals should be knowledgeable of ethical and legal issues and disaster response. These include: (a) their professional responsibility to treat victims (including those with potentially contagious conditions); (b) their rights and responsibilities to protect themselves from harm; (c) issues surrounding their responsibilities and rights as volunteers, and (d) associated liability issues.

(7) Believes physicians and medical societies should participate directly with state, local, and national public health, law enforcement, and emergency management authorities in developing and implementing disaster preparedness and response protocols in their communities, hospitals, and practices in preparation for terrorism and other disasters.

(8) Urges Congress to appropriate funds to support research and development (a) to improve understanding of the epidemiology, pathogenesis, and treatment of diseases caused by potential bioweapon agents and the immune response to such agents; (b) for new and more effective vaccines, pharmaceuticals, and antidotes against biological and chemical weapons; (c) for enhancing the shelf life of existing vaccines, pharmaceuticals, and antidotes; and (d) for improving biological chemical, and radioactive agent detection and defense capabilities.

Citation: (BOT Rep. 26, I-01; Reaffirmed: BOT Rep. 3, I-02; Modified: CSA Rep. 1, I-03; Reaffirmed: CME Rep. 1, I-11; Reaffirmation A-15)

#### **Domestic Disaster Relief Funding D-130.966**

1. Our American Medical Association lobby Congress to a) reassess its policy for expedited release of funding to disaster areas; b) define areas of disaster with disproportionate indirect and direct consequences of disaster as "public health emergencies"; and c) explore a separate, less bureaucratic process for providing funding and resources to these areas in an effort to reduce morbidity and mortality post-disaster.

2. Our AMA will lobby actively for the recommendations outlined in the AMA/APHA Linkages Leadership Summit including: a) appropriate funding and protection of public health and health care systems as critical infrastructures for responding to day-to-day emergencies and mass casualty events; b) full integration and interoperable public health and health care disaster preparedness and response systems at all government levels; c) adequate legal protection in a disaster for public health and healthcare responders and d) incorporation of disaster preparedness and response competency-based education and training in undergraduate, graduate, post-graduate, and continuing education programs.

Citation: (Res. 421, A-11; Reaffirmation A-15)

#### **Impact of SARS-CoV-2 Pandemic on Post-Acute Care Services and Long-Term Care and Residential Facilities D-280.983**

Our AMA will collaborate with other stakeholders to develop policy to guide federal, state, and local public health authorities to ensure safe operation of Post-Acute Care (PAC) and long-term care (LTC) facilities during public health emergencies and natural disasters with policy recommendations to include but not limited to:

- a) Planning for adequate funding and access to resources;
- b) Planning for emergency staffing of health care and maintenance personnel;
- c) Planning for ensuring safe working conditions of PAC and LTC staff; and
- d) Planning for mitigation of the detrimental effects of increased isolation of residents during a natural disaster, other environmental emergency, or pandemic, or similar crisis.

Citation: Res. 407, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214  
(I-22)

Introduced by: Georgia

Subject: Universal Good Samaritan Statute

Referred to: Reference Committee B

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1 Whereas, Good Samaritan statutes exist in all 50 states and the District of Columbia for the  
2 purpose of promoting aid to individuals in need of emergency care; and  
3

4 Whereas, These statutes widely vary from state to state. This impedes the desired intent of  
5 these laws and may prevent physicians from rendering much needed care to patients who are in  
6 need of emergency care for a medical condition outside of healthcare settings due to fear of  
7 litigation; and  
8

9 Whereas, Some states only cover physicians licensed in that state. Physicians without the local  
10 state license may be held liable for Good Samaritan acts if physicians are from a different state  
11 and may be unfamiliar with the details of the local statutes; and  
12

13 Whereas, "Enumeration of Immunity" of Good Samaritan statutes may vary from state to state in  
14 such a way that it may not protect every rescuer depending upon the location of the event; and  
15

16 Whereas, "Good faith requirement" in the statute may differ from state to state; and  
17

18 Whereas, "Specific site of covering" may also vary based on the location of the accident and the  
19 rescue; and  
20

21 Whereas, "Minimal standard of care" may vary from state to state; and  
22

23 Whereas, Federal laws only exist for specific circumstances, such as Aviation Medical  
24 Assistance Act and Federal Law Enforcement Officers' Good Samaritan Act of 1998; therefore  
25 be it  
26

27 RESOLVED, That our American Medical Association help protect patients in need of emergency  
28 care and protect physicians and other responders by advocating for a national "universal" Good  
29 Samaritan Statute (Directive to Take Action); and be it further  
30

31 RESOLVED, That our AMA advocate for the unification of the disparate statutes by creation of a  
32 national standard via either federal legislation or through policy directed by the Department of  
33 Health and Human Services [HHS] to specify terms that would protect rescuers from legal  
34 repercussion as long as the act by the rescuer meets the specified universal minimal standard  
35 of conduct and the good faith requirement, regardless of the event location; thus, effectively  
36 eliminating variations in the state statutes to facilitate the intent of the Good Samaritan statutes  
37 removing barriers that could impede the prompt rendering of emergency care. (Directive to Take  
38 Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 09/26/22

## **RELEVANT AMA POLICY**

### **Delivery of Health Care by Good Samaritans H-130.937**

1. Our AMA will work with state medical societies to educate physicians about the Good Samaritan laws in their states and the extent of liability immunity for physicians when they act as Good Samaritans.
  2. Our AMA encourages state medical societies in states without "Good Samaritan laws," which protect qualified medical personnel, to develop and support such legislation.
  3. Where there is no conflict with state or local jurisdiction protocol, policy, or regulation on this topic, the AMA supports the following basic guidelines to apply in those instances where a bystander physician happens upon the scene of an emergency and desires to assist and render medical assistance. For the purpose of this policy, "bystander physicians" shall refer to those physicians rendering assistance voluntarily, in the absence of pre-existing patient-physician relationships, to those in need of medical assistance, in a service area in which the physician would not ordinarily respond to requests for emergency assistance. (a) Bystander physicians should recognize that prehospital EMS systems operate under the authority and direction of a licensed EMS physician, who has both ultimate medical and legal responsibility for the system. (b) A reasonable policy should be established whereby a bystander physician may assist in an emergency situation, while working within area-wide EMS protocols. Since EMS providers (non-physicians) are responsible for the patient, bystander physicians should work collaboratively, and not attempt to wrest control of the situation from EMS providers. (c) It is the obligation of the bystander physician to provide reasonable self-identification. (d) Where voice communication with the medical oversight facility is available, and the EMS provider and the bystander physician are collaborating to provide care on the scene, both should interact with the local medical oversight authority, where practicable. (e) Where voice communication is not available, the bystander physician may sign appropriate documentation indicating that he/she will take responsibility for the patient(s), including provision of care during transportation to a medical facility. Medical oversight systems lacking voice communications capability should consider the addition of such communication linkages to further strengthen their potential in this area. (f) The bystander physician should avoid involvement in resuscitative measures that exceed his or her level of training or experience. (g) Except in extraordinary circumstances or where requested by the EMS providers, the bystander physician should refrain from providing medical oversight of EMS that results in deviation from existing EMS protocols and standing orders.
  4. Our AMA urges the International Civil Aviation Organization to make explicit recommendations to its member countries for the enactment of regulations providing "Good Samaritan" relief for those rendering emergency medical assistance aboard air carriers and in the immediate vicinity of air carrier operations.
- Citation: (CCB/CLRPD Rep. 3, A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215  
(I-22)

Introduced by: International Medical Graduates Section

Subject: Eliminating Practice Barriers for Immigrant Physicians During Public Health Emergencies

Referred to: Reference Committee B

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1 Whereas, Minoritized populations, including people of color, immigrants, and people with  
2 chronic diseases were disproportionately affected by the pandemic; and  
3

4 Whereas, International medical graduates, board-certified and trained in the U.S. institutions,  
5 are often the frontline physicians in the federally designated health professional shortage areas  
6 (HPSA) for their waiver requirements; and  
7

8 Whereas, Physicians in the HPSA serve the lower income and immigrant population, and the  
9 older and sicker population covered by Medicare and Medicaid; and  
10

11 Whereas, In response to the COVID-19 pandemic, most states took measures to alleviate  
12 practice restrictions for in-training, out-of-state, and retired physicians to allow the additional  
13 workforce to join hands in managing critical staff shortages during public health emergencies;  
14 and  
15

16 Whereas, IMG physicians serving in the HPSA are restricted to one healthcare organization,  
17 further limited to one geographical location by definition of the work location listed in their Labor  
18 Condition Application (ETA Form 9035) as a prerequisite to their work Visa, H1B; and  
19

20 Whereas, Except for a few specific instances like that in New York and New Jersey states, IMG  
21 physicians were excluded from the special provisions for in and out-of-state expedited  
22 physicians licensing, preventing them from helping out the workforce shortage during the public  
23 health emergency, and providing urgent access to medical care for underserved patient  
24 populations; therefore be it  
25

26 RESOLVED, That our American Medical Association advise the state medical boards and other  
27 stakeholders to allow physicians in the health professional shortage areas to have temporary  
28 access to all unique and expedited licensing options, both inside and outside of the state of their  
29 practice during public health emergencies, to facilitate workforce utilization at the time of critical  
30 shortage (Directive to Take Action); and be it further  
31

32 RESOLVED, That our AMA advocate at the state and national level and advise the Department  
33 of Labor and the Department of Homeland Security to allow temporary provisions for such  
34 licensing inclusions for the physicians on a Visa during public health emergencies. (Directive to  
35 Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 09/27/22

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## Reference Committee C

### **CME Report(s)**

- 01 The Impact of Private Equity on Medical Training
- 02 Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process

### **Resolution(s)**

- 302 Expanding Employee Leave to Include Miscarriage and Stillbirth
- 303 Medical Student Leave Policy
- 304 Protecting State Medical Licensing Boards from External Political Influence
- 305 Encouraging Medical Schools to Sponsor Pipeline Programs to Medicine for Underrepresented Groups
- 306 Increased Credit for Continuing Medical Education Preparation
- 307 Fair Compensation of Residents and Fellows
- 308 Paid Family/Medical Leave in Medicine
- 309 Bereavement Leave for Medical Students and Physicians

REPORT 1 OF THE COUNCIL ON MEDICAL EDUCATION (I-22)  
The Impact of Private Equity on Medical Training  
(Reference Committee C)

EXECUTIVE SUMMARY

Private equity (PE) refers broadly to any activity where investors buy an ownership, or equity, stake in companies or other financial assets that are not traded on public stock or bond exchanges. In recent years, the AMA Council on Medical Education and Council on Medical Service have studied related issues as demonstrated in their reports, “Graduate Medical Education and the Corporate Practice of Medicine” (CME 2-N-20), “Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure” (CME 3-N-20), “Corporate Investors” (CMS 11-A-19), and “Sources of Funding for Graduate Medical Education” (CME 1-I-15). Per a new directive from the House of Delegates, the AMA has been asked to study the level of financial involvement and influence private equity firms have in graduate medical education training programs and report back to the House of Delegates with possible publication of their findings.

PE’s role in health care has increased in recent years, as has its influence on graduate medical education (GME). This report reviews the extent of PE in health care and provides examples of PE and for-profit ownership of GME. It also summarizes the impact of PE on the GME learning environment and trainees and offers perspectives from key stakeholders, including the AMA and its related policies.

Understanding of the impact and mitigating any potential negative consequences of PE and for-profit entities in GME will take a concerted effort on the part of the medical and academic communities. There are numerous layers of complexity in what is a rapidly evolving health care practice model, and increasing data collection to recognize trends and ultimately outcomes is warranted. As PE involvement evolves, sponsoring institutions must be open to many kinds of partnerships that can support excellent residency and fellowship programs. This includes diligent monitoring of these programs to minimize disruptions to training and ensure that continuity of excellent education is maintained. The commitment to the educational mission is not only a commitment to residents, fellows, and faculty, but also to the communities and patients they serve.

This report proposes amendments to current AMA policy as well as new recommendations which support institutions or medical education training programs in upholding current policies and developing new policies; protect trainees and empower designated institutional officials (DIOs); encourage transparency as well as changes to the Public Student Loan Forgiveness Program (PSLF); and promote more research and public statements on PE in order to heighten awareness among the physician community.

# REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-22

Subject: The Impact of Private Equity on Medical Training

Presented by: John Williams, MD, Chair

Referred to: Reference Committee C

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## 1 INTRODUCTION

2  
3 American Medical Association (AMA) Policy D-310.947, adopted at the June 2021 Special  
4 Meeting, asks that our AMA:

5  
6 Work with relevant stakeholders including specialty societies and the Accreditation Council for  
7 Graduate Medical Education to study the level of financial involvement and influence private  
8 equity firms have in graduate medical education training programs and report back to the  
9 House of Delegates with possible publication of their findings.

10  
11 This report is in response to the directive. Testimony on this item raised concern for recent  
12 incidents where private equity has impacted graduate medical education (GME) funded training  
13 positions, such as the Hahnemann closure in the fall of 2019. Additional testimony recognized the  
14 importance of recent Council reports on similar topics.

## 15 BACKGROUND

16  
17 *What is private equity?*

18  
19  
20 The American Investment Council (AIC), an advocacy and resource organization established to  
21 develop and provide information about the private investment industry, describes private equity  
22 (PE) such that “private equity invests capital in companies that are perceived to have growth  
23 potential and then works with these companies to expand or turnaround the business. This capital is  
24 contributed by large institutional investors and is organized into a fund. After three to seven years  
25 of ownership and working with the company, the fund manager will seek to ‘exit’ the company by  
26 taking the business public or selling it for a higher valuation than it was purchased. This exit  
27 distributes profits from the sale (‘returns’) to the investors in the fund and the fund manager.”<sup>1</sup>

28  
29 The Medicare Payment Advisory Commission (MedPAC) adds to this definition: “Private equity  
30 refers broadly to any activity where investors buy an ownership, or equity, stake in companies or  
31 other financial assets that are not traded on public stock or bond exchanges.”<sup>2</sup>

32  
33 According to the National Association of Securities Dealers Automated Quotations (NASDAQ), a  
34 private equity firm is one that uses its own capital or capital raised from investors to take  
35 companies private with the aim of running them better and later taking them public or selling them  
36 at a profit.<sup>3</sup>

1 Simply put, PE firms invest in health systems and in health care to make a profit. Investors pool  
 2 money to accumulate large sums of cash that are used to invest through the purchase of a business  
 3 (e.g., physician practice or health system) with the goal of streamlining operations and cutting costs  
 4 to make a short-term profit after selling the business. Sometimes, the return on the investment can  
 5 be 20-30% of the original investment.

6  
 7 Strategies used by PE firms to ultimately turn a profit include the merging of multiple health care  
 8 practices, reducing staff, closing down portions of a hospital or health care practice’s operations,  
 9 focusing on growing a specific aspect of a health care practice’s offerings, and renegotiating  
 10 reimbursement rates with insurers.<sup>4</sup> As PE is not publicly traded, there is little transparency to the  
 11 public regarding the business dealings of the PE firm, and with a focus on short-term profit, there is  
 12 often little regard to the downstream effects of these strategies on employees, patients, or in the  
 13 present case, the residents/fellows training at the institution.

14  
 15 In 2020, it was found that hospitals acquired by PE were associated with larger increases in net  
 16 income, charges, charge to cost ratios, and case mix index as well as with improvement in some  
 17 quality measures when compared to control.<sup>5</sup> In 2018, PE hospitals were on average located in  
 18 lower-income, more-rural areas and had fewer patients discharged and employees per bed.<sup>6</sup>

19  
 20 In recent years, the AMA Council on Medical Education and Council on Medical Service have  
 21 studied related issues as demonstrated in their reports, “Graduate Medical Education and the  
 22 Corporate Practice of Medicine” (CME 2-N-20), “Protection of Resident and Fellow Training in  
 23 the Case of Hospital or Training Program Closure” (CME 3-N-20), “Corporate Investors” (CMS  
 24 11-A-19) and related issue brief, and “Sources of Funding for Graduate Medical Education” (CME  
 25 1-I-15). Further, the AMA developed a guide designed to answer some of the frequently asked  
 26 questions posed by trainees faced with closure of their hospital or residency program.

27  
 28 *Extent of Private Equity in Health Care*

29  
 30 Investments by PE firms in U.S. health care increased from \$23.1B in 2015 to \$78.9B in 2019<sup>7</sup>  
 31 with hospitals that are owned by PE firms being a subset of investor-owned hospitals that has  
 32 increased in recent years.

33

<u>American Hospital Association (AHA) Annual Survey</u>	<u>FY 2019<sup>8</sup></u>	<u>FY 2015<sup>9</sup></u>
<b>Total Number of All U.S. Hospitals<sup>8</sup></b>	6,090	5,564
Number of U.S. Community Hospitals (i.e., all nonfederal, short-term general, and other special hospitals)	5,141	4,862
• Number of Nongovernment Not-for-Profit Community Hospitals	2,946	2,845
• Number of Investor-Owned (For-Profit) Community Hospitals	1,233	1,034
• Number of State and Local Government Community Hospitals	962	983

Number of Federal Government Hospitals	208	212
Number of Nonfederal Psychiatric Hospitals	625	401
Other Hospitals (i.e., nonfederal long term care hospitals and hospital units within an institution such as a prison hospital or school infirmary)	116	89

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While there is no clear picture of how many for-profit hospitals, or those owned by PE, have one or more GME programs, the most recent results of the National GME Census of active GME programs provide a glimpse. Results indicated that 7,695 programs’ trainees are paid by a nonprofit entity; 1,620 programs’ trainees are paid by a for-profit; while 3,550 programs did not answer.<sup>10</sup> When analyzing this data, it is important to note that the salary-paying entity may not always be the same as the sponsoring institution or hospital.

As the number of investor-owned (for-profit) hospitals grows in GME, the greater the dependency of GME programs on their stability and success. Conversely, the closure of such institutions directly impacts GME programs including the residents, fellows, and physician faculty who rely on them for training and employment. One such recent example was the sudden closure of Hahnemann.

EXAMPLES OF PRIVATE EQUITY AND FOR-PROFIT OWNERSHIP OF GME

*Closure of Hahnemann University Hospital*

In fall 2019, Hahnemann University Hospital (HUH), a 500-bed teaching hospital and community safety net in downtown Philadelphia, closed. The closure was the culmination of 20+ years of financial troubles and changing ownerships. Tenet Healthcare Corporation, a for-profit health care company, acquired the hospital in 1998. American Academic Health System, LLC (AAHS), an affiliate of the private equity firm Paladin Healthcare Capital, LLC, purchased HUH in 2018 in partnership with a Chicago-based health care real estate private equity firm, Harrison Street Real Estate Capital, LLC. At the time, suspicions loomed that the purchase of the hospital was really a means to acquire and develop the valuable Center City Philadelphia real estate property rather than to provide patient care in service to the community. While there is a state law that a hospital cannot be closed with less than 90 days’ notice, AAHS filed for bankruptcy and shut down HUH’s service to the community in about half that time. This left 572 trainee physicians without an Accreditation Council for Graduate Medical Education (ACGME)-accredited program in which to continue their medical education.<sup>11</sup> This included 140 newly matched trainees and 59 individuals on J-1 visas who were required to find a position with another GME program within 30 days of the hospital closing or face deportation from the U.S.<sup>12</sup>

To improve their financial gain, AAHS attempted to sell its government-funded residency slots as “assets” during bankruptcy proceedings, which was allowed by the presiding judge at the time.<sup>6</sup> Bids included a coalition of local hospitals (\$55 million) intending to keep the residency positions in the Philadelphia region, as well as a health care firm in California (\$60 million) that wanted to increase the number of funded physicians in its hospitals. However, the Centers for Medicare & Medicaid Services (CMS) objected to the judge’s ruling, arguing that the allocation of Medicare-funded slots is their sole purview and that the auction would set a dangerous precedent. As a result, the auction did not go forward,<sup>13</sup> and the residency positions were redistributed by CMS using their existing process which prioritizes local hospitals without charge.<sup>14</sup>

1 Not only were these professionals left to endure the stress of finding new training positions  
2 elsewhere throughout the country, but they were also faced with the loss of the long-tail medical  
3 liability insurance coverage needed to continue practice. The [AMA](#) and other organizations took  
4 action in support of the affected trainees. Specifically, the AMA joined the Pennsylvania Medical  
5 Society (PAMED) and the Philadelphia County Medical Society (PCMS), as well as the  
6 Educational Commission for Foreign Medical Graduates (ECFMG), Association of American  
7 Medical Colleges (AAMC), and ACGME to pursue a solution for the physicians affected by the  
8 closure. This advocacy included encouraging the purchasing of tail coverage by the institutions that  
9 accepted HUH trainees among a host of other measures.

10  
11 Ultimately, a federal bankruptcy judge approved a settlement with AAHS in early 2020 to pay for  
12 the long-tail medical liability insurance coverage for the residents, fellows, and alumni of the  
13 hospital's training programs.<sup>15</sup> Since Pennsylvania required that all physicians have tail coverage  
14 from previous employers, this effort was particularly important.<sup>16</sup>

15  
16 Together, the AMA and AMA Foundation committed \$70,000 to assist the trainees affected. Many  
17 other organizations contributed to the Hahnemann University Displaced Resident Fund including  
18 the American Osteopathic Association, American Board of Medical Specialties, Council of  
19 Medical Specialty Societies, National Board of Medical Examiners, PAMED, PCMS, and AAMC.  
20 In addition, the ECFMG, now a member of Intealth, created a fund for trainees who had J-1 visas.<sup>17</sup>  
21 The ACGME also took several steps to support these trainees such as the enactment of their  
22 Extraordinary Circumstances Policy to expediently arrange for the transfer of trainees, drafting a  
23 compilation of available positions, and making two separate filings with the bankruptcy court.<sup>18</sup>

#### 24 25 *Closure of Emergency Medicine department at Summa Health Care*

26  
27 Summa Health<sup>TM</sup> is an integrated nonprofit health care delivery system in the Akron, OH area that  
28 sponsors 19 GME programs, of which 15 are ACGME-accredited residency and fellowship  
29 programs. While Summa's employed physician group provided most of the educational and clinical  
30 services for these programs, the emergency medicine (EM) services (i.e., staffing of five  
31 emergency departments; faculty for EM residency program) were provided by a contracted third-  
32 party vendor owned by the private equity company U.S. Acute Care Solutions (USACS). A  
33 contract dispute between Summa Health<sup>TM</sup> and USACS in late 2016 ended in nonrenewal of the  
34 longstanding contract. The EM service physicians were forced to leave the institution and program.  
35 The program acquired new leadership and faculty but ultimately lost accreditation causing  
36 disruption of services for patients as well as for the trainees within the EM residency program.<sup>19</sup>

37  
38 The experience for the trainees who went through the change in groups and subsequent closure of  
39 the program was difficult for all and devastating for some. It was particularly difficult for the  
40 PGY3s given they had long-standing relationships and mentoring from their former attendings,  
41 faculty, and program leadership, not to mention a familiarity and comfort from working in a stable  
42 learning environment. The AMA, AMA Foundation, and others offered financial support to the  
43 affected trainees in need of relocating.<sup>20</sup>

44  
45 This experience led to a revision of Summa's GME Disaster or Interruption in Patient Care Policy  
46 as well as a comprehensive restructuring of the institutional contracting process. This overhaul  
47 included clarifying the definition of a disaster to include a "catastrophic loss of faculty";  
48 reinforcing the authority and responsibilities of the GME Committee (GMEC) members to call an  
49 emergency GMEC meeting to discuss a potential impending disaster; making transparent the  
50 disaster action steps and procedure; creating a linkage of the GME Disaster Policy to the new  
51 contracting process; cataloging all clinical and education service agreements and contracts that

1 involved third-party groups; and quarterly review by the Designated Institutional Official (DIO) of  
 2 the status of each agreement at a GMEC meeting to provide the committee oversight of this aspect  
 3 of the learning environment. USACS continues to invest in education and has shared best practices  
 4 from other institutions where they provide care and operate residencies. In September 2019,  
 5 Summa's EM Program was given initial accreditation status by the ACGME effective  
 6 immediately.<sup>21</sup> Emergency medicine training at Summa is once again thriving.

### 7 *Example of extensive PE ownership of GME*

9  
 10 HCA Healthcare is the nation's leading provider of GME and has 5000+ trainees working across  
 11 61 hospitals in 16 states. They were responsible for 20% of the 667 new EM residency slots created  
 12 in the U.S. from 2016-2019.<sup>22</sup> In 2006, HCA was acquired by Bain Capital, Kohlberg Kravis  
 13 Roberts & Co. (KKR), and Merrill Lynch and facilitated massive multi-hospital consolidation with  
 14 seemingly marginal benefit for patients as well as increased cost-to-charge ratios/profits.<sup>23,24,25</sup> In  
 15 2011, HCA became a public company again. In the meantime, the PE investors had turned a \$956  
 16 million contribution into \$3.14 billion in proceeds.<sup>25</sup> HCA bought back 3.8 million shares from  
 17 Bain for about \$294 million and spent \$750 million to buy back 9.4 million of its common shares  
 18 from KKR in 2016.<sup>26</sup> The potential impacts of HCA's enormous market share within GME is  
 19 concerning and highlights the need for publicly funded, independent research on the impact of  
 20 private equity in GME and health care delivery alike.

## 21 PRIVATE EQUITY AND THE GME LEARNING ENVIRONMENT

22  
 23  
 24 As mentioned previously, PE is fundamentally driven by the desire to generate a positive margin  
 25 for investors through a variety of strategies. Ultimately, these strategies are to grow, repackage, and  
 26 sell.<sup>27</sup> While it does not appear that PE invests in hospitals, health systems, or practices with the  
 27 intent of eliminating or dramatically altering GME, such programs as well as their trainees can be  
 28 impacted. Examples include but are not limited to:

- 30 • Erosion of educational mission: One key outcome of GME training is the intentional  
 31 exploration of self-directed learning and pursuit of scholarly activity. The focus of PE is on  
 32 creating a wide profit margin through operational decisions and efficiencies, and these are  
 33 likely to directly or indirectly impact a trainee's ability to learn. Education and learning  
 34 require time and mentoring, especially in GME, and thus it is inherently inefficient. PE  
 35 firms driven toward profit are likely to eliminate or minimize key aspects of trainee  
 36 professional development.
- 37 • Disruption to trainee supervision: A sudden transition of leadership can result in new  
 38 faculty not familiar with ACGME common program requirements and/or institutional  
 39 requirements which mandate resident supervision of trainees.
- 40 • Residents are not employees: Trainees are commonly in a unique situation in which they  
 41 are able to provide significant value to a health system by caring for patients and making  
 42 independent decisions that generate clinical revenue. For institutions driven by profit,  
 43 however, there may be undue pressure for trainees to contribute to the positive margin  
 44 either through their medical practice or being utilized as a relatively low-cost employee  
 45 (e.g., shift scheduling).
- 46 • Replacing residents with non-physicians: There is concern that some for-profit institutions  
 47 are driving to replace resident physicians with non-physicians in order to not be beholden  
 48 to regulatory rules, reduce recruiting budgets, and pay lower cumulative salaries over the  
 49 long term.

- 1 • Academic instability: The situation at Hahnemann has been described as a "...concerning  
2 trend that underscores the dissonance in mission of private equity and academic  
3 medicine."<sup>28</sup> This dissonance creates an unstable, if not adverse, working and learning  
4 environment that unquestionably impacts trainees and their professional growth.  
5

## 6 IMPACT ON PHYSICIANS IN TRAINING 7

8 As referenced in the above examples, trainees and faculty are significantly impacted by disruptions  
9 to GME imposed by PE. The interruption to a trainee's education and experience can impact their  
10 ability to finish as scheduled, which has natural implications for their future careers and leaves  
11 them at financial risk. The potential loss of long-tail medical liability insurance coverage needed to  
12 continue practice as well as confusion regarding the amount of funding that would travel with a  
13 transferring trainee from a suddenly closed program is problematic.  
14

15 Additionally, the stress of uncertainty, having to find a new GME program, needing to upend their  
16 lives to move to the next location, and the cost of moving and rehoming place a heavy weight on  
17 the shoulders of residents, faculty, and their families. This problem is further compounded by the  
18 likely change of mentorship and planned educational trajectory for learners as they re-enter at  
19 another institution.  
20

21 International medical graduates (IMGs) with J-1 visas must adhere to rules set forth by their J-1  
22 visa status. In the event of a sudden hospital/GME program closure, the implication for these  
23 trainees is that they face deportation to their home country if they do not find a new position at  
24 another GME program within 30 days of such closure. This short timeline presents significant  
25 challenges to professional continuity for reasons in which the IMG has no control.  
26

27 Further, the trainees may not have received clarity from all the boards on how the closure could  
28 impact the number of rotations or number of procedures (especially those nearing the end of  
29 training) they need to complete. The ABIM did state that "all accredited training continues to meet  
30 ABIM's policies for initial certification eligibility. Additionally, should a trainee have a 'gap' in  
31 training due to relocation, we are committed to working with you and the receiving  
32 institutions/program directors to ensure that the maximum flexibility possible under ABIM's Leave  
33 and Deficits in Required Training Time policies can be applied."<sup>29</sup>  
34

35 As a result of the Hahnemann closure, CMS changed its rules related to the transfer of indirect  
36 medical education (IME) and direct graduate medical education (DGME) funding to accepting  
37 institutions. Current Medicare policy allows a temporary cap adjustment for hospitals that accept  
38 displaced residents from a hospital or program that is closing so that these hospitals can receive  
39 Medicare funding for the displaced residents for the duration of their training. The definition of a  
40 displaced resident was such that the resident be physically present at the hospital training on the  
41 day prior to or the day of hospital or program closure; however, the revised definition now states  
42 that a resident will be considered displaced from the day the hospital or training program publicly  
43 announces the closure.<sup>30</sup> This rule, however, does not impact GME trainees whose salaries are not  
44 paid for through Medicare funds (e.g., trainees in programs that are not accredited by the ACGME,  
45 such as sub-specialties that receive approval/certification from specialty societies). Without  
46 guarantees for ongoing trainees, the educational continuity of these learners is dramatically  
47 impacted.  
48

49 The impact on the income of trainees is another important consideration. One study found that  
50 while there was significant growth of newly ACGME accredited for-profit affiliated EM residency  
51 programs from 2016–2021, the for-profit affiliated programs paid lower salaries to first-year

1 trainees than the nonprofit affiliated programs (even after controlling for other factors that could  
2 influence salary). It concluded that better oversight of the salary determination process is needed to  
3 protect trainees from underpayment and ensure equity.<sup>31</sup> While this study was specific to EM  
4 programs, there could be broader implications to other specialties where PE investment is a factor.

5  
6 Finally, the emotional and psychological toll on trainees working in an unfamiliar, possibly  
7 unwelcoming, learning environment likely has significant implications on professional identity  
8 formation. Most trainees do not understand and have not received formal education regarding the  
9 corporate practice of medicine and thus may not understand or appreciate the economic forces that  
10 directly or indirectly impact their education.

### 11 *Public Service Loan Forgiveness Program*

12  
13  
14 The involvement of private equity can also impact a physician's eligibility for the Public Service  
15 Loan Forgiveness Program (PSLF). The PSLF Program forgives the remaining balance on an  
16 individual's direct loans after making 120 qualifying monthly payments under a qualifying  
17 repayment plan while working full-time for a qualifying employer. From the 2019 data presented in  
18 the AHA table above, 4,116 hospitals are PSLF-eligible, or roughly about 68 percent of hospitals in  
19 the U.S. Although most residency and fellowship programs are in nonprofit institutions, the for-  
20 profit or nonprofit status of programs is not generally readily discernible to a medical student or  
21 resident investigating training options. Additionally, residents and fellows who are training in a  
22 nonprofit university-based residency or fellowship program will be excluded from the PSLF  
23 Program if they are officially employees of an affiliated for-profit hospital or health system. During  
24 the match process, medical students may not be aware of or have access to information about the  
25 for-profit status of the entity that will pay their salary as GME often takes place within complicated  
26 institutional arrangements of "sponsoring" and "participating" institutions. Even if residents and  
27 fellows rotate to several nonprofit clinical sites and funds are contributed to that salary by nonprofit  
28 or government institutions, the institution writing the salary check may not be a nonprofit and thus  
29 not be a qualifying employer for the PSLF Program. This system can create multiple hurdles for  
30 physicians hoping to enter the PSLF Program and means that students will need to be cautious  
31 about choosing institutions as part of the residency matching process and physicians must do the  
32 same when picking their future place of employment.

33  
34 In July 2022, the Department of Education (DOE) announced [proposed rule changes](#) including  
35 amendments to regulations governing PSLF in the Direct Loan program to improve the application  
36 process and to clarify and expand definitions for full-time employment, qualifying employers, and  
37 qualifying monthly payments. The AMA responded to the open comment period encouraging the  
38 DOE to adopt the clarifying language developed by the California Medical Association and Texas  
39 Medical Association following the definition of "employee" or "employed" so that CA and TX  
40 physicians working full-time in private nonprofit hospitals and other organizations that meet the  
41 definition of "public service organization" and satisfy all the other PSLF requirements may  
42 lawfully participate in the program. The AMA letter also encouraged extension of the current PSLF  
43 waiver deadline and expansion of the program so that more associations and a larger range of  
44 nonprofits be considered "qualified employers." Further, the letter urged reconsideration of the  
45 proposed definition of "public education service" as being too narrow and unclear, as well as  
46 reconsideration of the proposal which would allow a total and permanent disability discharge  
47 application to be certified by a nurse practitioner, physician's assistant, or a licensed certified  
48 psychologist, in addition to an MD or DO.

### 49 50 PERSPECTIVES FROM STAKEHOLDERS

51

1 Medical specialties that have notably attracted the majority of PE investment include dermatology,  
2 orthopaedics, radiology, cardiology, gastroenterology, urgent care/emergency medicine,  
3 anesthesiology, and ophthalmology.

4  
5 To illustrate, dermatology practices represent 15 percent of recent private equity acquisitions of  
6 medical practices even though dermatologists account for only one percent of physicians in the  
7 U.S.<sup>32</sup> PE firms invest in dermatology management groups (DMGs) which operate multiple clinics  
8 and have been known to acquire smaller, physician-owned practices. Research suggests that this  
9 consolidation of dermatology practices may be associated with changes in practice management  
10 and that PE firms have a financial stake in an increasing number of dermatology practices in the  
11 U.S.<sup>33</sup> PE's interest in dermatology points to several factors including: treatment of skin cancer,  
12 which is the most common cancer in the U.S.<sup>34</sup>; a growing older population in need of skin care; a  
13 specialty with a history of fragmentation; demand for dermatologists; and profitability of the  
14 specialty as well as its specialized services such as Mohs and dermatopathology.<sup>35</sup> However, there  
15 are considerations for dermatologists. As stated by AMA President Jack Resneck, Jr., MD,  
16 "Practice acquisitions at inflated prices in a competitive quest to quickly consolidate fragmented  
17 markets and sell practices at a profit to future investors may eventually lead to bankruptcies,  
18 leaving dermatologists without practices and patients without services."<sup>36</sup> Further, the impact on  
19 dermatology training programs is unclear. The American Academy of Dermatology and American  
20 Board of Dermatology do not appear to have issued statements regarding private equity and its role  
21 in the specialty or impact on GME.

22  
23 Another example of PE growth is within ophthalmology, for reasons similar to dermatology. As of  
24 2019, 30-35 PE firms were in this market.<sup>27</sup> PE's focus is on large and regionally important  
25 practices as well as those with a strong ambulatory surgery center (ASC) component. It is believed  
26 that such interest in ASCs will increase, as "stable ASC profits and comparatively low enterprise  
27 complexity are most in keeping with a corporate environment—much more so than the massive  
28 complexity and volatility of the underlying practices themselves."<sup>46</sup> The American Academy of  
29 Ophthalmology (AAO) notes, "Purchases of private equity in the health care market have soared in  
30 recent years with hospitals and larger practice acquiring smaller practices. The Academy urges  
31 every physician who is considering a practice equity acquisition to perform careful due diligence  
32 and seek good counsel." The [AAO](#) offers information to physicians who are considering such  
33 opportunities.<sup>47</sup>

34  
35 In April 2022, the American College of Emergency Physicians (ACEP) issued a statement on  
36 Private Equity and Corporate Investment in Emergency Medicine. In it, they expressed increased  
37 concerns about the expanding presence of PE and corporate investment in health care, including  
38 emergency medicine.<sup>48</sup>

39  
40 Prior to this, the American Academy of Emergency Medicine (AAEM) Resident and Student  
41 Association issued an open letter addressing their concerns with regards to training in an  
42 environment influenced by corporate entities. Specifically, they urge the profession to, "Purge our  
43 specialty societies from the influence and funding from corporate entities" among other  
44 recommendations.<sup>49</sup> Further, this letter calls for a moratorium on new EM residency training  
45 programs until issues are addressed, namely concerns about program quality as well as the  
46 oversupply of EM physicians.

47  
48 Likewise, a 2021 position paper from the American College of Physicians (ACP) concluded,  
49 "Ultimately, professionalism, medical ethics, and the patient-physician relationship must guide  
50 how physicians navigate the business side of medicine. Nonprofits must act like nonprofits and  
51 have a community-oriented mission, private equity firms and investor-owned organizations must

1 attend to the needs of patients and not just shareholders, and physicians should not have a financial  
2 stake in an organization with which they have a referral relationship.”<sup>50</sup>

3  
4 The ACGME is actively monitoring this situation as indicated in the 2021 National Reporting of  
5 Findings from their Clinical Learning Environment Review (CLER) Site Visits. This report noted,  
6 “Over the past few years, U.S. health care has experienced a number of accelerated changes. There  
7 has been a dramatic increase in mergers and acquisitions of hospitals and related health care  
8 entities, resulting in increasingly large and complex health care organizations. There has also been  
9 rapid entry of private equity in ownership of physician group practices, particularly among certain  
10 specialty-based clinical practices.” By examining clinical learning environments (CLE) during this  
11 rapid evolution of the U.S. health care system, the ACGME can illuminate the challenges and  
12 opportunities related to how CLEs engage their trainees in planning for and implementing system  
13 changes. ACGME programs continue to assist the GME community in testing and sharing new  
14 approaches to improving complex challenges in the CLE. Also, the ACGME will revise its  
15 institutional requirements in 2022 as part of a 10-year major revision cycle. Thus, the CLER  
16 Evaluation Committee is studying the results of their current report and past reports to highlight  
17 opportunities for improvement to be considered by the Institutional Review Committee.<sup>51</sup>

18  
19 Despite the significant level of concern that has been expressed, not all stakeholders have  
20 implemented policies designed to combat the impact of PE on GME. The associations and societies  
21 that represent residents and physicians should have a vested interest in the impact that PE may have  
22 on trainees who belong in the GME programs of said specialties. However, few have released  
23 policy statements or positions on the subject; for those who have not, such action may be  
24 considered. Further, the water gets muddied when physicians associated with PE firms are  
25 outspoken in their societies or if the leadership of such societies has financial relationships with  
26 PE-backed management firms.

27  
28 Clearly there is concern about PE and its impact on the practice of medicine, but little is known or  
29 commented about the impact of PE on GME, whether that be for an individual residency program  
30 or for an institution.

### 31 32 CHANGES TO DATE

33  
34 As a result of the Hahnemann closure, CMS implemented a rule change related to the transfer of  
35 GME funding from one institution to another in the case of sudden closure of an institution or a  
36 program. As described earlier, this change updated the definition of a “displaced resident” and  
37 applies to residents currently training in the closing program as well as residents who are not  
38 physically present because they have not started training or do not intend to return to training at the  
39 closing institution.<sup>30</sup> Allowing the closing hospital to temporarily transfer the slots as soon as the  
40 closing is made public allows trainees flexibility in finding new programs and allows for more  
41 certainty in the continuity of training. This change was encouraged by AMA and AAMC.<sup>52</sup>

42  
43 The Summa example provides other changes that have occurred at an institutional or systemic level  
44 that have helped to optimize training at that institution while also taking provisional steps to  
45 prevent dramatic closures from recurring in the future.

46  
47 While positive developments, there remains concern that the positive changes implemented to date  
48 are only temporary and may not lead to lasting change or prevent dramatic closures from  
49 happening again as a result of PE investment.

50  
51 *Proposed federal legislation*

1 In October 2021, the Stop Wall Street Looting Act ([S. 3022](#)) was introduced to subject certain  
2 private funds to joint and several liability with respect to the liabilities of firms acquired and  
3 controlled by those funds. The sponsor described it as “a comprehensive bill to fundamentally  
4 reform the private equity industry and level the playing field by forcing private investment firms to  
5 take responsibility for the outcomes of companies they take over, empowering workers, and  
6 protecting investors.”<sup>53</sup> A similar bill by the same name, [H.R. 5648](#), also was introduced. Such  
7 legislation could pave the way for greater scrutiny and accountability of PE, and ultimately, more  
8 protection for trainees and residency programs.

9  
10 RELEVANT AMA POLICY

11  
12 The AMA has extensive policy addressing the financial involvement of for-profit institutions in  
13 GME and the influence of private equity firms on the practice of medicine. The most specific  
14 policies related to this topic are as follows:

- 15 • [D-310.948](#), “Protection of Resident and Fellow Training in the Case of Hospital or  
16 Training Program Closure,” addresses concerns related to the protection of residents and  
17 fellows in the case of training program closures and specifically encourages the AMA to  
18 work with other stakeholders to ensure that GME trainees can continue safely on their  
19 training pathway despite needing to change institutions mid-training.  
20
- 21 • [H-310.904](#), “Graduate Medical Education and the Corporate Practice of Medicine,”  
22 acknowledges that the learning environment for trainees must be free of conflict between  
23 fiduciary responsibilities of an institution and the educational mission.  
24
- 25 • [H-310.943](#), “Closing of Residency Programs,” provides recommendations for some  
26 medical education regulatory bodies to actively monitor GME programs for non-  
27 educational closing and accommodate those trainees who are impacted when GME  
28 programs close for this reason. In addition, it calls for federal regulation to increase  
29 transparency and accountability of the training institution in the event of hospital or  
30 training program closure.  
31
- 32 • [H-310.929](#), “Principles for Graduate Medical Education,” identifies a list of principles for  
33 GME including the institutional responsibility as it relates to supporting trainees and their  
34 program as well as promoting an environment that is conducive to learning.  
35
- 36 • [H-160.891](#), “Corporate Investors,” provides a list of detailed guidelines for physicians who  
37 are contemplating investor partnerships.  
38
- 39 • [H-215.981](#), “Corporate Practice of Medicine,” opposes federal legislation that preempts  
40 state laws prohibiting the corporate practice of medicine, offers guidance to state societies,  
41 and encourages continued monitoring of the corporate practice of medicine.  
42

43 These policies addressing PE are listed in full detail in Appendix A.

44  
45 SUMMARY AND RECOMMENDATIONS

46  
47 Understanding of the impact and mitigating any potential negative consequences of PE and for-  
48 profit entities in GME will take a concerted effort on the part of the medical and academic  
49 communities. There are numerous layers of complexity in what is a rapidly evolving health care  
50 practice model and increasing data collection to recognize trends and ultimately outcomes is

1 warranted. AMA Policy D-310.948 instructs the AMA to work with the ACGME to monitor issues  
2 related to training programs run by corporate entities and the effect on medical education. Research  
3 into this work should continue in concert with affected specialty societies and others.

4  
5 Specialty associations and societies that represent trainees and physicians have a vested interest in  
6 the impact of PE on GME training, yet few have studied the issue and released policy or statements  
7 on the subject. The AMA Council on Medical Education encourages this work from the physician  
8 and medical education communities.

9  
10 The AMA must continue to advocate that full GME funding follows trainees of a suddenly closed  
11 institution to the new location and that funding stays with the institution for the duration of the  
12 displaced resident's term. For institutions and systems, tail coverage for malpractice insurance  
13 should be mandated and institutional transparency increased to trainees on the closure process as  
14 well as disclosure of the intent to sell or close. Benefits (such as COBRA) should be continued in  
15 instances where new residency programs are not found in a timely manner. Finally, upon a  
16 shutdown, all trainees should be protected from being held captive at a hospital that is not actively  
17 admitting patients but hasn't officially "closed." The AMA must also continue to work with the  
18 ACGME, ABMS, and ABOMS to accommodate trainees who have been displaced because of  
19 program or institutional closure.

#### 20 21 *Conclusion*

22  
23 It is likely that the involvement of PE in health care systems, physician practices, and thus, GME  
24 programs, is not going away. As this space evolves, sponsoring institutions must be open to many  
25 kinds of partnerships that can support excellent residency and fellowship programs. This includes  
26 diligent monitoring of these programs to minimize disruptions to training and ensure that continuity  
27 of excellent education is maintained. The commitment to the educational mission is not only a  
28 commitment to residents, fellows, and faculty, but also to the communities and patients they serve.

29  
30 The Council on Medical Education therefore recommends that the following recommendations be  
31 adopted, and the remainder of this report be filed. That our AMA:

- 32  
33 1. Affirm that an institution or medical education training program academic mission should  
34 not be compromised by a clinical training site's fiduciary responsibilities to an external  
35 corporate or for-profit entity. (New HOD Policy)
- 36  
37 2. Encourage GME training institutions, programs, and relevant stakeholders to:
- 38 a. demonstrate transparency on mergers and closures, especially as it relates to  
39 private equity acquisition of GME programs and institutions, and demonstrate  
40 institutional accountability to their trainees by making this information available to  
41 current and prospective trainees;
  - 42 b. uphold comprehensive policies which protect trainees, including those who are not  
43 funded by Medicare dollars, to ensure the obligatory transfer of funds after  
44 institution closure;
  - 45 c. empower designated institutional officials (DIOs) to be involved in institutional  
46 decision-making to advance such transparency and accountability in protection of  
47 their residents, fellows, and physician faculty;
  - 48 d. develop educational materials that can help trainees better understand the business  
49 of medicine, especially at the practice, institution, and corporate levels;
  - 50 e. develop policies highlighting the procedures and responsibilities of sponsoring  
51 institutions regarding the unanticipated catastrophic loss of faculty or clinical

- 1 training sites and make these policies available to current and prospective GME  
2 learners. (Directive to Take Action)  
3
- 4 3. Encourage necessary changes in Public Service Loan Forgiveness Program (PSLF) to  
5 allow medical students and physicians to enroll in the program even if they receive some or  
6 all of their training at a for-profit or governmental institution. (Directive to Take Action)  
7
- 8 4. Support publicly funded independent research on the impact that private equity has on  
9 graduate medical education. (New HOD Policy)  
10
- 11 5. Encourage physician associations, boards, and societies to draft policy or release their own  
12 issue statements on private equity to heighten awareness among the physician community.  
13 (Directive to Take Action)  
14
- 15 6. Encourage physicians who are contemplating corporate investor partnerships to consider  
16 the ongoing education and welfare for trainee physicians who train under physicians in that  
17 practice, including the financial implications of existing funding that is used to support that  
18 training. (Directive to Take Action)  
19
- 20 7. Amend Policy [D-310.948](#) “Protection of Resident and Fellow Training in the Case of  
21 Hospital or Training Program Closure” by addition to read as follows:  
22
- 23 Our AMA: (6) will continue to work with ACGME, interested specialty societies,  
24 and others to monitor issues, collect data, and share information related to training  
25 programs run by corporate and nonprofit entities and their effect on medical  
26 education. (Modify HOD Policy)  
27
- 28 8. Reaffirm the following policies:  
29
- 30 • [H-310.904](#) “Graduate Medical Education and the Corporate Practice of Medicine”
  - 31 • [H-310.943](#) “Closing of Residency Programs”
  - 32 • [H-310.929](#) “Principles for Graduate Medical Education”
  - 33 • [H-215.981](#) “Corporate Practice of Medicine” (Reaffirm HOD policy)
- 34 9. Rescind AMA Policy D-310.947 as having been accomplished by this report. (Rescind  
35 HOD policy)

Fiscal note: \$1,000

## APPENDIX A: RELEVANT AMA POLICY

### Corporate Investors H-160.891

1. Our AMA encourages physicians who are contemplating corporate investor partnerships to consider the following guidelines:
  - a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor.
  - b. Due diligence should be conducted that includes, at minimum, review of the corporate investor's business model, strategic plan, leadership and governance, and culture.
  - c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.
  - d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
  - e. Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
  - f. Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.
  - g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.
  - h. Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
  - i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships.
2. Our AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices.
3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty.
4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine.

### Graduate Medical Education and the Corporate Practice of Medicine H-310.904

Our AMA: (1) recognizes and supports that the environment for education of residents and fellows must be free of the conflict of interest created between a training site's fiduciary responsibility to shareholders and the educational mission of residency or fellowship training programs; (2) encourages the Accreditation Council for Graduate Medical Education (ACGME) to update its "Principles to Guide the Relationship between Graduate Medical Education, Industry, and Other Funding Sources for Programs and Sponsoring Institutions Accredited by the ACGME" to include corporate-owned lay entity funding sources; and (3) will continue to monitor issues, including waiver of due process requirements, created by corporate control of graduate medical education sites.

### Corporate Practice of Medicine H-215.981

1. Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine.
2. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.

3. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care, and other relevant issues.

Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure D-310.948

Our AMA:

1. will ask the Centers for Medicare & Medicaid Services (CMS) to stipulate in its regulations that residency slots are not assets that belong to the teaching institution;
2. will encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to develop a process similar to the Supplemental Offer and Acceptance Program (SOAP) that could be used in the event of a sudden teaching institution or program closure;
3. will encourage the Accreditation Council for Graduate Medical Education (ACGME) to specify in its Institutional Requirements that sponsoring institutions are to provide residents and residency applicants information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger;
4. will work with AAMC, AACOM, ACGME, and relevant state and specialty societies to coordinate and collaborate on the communication with sponsoring institutions, residency programs, and resident physicians in the event of a sudden institution or program closure to minimize confusion, reduce misinformation, and increase clarity;
5. will encourage ACGME to revise its Institutional Requirements, under section IV.E., Professional Liability Insurance, to state that sponsoring institutions must create and maintain a fund that will ensure professional liability coverage for residents in the event of an institution or program closure; and
6. will continue to work with ACGME to monitor issues related to training programs run by corporate entities and the effect on medical education.

Closing of Residency Programs H-310.943

1. Our AMA: (a) encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs; (b) reminds all institutions involved in educating residents of their contractual responsibilities to the resident; (c) encourages the ACGME and the various Residency Review Committees to reexamine requirements for “years of continuous training” to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing; (d) will work with the American Board of Medical Specialties Member Boards to encourage all its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training; (e) urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements; (f) opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding; and (g) will work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure.
2. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for:

- A. Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed;
  - B. Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution;
  - C. Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution; and
  - D. Protections against the discrimination of displaced residents and fellows consistent with H-295.969.
3. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which displaced residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program.
4. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to:
- A. Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions;
  - B. Create a centralized, regulated process for displaced residents and fellows to obtain new training positions; and
  - C. Develop pathways that ensure that closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents.

#### Principles for Graduate Medical Education H-310.929

Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.

1) **PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE.** There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.

Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care.

Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.

(2) **RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING.**

Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.

(3) **EDUCATION IN THE BROAD FIELD OF MEDICINE.** GME should provide a resident physician with broad clinical experiences that address the general competencies and

professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.

(4) **SCHOLARLY ACTIVITIES FOR RESIDENTS.** Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.

(5) **FACULTY SCHOLARSHIP.** All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.

(6) **INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS.** Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form house staff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.

(7) **COMPENSATION OF RESIDENT PHYSICIANS.** All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

(8) **LENGTH OF TRAINING.** The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.

(9) **PROVISION OF FORMAL EDUCATIONAL EXPERIENCES.** Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.

(10) **INNOVATION OF GRADUATE MEDICAL EDUCATION.** The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome

management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.

(11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.

(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.

(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.

(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.

(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.

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REPORT 2 OF THE COUNCIL ON MEDICAL EDUCATION (I-22)  
Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection  
Process  
(Reference Committee C)

EXECUTIVE SUMMARY

American Medical Association (AMA) Policy D-295.963 (5) calls on our AMA to:

work with appropriate stakeholders to study reforms to mitigate demographic and socioeconomic inequities in the residency and fellowship selection process, including but not limited to the selection and reporting of honor society membership and the use of standardized tools to rank applicants, with report back to the House of Delegates.

This report, which is in response to this directive, reviews the current status of the residency selection process, which has led to increasing pressures for both applicant and program; responses to those pressures; and the potential downstream consequences of the residency selection process on perpetuating demographic and socioeconomic inequities. (Note: This report uses the term “residency selection process” to comprise both residency and fellowship program selection.)

To provide context, the report starts by providing data regarding recent trends in application processing, including specific factors used by program directors when determining which applicants to interview for residency. Specific discussion about the use of “filters” of objective metrics is included. Next the report reviews three medical honor societies—Alpha Omega Alpha, Gold Humanism Honor Society, and Sigma Sigma Phi—and their efforts to address the perpetuation of inequities within their honoree selection processes.

Lastly, the report reviews various attempts, including several pilot programs, designed to optimize the residency selection process, including a review of various standardized tools and other innovations designed to help minimize the burden on program directors while ensuring ample opportunity for applicants and programs to find a good “fit” with each other. It concludes with recommendations calling for AMA action to promote equity in the residency application and selection process.

# REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-I-22

Subject: Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process

Presented by: John P. Williams, MD, Chair

Referred to: Reference Committee C

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1 American Medical Association (AMA) Policy D-295.963 (5) calls on our AMA to:

2  
3 work with appropriate stakeholders to study reforms to mitigate demographic and  
4 socioeconomic inequities in the residency and fellowship selection process, including but not  
5 limited to the selection and reporting of honor society membership and the use of standardized  
6 tools to rank applicants, with report back to the House of Delegates.  
7

8 This report is in response to that directive and encompasses a review of the current residency  
9 selection process, which has led to increasing pressures for both applicant and program; responses  
10 to those pressures, including the use of innovative processes and tools; and the potential  
11 downstream consequences of the residency selection process on perpetuating demographic and  
12 socioeconomic inequities. Examination of these issues is important as disparities in the medical  
13 student population are transmitted into residency and fellowship, as matriculants of U.S. medical  
14 schools comprise the largest pool of applicants to those programs.  
15

## 16 BACKGROUND

### 17 *Current Medical Student and Resident/Fellow Demographics*

18  
19  
20 Racial, ethnic, socioeconomic, and geographic diversity is lacking in the physician workforce. A  
21 2019 study of allopathic medical school programs revealed that, “Hispanic individuals are  
22 underrepresented among medical school applicants and matriculants by nearly 70% relative to the  
23 age-adjusted US population; black male applicants and matriculants, nearly 60%; black female  
24 applicants, nearly 30%; and black female matriculants, nearly 40%. Similarly, [American Indian  
25 and Alaska Native] AIAN individuals are underrepresented by more than 60% among applicants  
26 and matriculants.”<sup>1</sup> Likewise, data from the Association of American Medical Colleges (AAMC)  
27 for academic years 2018-2019 through 2021-22 show little appreciable change in disparities in  
28 socioeconomic status among applicants and matriculants to medical school as determined by  
29 parental occupation and highest level of education completed.<sup>2</sup> Examination of family income of  
30 medical students also indicates a lack of diversity, with approximately three-quarters of medical  
31 school matriculants from the top two household-income quintiles—a distribution that has not  
32 changed in three decades.<sup>3</sup>  
33

34 Furthermore, Shipman et al. reported a 15-year decline in the number of medical students from  
35 rural areas, to fewer than five percent of all incoming medical students in 2017. In addition, fewer  
36 than 0.5 percent of new medical students in 2017 with rural backgrounds were from  
37 underrepresented racial/ethnic minoritized groups in medicine (URM). The authors conclude,

1 “Both URM and non-URM students with rural backgrounds are substantially and increasingly  
2 underrepresented in medical school. If the number of rural students entering medical school were to  
3 become proportional to the share of rural residents in the US population, the number would have to  
4 quadruple.”<sup>4</sup>

5  
6 Current trends, however, have shown positive outcomes stemming from efforts to diversify the  
7 physician workforce in recent years. For allopathic medical schools, the number of Black or  
8 African American students increased by 21.0 percent from 2020 to 2021, which is likely due to a  
9 9.5 percent increase in matriculants (first-year students), with Black or African American men  
10 making the most significant gains. Likewise, matriculants who identify as Hispanic, Latino, or of  
11 Spanish origin increased by 7.1 percent (although American Indian or Alaska Native matriculants  
12 declined by 8.5 percent during this time period).<sup>5</sup> While these gains are important, disparities  
13 remain.

14  
15 Existing disparities in the applicant pool may also be exacerbated as URM applicants match  
16 disproportionately into certain specialties (e.g., primary care fields) versus more competitive and  
17 remunerative specialties (e.g., surgical subspecialties). Overall, these disparities influence the  
18 composition of the physician workforce, which may have repercussions for patient care. For  
19 example, studies have demonstrated that health outcomes are improved when there is racial  
20 concordance between physician and patient.<sup>6</sup>

#### 21 22 *Residency Selection Process*

23  
24 After completion of medical school, nearly all medical students enter a residency program to  
25 continue their training. The competition for these programs can be intense, especially for some  
26 specialties with a limited number of residency positions. While competition between students is  
27 nothing new, the pressure felt by a student to match into a residency program in their specialty of  
28 choice has increased over recent years. A proxy measure for this perceived pressure is an increase  
29 in the number of applications per applicant.

	2017	2021	% change
31 Applicants using Electronic Residency			
32 Application Service (ERAS)	45,395	50,830	+12.0%
33 Average number of applications			
34 per applicant	90	101	+12.3%
35 Average number of applications			
36 received by program (all applicants)	1,206	1,058	-13.3%
37 Average number of applications			
38 received by program (USMGs only)	387	469	+21.2%

39  
40  
41 Source: [AAMC ERAS Statistics website](#)

42  
43 The reasons for this increase in the number of applications per applicant are numerous and likely  
44 include the perception of an increasing number of students applying to a relatively static number of  
45 residency positions, the ever-increasing medical education debt in relation to potential future  
46 earning potential, and lifestyle priorities of younger generations. The increasing number of  
47 applications likely has been exacerbated since the onset of the COVID-19 pandemic, when  
48 residency interviews transitioned to a fully virtual format, thereby allowing students to apply to,  
49 accept, and conduct interviews at a larger number of programs.

1 This trend causes significant pressure on program directors, as the administrative burden to review  
 2 such a large volume of applications per residency position can understandably lead to the use of  
 3 objective metrics such as GPA, standardized test scores, or honor society membership to narrow a  
 4 large pool of applications to a more manageable size for detailed review. Program directors can use  
 5 these and other objective metrics that are reported on the ERAS application as searchable “filters”  
 6 to help determine which candidates to consider.

7  
 8 The National Resident Matching Program (NRMP) program director survey provides insight into  
 9 how program directors review applications and choose to offer interview positions. The 2021  
 10 survey<sup>7</sup> showed the percentage of program directors (all specialties) who cite a specific factor when  
 11 considering whether to offer an interview to an applicant and, for those who cite these factors, their  
 12 average importance on a scale of 1 (not important at all) to 5 (very important). These factors can be  
 13 broken out into those that reflect academic performance and those that reflect personal  
 14 characteristics. The following tables highlight the top five factors identified for each category; see  
 15 Appendix C for graphics illustrating the full data. (Note: The survey response rate was 24.3  
 16 percent.)

17  
 18 *Factors Reflecting Education and Academic Performance*

19

	Percent Citing as a Factor	Average Weight
20 United States Medical Licensing Examination <sup>®</sup>		
21 (USMLE <sup>®</sup> ) Step 1 Score	86.2	3.7
22 Medical Student Performance Evaluation		
23 (MSPE/Dean’s Letter)	85.9	4.0
24 USMLE Step 2 CK Score	78.8	3.8
25 Grades in required clerkships	74.6	3.9
26 Any failed attempt at USMLE	74.1	4.4

27  
 28  
 29 *Factors Reflecting Personal Characteristics*

30

	Percent Citing as a Factor	Average Weight
31 Letters of recommendation in specialty	85.1	4.2
32 Personal statement (overall)	83.8	3.9
33 Diversity characteristics	80.9	4.1
34 Perceived commitment to specialty	79.5	4.3
35 Having overcome significant obstacles	75.5	4.1

36  
 37  
 38 While providing insight into what program directors consider important, this survey only  
 39 tangentially looks at the process of filtering the objective metrics that are available through the  
 40 ERAS application. Other data available in the same survey show that of those programs that use  
 41 USMLE Step 1 scores in determining which applicants to interview, 60 percent use a set target  
 42 score while 41 percent require only a passing score. These numbers are 68 percent and 25 percent,  
 43 respectively, for those programs that screen using USMLE Step 2 CK. Comparable data for  
 44 graduates of osteopathic medical school programs who take the Comprehensive Osteopathic  
 45 Medical Licensing Examination of the United States (COMLEX-USA) Level 1 are 51 percent and  
 46 31 percent, respectively, with COMLEX-USA Level 2-CE scores 57 percent and 23 percent,  
 47 respectively. (Note: These data on USMLE and COMLEX were gathered before conversion of  
 48 USMLE Step 1 and COMLEX Level 1 reporting to pass/fail, which may have impact on program  
 49 interpretation of Step 1/Level 1 and Step 2/Level 2 scores.)

1 It should be noted that while considering academic performance as a factor in choosing whom to  
2 interview, the weight provided to those factors is relatively low compared to some other factors,  
3 with the exception of “any USMLE failure.” Still, a significant number of programs acknowledge  
4 filtering applicants based upon academic performance on standardized exams.

5  
6 One positive sign is that a significant number of program directors use an applicant’s diversity  
7 characteristics as an influence on their decision regarding whether to interview that applicant. This  
8 practice is in alignment with the intent of the Common Program Requirements of the Accreditation  
9 Council for Graduate Medical Education, which state that residency programs and their sponsoring  
10 institutions “must engage in practices that focus on mission-driven, ongoing, systematic  
11 recruitment and retention of a diverse and inclusive workforce of residents, fellows, faculty  
12 members, senior administrative staff members and other relevant members of the academic  
13 community.”<sup>8</sup>

14  
15 Overall, in the 2021 Residency Match, the average number of residency positions for all programs  
16 was nine, for which the average number of applications received by a program was 1,013. Of these  
17 applications, 506 (49.9 percent) were rejected based upon a standardized screening process and 423  
18 (41.8 percent) received an in-depth holistic review.<sup>7</sup>

19  
20 Although these data do not provide information on what the standardized screening process  
21 entailed, one survey of internal medicine program directors (who can receive up to 3,000 applicants  
22 per program) found that USMLE Step 2 CK score, USMLE Step 1 score, and attendance at a  
23 specific medical school were the top three filters used for initial application review.<sup>9</sup>

24  
25 While evidence is limited, there is concern that the use of test scores for this type of initial  
26 screening review may introduce and exacerbate racial and socioeconomic biases into the selection  
27 process. Numerous studies have demonstrated the link between standardized tests—common in K-  
28 12 as well as higher education, along with the medical education continuum—and perpetuation of  
29 racial and socioeconomic bias. It is not the examinations themselves, however, that are the issue  
30 (for example, the Medical College Admission Test, or MCAT, for which the psychometric  
31 literature shows no evidence of bias) but rather the larger and more insidious patterns of systemic  
32 racism, which limit economic success and educational opportunity for minoritized populations.  
33 Finally, and most importantly, research shows that the ability to pass a test is not especially  
34 relevant to one’s ability to provide quality medical care. Emotional intelligence, empathy, and  
35 communication are more valuable to the successful practice of medicine than sheer raw  
36 intelligence. Indeed, as Lucey and Saguil note, “the MCAT exam is designed to measure  
37 applicants’ academic preparation for medical school . . . not . . . to measure or predict their  
38 performance related to other, essential competencies, such as interpersonal skills and  
39 communication, professionalism, and ethical behavior, or to take the place of other attributes that  
40 nonexam aspects of the admissions process evaluate.”<sup>10</sup>

## 41 42 MEDICAL HONOR SOCIETIES AND THEIR ROLE IN RESIDENCY SELECTION

### 43 44 *Background*

45  
46 Similar to concerns about overreliance on standardized testing for advancement in higher education  
47 and medical education, the use of medical honor society membership to screen applicants has  
48 become a subject of increasing scrutiny in recent years. The next section considers three medical  
49 honor societies, their role in the residency selection process, and their respective work to increase  
50 attention to diversity and equity.

### Alpha Omega Alpha

Formed in 1902, Alpha Omega Alpha (ΑΩΑ) has as its mission recognizing high educational achievement, honoring gifted teaching, encouraging the development of leaders in academia and the community, supporting the ideals of humanism, and promoting service to others. With over 200,000 members, ΑΩΑ has chapters in the majority of Liaison Committee on Medical Education (LCME)-accredited medical schools in the US, including all historically Black colleges and universities (HBCUs).

According to the ΑΩΑ website, “Membership in ΑΩΑ may be attained as a medical student, resident, fellow, faculty member, alumni, clinician, or distinguished leader in medicine. Each school may elect up to 20% of the graduating class of students, up to 25 residents/fellows, up to 10 faculty, and three to five alumni, who, based on merit, demonstrate the characteristics of excellent physicians in alignment with ΑΩΑ’s mission and values.”<sup>11</sup> Each chapter makes decisions on proposed members in alignment with that institution’s mission statement. As to diversity of membership, individual chapters may collect those data, but at the national level, the ΑΩΑ collects only member name, school, year of induction, and contact information (along with specialty if provided by the member).

### Gold Humanism Honor Society

The Gold Foundation was founded in 1988 to preserve and elevate the tradition of humanism in health care. To focus and enhance the foundation’s efforts, the Gold Humanism Honor Society (GHHS) was founded in 2002; this international program now comprises 180 chapters and has close to 45,000 members. As stated in a February 7, 2022, memorandum from the Gold Foundation to the AMA (see Appendix A), the GHHS “identifies medical student exemplars of humanism using a validated, peer-nomination system.” No information is available regarding the diversity of its membership.

### Sigma Sigma Phi

Founded in 1921, Sigma Sigma Phi (SSP) is an honorary service organization for osteopathic medical students who are selected by peers. Selection into SSP includes a blinded process that considers a minimum grade requirement and good standing by the medical school and then predominately the contributions made by the candidate to serve the community and humanity. Membership is open to all who apply and meet the minimum standards and is limited to no more than 25 percent of the total population of the student body. Students must have completed at least one semester of classroom work and show a high degree of scholarship and service to the college and/or profession. The SSP website lists 47 chapters as of February 2022. No information is available regarding the diversity of its membership.

### *Role of honor societies in the residency selection process*

Medical honor societies are intended to recognize excellence in academic achievement and other markers of future success as physicians, including scholarship, aptitude for research, humanism, and professionalism. As with other variables previously mentioned, induction into these organizations may be used by program directors and other program personnel to evaluate applicants during the residency selection process; evidence suggests, however, that this factor is not as important as others.

1 In the 2021 NRMP data set, student membership in ΑΩΑ was 13<sup>th</sup> on the list of important factors  
2 of an applicant, cited by 50.6 percent of program directors. Comparable data showed GHHS  
3 membership at 14<sup>th</sup> (50.5 percent) and SSP membership at 22<sup>nd</sup> (21 percent).

4  
5 *Concern about perpetuating disparities*

6  
7 Despite the perceived value of recognizing excellence, medical honor societies have come under  
8 criticism in recent years as potentially exclusionary if not antithetical to efforts to increase equity,  
9 diversity, and belonging (EDB) in medical education and practice. One of the first institutions to  
10 address this concern was the Icahn School of Medicine at Mount Sinai, which in 2018 put a  
11 moratorium on student nominations to ΑΩΑ “because it determined the selection process  
12 discriminates against students of color.”<sup>12</sup> Additionally, in May 2020, the University of California  
13 – San Francisco School of Medicine announced that it was suspending its ΑΩΑ affiliation,  
14 beginning with the class of 2021, stating, in part, that the selection process and membership  
15 limitations may subvert efforts toward increased equity, through a misplaced emphasis on grades,  
16 assessments, and performance and demonstrated bias against non-white students.<sup>13</sup>

17  
18 Evidence to support these concerns exists. One study, published in *JAMA*, found that, “the odds of  
19 ΑΩΑ membership for white students were nearly 6 times greater than those for black students and  
20 nearly 2 times greater than for Asian students” which “may undermine the pipeline of minorities  
21 entering the academic health care workforce.”<sup>14</sup> Other research shows that these trends extend  
22 beyond race/ethnicity to socioeconomic status, as students from backgrounds with lower income  
23 than their peers were less likely to be ΑΩΑ members.”<sup>15</sup> This phenomenon has been described as  
24 an “amplification cascade,” in which “small differences in assessed performance lead to larger  
25 differences in grades and selection for awards,” such that medical students from populations  
26 underrepresented in medicine (UIM) “received approximately half as many honors grades as not-  
27 UIM students and were three times less likely to be selected for honor society membership.”<sup>16</sup>

28  
29 *Addressing disparities in medical honor society selection*

30  
31 ΑΩΑ

32  
33 The upper limit for the percentage of medical student electees from a given chapter rose from 16  
34 percent to 20 percent in October 2020, when the organization changed its constitution. This change  
35 was intended to help reduce the focus on grades as one of the highest determinants of achievement  
36 and instead highlight character attributes such as “trustworthiness, character, caring, knowledge,  
37 scholarship, proficiency in the doctor-patient relationship, leadership, compassion, empathy,  
38 altruism, and servant leadership,” as described on the ΑΩΑ website. The move reflects changes at  
39 many medical schools to eliminate or reduce grading and use a more holistic approach to selection  
40 and advancement.

41  
42 In 2020, ΑΩΑ declared a renewed focus on EDB to mitigate both conscious and unconscious bias  
43 in medical education, including assessments of medical students, resident physicians, and faculty in  
44 the nominations, selection, and election processes for the ΑΩΑ.<sup>17</sup> These principles are reflected in  
45 a statement on the ΑΩΑ website, which notes that the organization “advocates for diversity in all of  
46 its forms – identity, cultural, geographic, experiential, race, ethnicity, gender, age, economic and  
47 social status, physical abilities, aptitude, and religious beliefs, political beliefs, and other  
48 ideologies.” In addition, an ΑΩΑ award recognizes medical schools that “demonstrate exemplary  
49 leadership, innovation, and engagement in fostering an inclusive culture that transforms the ideals  
50 of inclusion, diversity, and equity into successful programs.” This work has also included efforts to  
51 increase the diversity of the ΑΩΑ board. Potential future reforms include the annual reporting of

1 member demographic data; standardized, transparent criteria for selecting members that mitigate  
2 the potential for bias; and increased diversity within organizational leadership. Individual chapters  
3 also have a role to play, through such actions as implementing holistic review of potential members  
4 and annually reviewing newly elected cohorts to ensure that they match the institution's overall  
5 demographics.<sup>18</sup>

## 6 7 GHHS

8  
9 In the memo noted above, the Gold Foundation states, "In the past 23 months, the foundation and  
10 the GHHS have pivoted to respond vigorously to the challenges of COVID-19 and have redoubled  
11 our efforts to address [diversity, equity, and inclusion] in response to the racial reckoning following  
12 George Floyd's murder to support healthcare in which human interests, values, and dignity  
13 predominate." One of the organization's actions in this regard is the 2020-2021 GHHS national  
14 initiative, "Humanism and Healing: Structural Racism and its Impact on Medicine," which was  
15 followed by a virtual conference of the same name hosted by GHHS. In addition, the Gold  
16 Foundation is engaged in a continuous improvement project to determine best practices in diversity  
17 and inclusivity through work with the AAMC and individual GHHS chapters. To further the  
18 collective understanding of this issue, the Foundation and GHHS are also conducting research on  
19 the socio-demographic makeup of GHHS members to determine where differences exist to mitigate  
20 future issues. The results of this analysis are forthcoming.

## 21 22 SSP

23  
24 Related to diversity of applicants or honorees, SSP staff indicate that such data are not tracked at  
25 the national level, but that meetings with chapter presidents and review of the lists of graduating  
26 seniors indicate an appropriate level of diversity. Staff added, "At this point we see no problems  
27 with the selection process. This has not been an issue or a problem with our organization, but if this  
28 is brought up and becomes a concern, we are ready to do whatever needs to be done to address this  
29 situation."

30  
31 That said, it is important to provide context and note that DO schools report even lower levels of  
32 diversity than allopathic schools. Data from the AAMC and the American Association of Colleges  
33 of Osteopathic Medicine Application Services (AACOMAS) show a medical school matriculation  
34 rate of 16.9 percent for URM individuals entering allopathic programs<sup>19</sup> versus 12.1 percent for  
35 osteopathic programs.<sup>20</sup> In short, the "appropriate" level of diversity may be proportionate to the  
36 overall level of diversity in a given field, but that does not mitigate the core issue of inequity.

## 37 38 ATTEMPTS TO OPTIMIZE THE RESIDENCY SELECTION PROCESS

### 39 40 *Standardized Tools*

41  
42 In 2018, the AAMC piloted a standardized video interview (SVI) for emergency medicine  
43 programs, with the intent of providing a useful supplementary tool for selecting applicants to  
44 interview. Its intent was to measure knowledge of professional behaviors along with interpersonal  
45 skills and communication. The SVI, however, was discontinued after three cycles due to lack of  
46 interest among both applicants and program directors. A letter from key stakeholders in emergency  
47 medicine to the AAMC delineated three reasons for the program's dissolution: "lack of evidence to  
48 support the SVI as an assessment tool, uncertainty around the cost of the program, and student  
49 perceptions."<sup>21</sup>

1 In addition to helping program directors decide which applicants to interview, it was hoped that use  
2 of the SVI would reduce bias in the selection process, as the interviews were scored by trained  
3 reviewers not associated with the programs, and the performance of those reviewers was subject to  
4 quality control. During the pilot phase, however, this standardized approach was subverted, in that  
5 the videos were shared with programs in addition to the scores.

6  
7 Other standardized approaches to ranking applicants include CASPer (Computer-based Assessment  
8 for Sampling Personal characteristics (<https://takealtus.com/casper/>), an online, open-response  
9 situational judgment test. CASPer is used by some medical schools in the application process and  
10 has seen limited but increasing use in the residency selection process as well. For the 2022-23  
11 application cycle, ophthalmology<sup>22</sup> is piloting the use of the Altus Suite for Graduate Medical  
12 Education,<sup>23</sup> comprising supplemental applications that include CASPer and two other tests:

- 13 • Snapshot, a one-way video interview designed to assess communication skills, self-  
14 reflection, and motivation for the profession, and
- 15 • Duet, designed to assess alignment of values between an applicant and a program.

16  
17 One article notes the use of CASPer in some general surgery residency programs led to a greater  
18 number of interview offers to applicants from minoritized populations.<sup>24</sup> With growing interest in  
19 ensuring professionalism, communication skills, and emotional intelligence among the physician  
20 workforce, the use of this and similar tools may grow. Currently, these are either used too  
21 infrequently or by so few programs that evidence is lacking to support or refute their use, especially  
22 in the context of equity.

23  
24 Another tool, described in a 2017 study, “validates a process for selecting and weighting  
25 components of the ERAS application and interview day to create a customizable, institution-  
26 specific tool for ranking candidates to postgraduate medical education programs.”<sup>25</sup> The authors do  
27 not discuss whether this tool might have any impact on equity or diversity of applicants.

### 28 29 *Holistic Review*

30  
31 Holistic review of applicants to medical school has been defined as “a flexible, individualized way  
32 of assessing an applicant’s capabilities by which balanced consideration is given to experiences,  
33 attributes, and academic metrics... and, when considered in combination, how the individual might  
34 contribute value as a medical student and future physician.”<sup>26</sup> The authors of a 2021 *NEJM*  
35 Perspective note that holistic review “has been shown to enhance diversity without affecting the  
36 average grade-point average or exam scores for the entering class.”<sup>27</sup> Extending this process,  
37 holistic review has been encouraged to mitigate biases in the residency selection process and shift  
38 focus to factors associated with success in residency

39  
40 While holistic review is viewed favorably by most, its practical use continues to face significant  
41 barriers. Widespread adoption is hampered by the growing number of residency applications,  
42 which exacerbates the administrative burden of reviewing a large volume of applications per open  
43 residency slot and can lead to the use of objective metrics to filter applications. One experiment  
44 seeks to use augmented intelligence and “big data” as tools for holistic screening of applicants to  
45 improve the process at the medical school admissions level. Research at New York University  
46 Grossman School of Medicine used clustering and other statistical techniques to develop profiles or  
47 “signatures” that charted the academic success and trajectory of four different types of applicants—  
48 “risers,” “improvers,” “solids,” and “statics.” Using this approach “can more sensitively uncover  
49 success potential since it takes into account the inherent heterogeneity within the student  
50 population.”<sup>28</sup>

### 1 *Supplemental ERAS Application and Preference Signaling*

2  
3 A recent effort by the AAMC, the Supplemental ERAS Application, seeks to empower applicants  
4 to share more information about themselves using a fair process and driving holistic review in the  
5 context of a high volume of applications. A list of FAQs on the AAMC website (see  
6 <https://students-residents.aamc.org/applying-residencies-eras/supplemental-eras-application-faq>)  
7 indicates that the application is “intended to help programs better identify applicants who are  
8 genuinely interested in their program, and whose interests and experience align well with the  
9 program’s setting, mission, and goals.” The supplemental application comprises three sections: past  
10 experiences about the applicant’s most meaningful work, volunteer or research experiences;  
11 geographic information (by region and by urban/rural setting); and preference signals for specific  
12 programs. It shows promise as a vehicle to communicate information more relevant to residency  
13 selection in these early pilots, but its impact on equity is still unknown. Use of the supplemental  
14 application is growing, from the three fields of dermatology, general surgery, and internal medicine  
15 in 2021 to 16 specialties planning to use it for the 2023 ERAS season, representing more than  
16 2,900 programs.

### 17 *Interview capping*

18  
19  
20 In response to the COVID-19 pandemic, ophthalmology, which participates in the San Francisco  
21 Match and thus has a different match timeline compared to most other specialties, has placed caps  
22 on the number of programs to which a student can apply.<sup>29</sup> This cap is currently at 15 programs for  
23 the 2022-23 application cycle.

### 24 *AMA ChangeMedEd Initiative*

25  
26  
27 The AMA funds a number of collaborative projects to address the transition from medical school to  
28 residency. During its ChangeMedEd<sup>®</sup> 2021 conference, for example, the AMA funded three  
29 submissions out of an initial pool of 135 applicants from institutions or collaborations related to  
30 improving EDB in medical education. One program looks to view medical student evaluation and  
31 assessment through an equity lens to make needed changes that support increased diversity. The  
32 other two aim to help future physicians representing first-generation college attendees and students  
33 from socioeconomically disadvantaged backgrounds make the transition from community college  
34 to medical school in an expeditious and cost-effective way and to provide mentorship and  
35 physician role models to young people considering a career in medicine.<sup>30</sup>

### 36 37 RELEVANT AMA POLICY

38  
39 The AMA has a number of policies related to increased diversity in medical education and  
40 (ultimately) practice, as shown in Appendix B. In particular, edits to D-200.985, “Strategies for  
41 Enhancing Diversity in the Physician Workforce,” are noted in this report’s recommendations, to  
42 extend policy in favor of holistic review from solely medical school admissions to encompass  
43 residency/fellowship program application as well.

### 44 45 CONCLUSION

46  
47 A 2020 article describes the opportunity for reform in the program application, interview, and  
48 matching process occasioned by the pandemic and the potential for positive impact related to EDB:  
49 “This transformation to virtual interviews may allow us to reconsider how our present systems  
50 perpetuate sociocultural biases.” The article also notes, “In the current social climate, it is

1 incumbent on program leaders to consider their own processes to minimize bias—both at a  
2 personal level for their interviewers, but also at a systemic level within the systems we use.<sup>31[00]</sup>

3  
4 A related article from the same authors, in a three-part series on recruiting, interviewing, and  
5 ranking residency program applicants, calls on program leadership to “deliberately incorporate  
6 procedures that ensure equity.”<sup>32</sup> When considering equity, virtual interviews have both pros and  
7 cons. On the plus side, students with less means, who were not as able as their more affluent peers  
8 to travel to multiple interviews, had greater access via virtual interviews. On the other hand,  
9 candidates and programs may not attain a true sense of each other, making ranking difficult and  
10 likely defaulting to familiarity and certainty, as opposed to choosing the best “fit.” This may  
11 perpetuate existing bias. A secondary concern is the potential for a digital divide, with some  
12 candidates lacking the technology and/or expertise with visual rhetoric to ensure a professionally  
13 enhancing video image; this may also exacerbate existing inequities.

14  
15 In their 2020 article, Lucey et al. classify equity in medical assessment and advancement as a  
16 “wicked problem”—in other words, one that is multilayered, complex, complicated, and rife with  
17 inherent conflict and dynamic tensions.<sup>33</sup> Addressing this problem will require continued  
18 innovation and sustained attention.

## 19 20 SUMMARY AND RECOMMENDATIONS

21  
22 The current pressures related to the residency selection process contributed to the use of readily  
23 accessible comparative metrics (e.g., membership in one or more medical honor societies) when  
24 determining which applicants to interview. Overreliance on these “objective” measures can  
25 unintentionally perpetuate inequities and inhibit diversity in medical education. The current  
26 pressures related to the residency selection process contributed to the use of readily accessible  
27 comparative metrics (e.g., membership in one or more medical honor societies) when determining  
28 which applicants to interview. However, measures once viewed as objective can unintentionally  
29 perpetuate inequities and inhibit diversity in medical education. Numerous projects are underway  
30 to optimize the residency selection process, including several sponsored by our AMA. Moving  
31 forward, the profession must develop a resident selection process that is mutually beneficial for  
32 applicants as well as program directors and institutions, while ensuring a commitment to a diverse,  
33 equitable, and inclusive workforce.

34  
35 The Council on Medical Education therefore recommends that the following recommendations be  
36 adopted and the remainder of this report be filed:

- 37  
38 1. That our AMA encourage medical schools, medical honor societies, and  
39 residency/fellowship programs to work toward ethical, equitable, and transparent recruiting  
40 processes, which are made available to all applicants. (New HOD Policy)  
41  
42 2. That AMA Policy D-200.985, “Strategies for Enhancing Diversity in the Physician  
43 Workforce,” be amended by addition and deletion, to read as follows:

44  
45 Our AMA will recommend that medical school admissions committees and  
46 residency/fellowship programs use holistic assessments of ~~admission~~ applicants that take  
47 into account the diversity of preparation and the variety of talents that applicants bring to  
48 their education with the goal of improving health care for all communities. (Modify  
49 Current HOD Policy)

- 1       3. That our AMA advocate for residency and fellowship programs to avoid using objective  
2       criteria available in the Electronic Residency Application Service (ERAS) application  
3       process as the sole determinant for deciding which applicants to offer interviews.  
4       (Directive to Take Action)  
5
- 6       4. That our AMA advocate to remove membership in medical honor societies as a mandated  
7       field of entry on the Electronic Residency Application Service (ERAS)—thereby limiting  
8       its use as an automated screening mechanism—and encourage applicants to share this  
9       information within other aspects of the ERAS application. (Directive to Take Action)  
10
- 11      5. That our AMA advocate for and support innovation in the undergraduate medical  
12      education to graduate medical education transition, especially focusing on the efforts of the  
13      Accelerating Change in Medical Education initiative, to include pilot efforts to optimize  
14      the residency/fellowship application and matching process. (New HOD Policy)  
15
- 16      6. That our AMA monitor use of novel online assessments for sampling personal  
17      characteristics for the purpose of medical school admissions or residency/fellowship  
18      selection and consider their impact on equity and diversity of the physician workforce.  
19      (New HOD Policy)  
20
- 21      7. That AMA Policy D-295.963(5), “Continued Support for Diversity in Medical Education,”  
22      be rescinded, as having been fulfilled through this report:  
23  
24      Our AMA will: ... ~~work with appropriate stakeholders to study reforms to mitigate~~  
25      ~~demographic and socioeconomic inequities in the residency and fellowship selection~~  
26      ~~process, including but not limited to the selection and reporting of honor society~~  
27      ~~membership and the use of standardized tools to rank applicants, with report back to the~~  
28      ~~House of Delegates.~~ (Rescind HOD Policy)

Fiscal note:     \$1,000.

APPENDIX A: MEMORANDUM FROM THE ARNOLD P. GOLD FOUNDATION TO THE AMA, FEBRUARY 7, 2022

This briefing by The Arnold P. Gold Foundation (Gold Foundation) is in response to the request from the American Medical Association (AMA) for information on honor societies in American medical schools as they relate to equity and diversity in medical education and practice.

The Gold Foundation was founded in 1988 to preserve and elevate the tradition of humanism in healthcare (see <https://www.gold-foundation.org/>). As a means to focus and enhance the foundation's efforts, we created the Gold Humanism Honor Society (GHHS) in 2002 (<https://www.gold-foundation.org/programs/ghhs/>), and it now is an international program with 180 chapters and close to 45,000 members.

As an expression of the Gold Foundation itself, and as described below, the GHHS identifies medical student exemplars of humanism using a validated, peer-nomination system ([McCormack et al., 2007](#)). In the past 23 months, the foundation and the GHHS have pivoted to respond vigorously to the challenges of COVID-19 and have redoubled our efforts to address DEI in response to the racial reckoning following George Floyd's murder to support healthcare in which human interests, values, and dignity predominate.

We appreciate that AMA is also working on ensuring diversity and equity in medical education and practice, and we are pleased to share these updates on our work with the AMA House of Delegates. Should you have any questions regarding this response, please let us know.

*Response to AMA regarding the GHHS in American Medical Education and Practice*

The Gold Foundation established the Gold Humanism Honor Society (GHHS) twenty years ago as a signature program to recognize exemplary medical students, residents, and faculty who practice patient-centered care by modeling the qualities of integrity, excellence, compassion, respect, and empathy.

What began in 2002 at only a few medical schools now includes 180 chapters, with more than 3,000 students inducted each year and a total membership that numbers close to 45,000. The GHHS is an active society promoting humanism within medical schools and hospitals. Chapters participate in annual programs such as Thank a Resident Day and Solidarity Week for Compassionate Patient Care, and also undertake individual chapter-initiated projects on their campuses and within their communities. GHHS members are expected to be leaders of humanism on their campus and throughout their careers.

The GHHS leadership structure includes a national Advisory Council of 23 members comprising both the career stages and the broad functions represented in healthcare and academic medicine. The Advisory Council provides guidance and support to the society with committees and working groups, and the GHHS Advisory Council Chair and the Chair-Elect sit on the Gold Foundation Board of Trustees. Medical schools wishing to start a GHHS chapter apply and are thoroughly vetted. As noted, student selection into a GHHS chapter is based on peer nomination using a validated tool (McCormack et al., 2007). The initial group of peer-nominated students is then typically evaluated by a selection committee that considers academic eligibility, program director evaluations, an additional essay, interview, or other indication of the nominee's demonstrated humanism. While GHHS allows for some flexibility, all selection processes are vetted and approved when a medical school applies for a chapter and then reviewed periodically thereafter.

The Gold Foundation has long understood that equity, diversity, and inclusion are part of the very fabric of humanism. This was further spurred by the pandemics of COVID-19 and racism, which have highlighted inequalities and disparities, and compelled a closer look at flaws within our healthcare system. Within this broad context, the Gold Foundation reviewed all its programming through the lens of diversity, equity, inclusion, and anti-racism and has placed explicit emphasis on these issues within our work and strategic plan. (Click to read [Gold Foundation statement on diversity, equity, inclusion and anti-racism](#))

The GHHS has specifically addressed this topic throughout the past two years in a number of ways, including:

1. Engaging a researcher to assess the demographics of GHHS
2. Establishing a National Initiative in 2020-21 for chapters on the impact of structural racism in medicine, which concluded with a large international conference in May 2021 to share what had been learned, as well as steps that schools and systems could take to begin addressing racism in medicine
3. Engaging in a continuous improvement project to determine best practices in diversity and inclusivity through work with the AAMC and individual GHHS chapters.

### *Research on GHHS Demographics*

While racial/ethnic disparities in Alpha Omega Alpha (ΑΩΑ) membership have been documented ([Boatright et al., 2017](#)) and formally responded to by the ΑΩΑ ([Byyny et al., 2020](#)), less is known about how the demographic composition of GHHS reflects the diversity of medical schools nationally. One study of GHHS published in *Academic Medicine* in 2019 demonstrated no difference in the likelihood of Black or African-American medical students being inducted into GHHS compared to white medical students ([Wijesekera, et al., 2019](#)).

Recognizing the importance of more deeply understanding the demographic composition of our members, the Gold Foundation decided in 2020 to reach out to an academic researcher to examine this issue. With the assistance of a Gold Foundation Board of Trustees advisory committee, [Dr. Dowin Boatright](#), MD, MBA, MHS, Assistant Professor of Emergency Medicine and Officer for Diversity and Inclusion at Yale School of Medicine, was identified and agreed to include GHHS in his work.

Dr. Boatright and his research team are examining the association between GHHS membership and several aspects of student identity including race/ethnicity, sex, sexual orientation, and socioeconomic status (SES) in a national cohort of medical students. Although the results are preliminary and currently unpublished, per Dr. Boatright, *so far, they are finding no disparities by sex, sexual orientation, or SES. Additionally, they are finding no difference in the likelihood of membership between Black, Hispanic, and Native American students and white students, but they are seeing some differences between white and Asian students favoring white students. The cause of this disparity is unknown and warrants further examination* (D. Boatright, personal communication, January 19, 2022). Dr. Boatright expects to finalize his analysis and publish later this year, and the Gold Foundation has committed to supporting open access publication of this research.

The Gold Foundation is committed to continuing to transparently assess, understand, and address inequities. To that end, Dr. Boatright notes:

*“Disparities in honor society membership are important to acknowledge and address. Nevertheless, it is unclear if removing honor societies from the ERAS application will solve the underlying problem contributing to these disparities nor ameliorate the downstream implication of these disparities on the physician workforce as medical students could always self-report honor society membership on the ERAS application.*

*Instead, it is likely more important for honor societies, like GHHS, to continuously examine honor society membership for systematic disparities and investigate evidence-based interventions to ensure equity in membership. Moreover, honor societies should be transparent in their findings and make data concerning disparities public. Additionally, as GHHS is committed to doing, the national honor societies should work with local chapters to promote equity and inclusion in membership selection.”* (D. Boatright, personal communication, January 19, 2022)

*GHHS Programmatic Focus on Diversity, Equity, Inclusion and Anti-Racism*

GHHS chapters have undertaken many projects dedicated to serving populations most in need. Recent projects include: Engagement in Justice in Middle Tennessee and the Nation (Vanderbilt), Chicago Street Medicine (University of Chicago, Illinois), The Invisible Minority: Healthcare Disparities in Appalachia (West Virginia University), How We Heal: Applying Structural Competency to Care for Immigrant Communities (UC Riverside), and many others.

The events of 2020 compelled GHHS leadership to create a focused National Initiative for 2020-2021 titled “Humanism and Healing: Structural Racism and its Impact on Medicine.” Chapters were encouraged to use their leadership roles to start or extend conversations about racism and its impact on healthcare in their local communities and beyond, to create space for grieving, processing, and bearing witness around this topic, or to take action in one of many powerful ways that humanism can begin to heal. Chapter projects included such activities as:

- Creation of an anti-racism library collection (Cooper Medical School)
- Video Vignettes of Bias and Racism workshop (Central Michigan University)
- Panel discussion titled “A Calculated Risk: Engaging with Black Patients in Discussion About the Covid-19 Vaccine” (Emory University)
- Panel discussion titled “Fad-vocacy Armchair Empathy: Maintaining Social Justice Momentum” (joint project with Howard University and University of Michigan)
- Panel discussion titled “The Dismissal of Black Suffering” (University of California Irvine)
- Panel discussion titled “Medical Students Partner and Learn from Women Who are Incarcerated” (GHHS member Michelle Harper, MD, and the Ohio State University)

The National Initiative concluded with a large virtual conference on May 6-8, 2021. The conference, hosted by GHHS, included presentations from GHHS members (including panel discussions, workshops, and poster sessions) as well as many other Gold Foundation partners. Keynote presentations included:

- “The Ultimate ‘Anti-Racism Statement’ that Medicine Can Make is to Diversify Our Ranks” (Quinn Capers, MD, Associate Dean for Faculty Diversity and Vice Chair for Diversity and Inclusion, Department of Internal Medicine, UT Southwestern)
- “Partnership with HBCUs: Challenging Systemic Racism in Health Education, A Nursing Story” (Dr. Gina S. Brown, Dean, College of Nursing and Allied Health Sciences at Howard University; Dr. Eileen Sullivan-Marx, Dean of the New York University Rory Meyers College of Nursing; Dr. George Thibault (Ignitor), Immediate Past President of the Josiah Macy Junior Foundation)
- “COVID-19 and the Racial Reckoning” (Dr. Richard I. Levin, President and CEO of the Gold Foundation; Dr. Wayne Riley, President of SUNY Downstate Health Sciences University)

Many insightful and thought-provoking sessions encouraging participants to work toward increased health equity and racial equality were part of the conference, including a panel discussion on advocacy and grassroots change, a film screening of *Black Men in White Coats*, a panel on vaccine deliberation, and many more. The 2021-23 GHHS International Initiative expands on this work, titled “Healing the Heart of Healthcare: Reimagining How We Listen, Connect and Collaborate.” GHHS members are leaders in humanism and will, with Gold Foundation support, continue to work toward greater diversity, equity, and inclusion within healthcare for years to come.

*Continuous Improvement Project to Determine Best Practices in Diversity and Inclusivity*

The Gold Foundation is continually working with GHHS chapters to provide guidance and determine best practices for ensuring that membership is inclusive and diverse. Currently, the GHHS leadership is nearing the conclusion of a biennial check-in with chapters. The 2021 check-in added questions to gather information regarding how each chapter is working to ensure and improve diversity and inclusion within its selection process, including members of the selection committee. The Gold Foundation is concurrently working with the AAMC to consider URM medical student representation within chapters as it compares with each chapter's medical school at large. These efforts will be used to create best practice strategies for GHHS chapters to ensure inclusivity and diversity.

*Summary*

The Gold Foundation established the Gold Humanism Honor Society (GHHS) twenty years ago as a signature program to recognize exemplary medical students, residents, and faculty who practice patient-centered care by modeling the qualities of integrity, excellence, compassion, respect, and empathy. What began in 2002 at only a few medical schools now includes 180 chapters, with more than 3,000 students inducted each year, and a membership that numbers close to 45,000. The Gold Foundation is committed to ensuring that the society is diverse and inclusive.

- Research on GHHS demographic makeup is underway by a Yale research team led by Dr. Dowin Boatright. Publication is expected shortly.
- The 2020-2021 GHHS National Initiative, "Humanism and Healing: Structural Racism and its Impact on Medicine," was followed by a virtual conference of the same name hosted by GHHS.
- The Gold Foundation is engaged in a continuous improvement project to determine best practices in diversity and inclusivity through work with the AAMC and individual GHHS chapters.

APPENDIX B: RELEVANT AMA POLICY

*D-200.985, "Strategies for Enhancing Diversity in the Physician Workforce"*

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
  2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
  3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
  4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
  5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
  6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
  7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
  8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
  9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
  10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
  11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
  12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
  13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.
- (CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21)

*D-295.963, "Continued Support for Diversity in Medical Education"*

Our AMA will: (1) publicly state and reaffirm its stance on diversity in medical education; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; and (5) work with appropriate stakeholders to study reforms to mitigate demographic and socioeconomic inequities in the residency and fellowship selection process, including but not limited to the selection and reporting of honor society membership and the use of standardized tools to rank applicants, with report back to the House of Delegates.

(Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13; Appended: CME Rep. 5, A-21)

*H-350.960, "Underrepresented Student Access to US Medical Schools"*

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.

(Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15)

*D-295.963, "Continued Support for Diversity in Medical Education"*

1. Our American Medical Association will publicly state and reaffirm its stance on diversity in medical education.
2. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.

(Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13)

*H-295.888, "Progress in Medical Education: the Medical School Admission Process"*

1. Our AMA encourages: (A) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (B) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly-educated applicant pool; and (C) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges.

2. Our AMA: (A) will continue to work with the Association of American Medical Colleges (AAMC) and other relevant organizations to encourage improved assessment of personal qualities

in the recruitment process for medical school applicants including types of information to be solicited in applications to medical school; (B) will work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants, including those used by related fields; (C) encourages the development of innovative methodologies to assess personal qualities among medical school applicants; (D) will work with medical schools and other relevant stakeholder groups to review the ways in which medical schools communicate the importance of personal qualities among applicants, including how and when specified personal qualities will be assessed in the admissions process; (E) encourages continued research on the personal qualities most pertinent to success as a medical student and as a physician to assist admissions committees to adequately assess applicants; and (F) encourages continued research on the factors that impact negatively on humanistic and empathetic traits of medical students during medical school.

(CME Rep. 8, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: CME Rep. 3, A-11)

*H-65.952, "Racism as a Public Health Threat"*

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

(Res. 5, I-20)

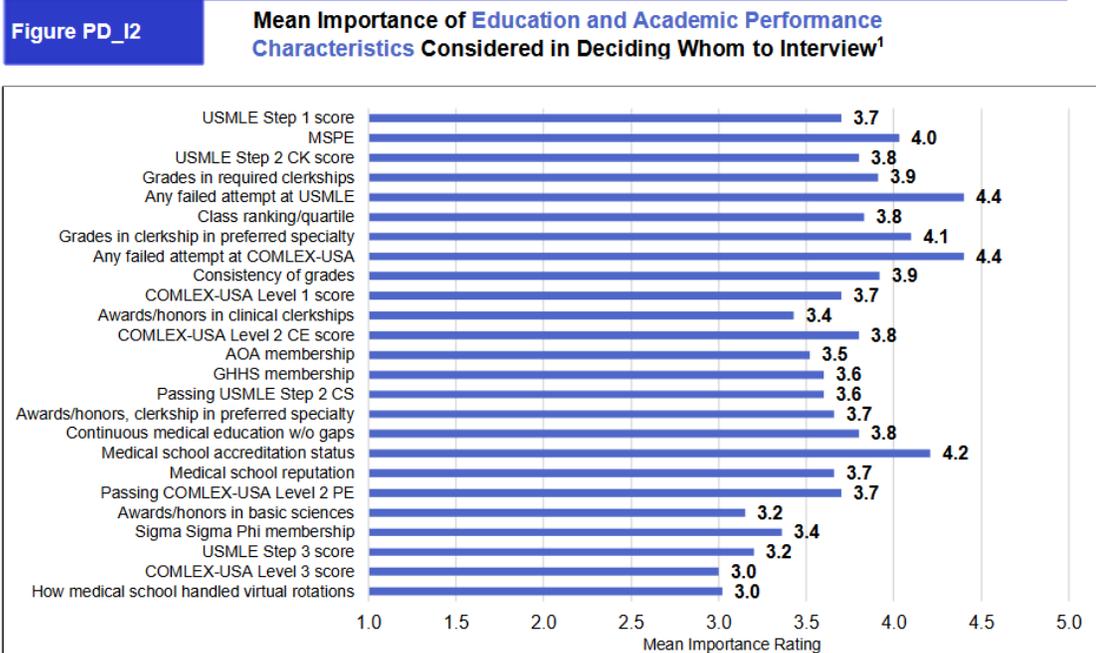
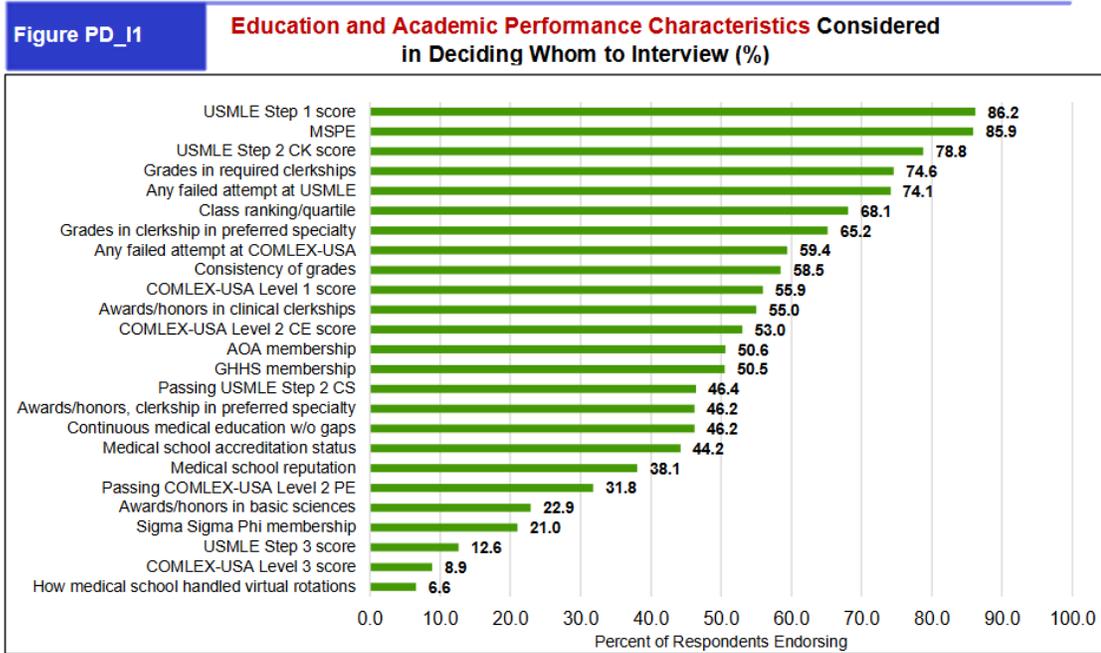
APPENDIX C – NRMP PROGRAM DIRECTOR SURVEY RESULTS

Source:

Results of the 2021 NRMP Program Director Survey.

National Resident Matching Program, August 2021.

<https://www.nrmp.org/wp-content/uploads/2021/11/2021-PD-Survey-Report-for-WWW.pdf>



<sup>1</sup> Rated on a scale of 1 (not at all important) to 5 (very important)

Figure PD\_13

**Personal Characteristics and Other Knowledge of Applicants Considered in Deciding Whom to Interview (%)**

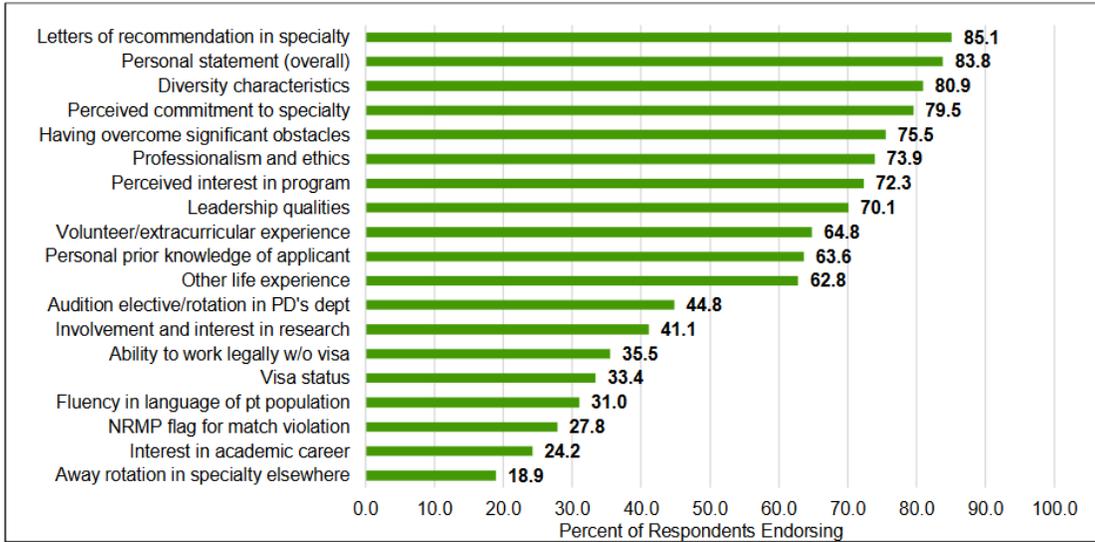
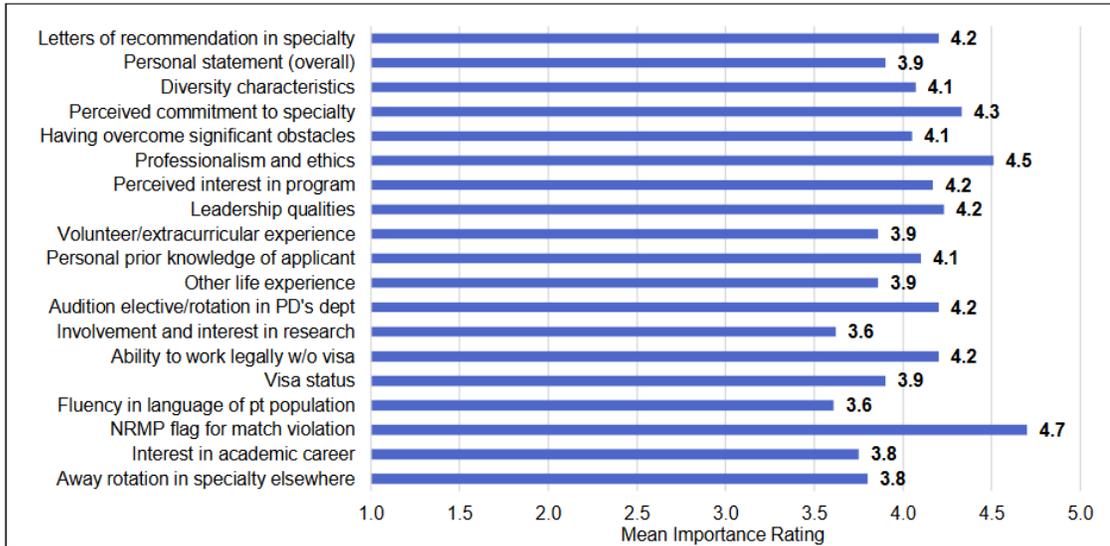


Figure PD\_14

**Mean Importance of Personal Characteristics and Other Knowledge of Applicants Considered in Deciding Whom to Interview<sup>1</sup>**



<sup>1</sup> Rated on a scale of 1 (not at all important) to 5 (very important)

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302  
(1-22)

Introduced by: Medical Student Section

Subject: Expanding Employee Leave to Include Miscarriage and Stillbirth

Referred to: Reference Committee C

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1 *We use the word "women" in the whereas clauses of this resolution when referring to people*  
2 *who have experienced pregnancy to stay consistent with the language of the sources and*  
3 *studies we have cited. However, this is not meant to be exclusionary, and we recognize that all*  
4 *people with a uterus, regardless of gender identity, can experience pregnancy loss.*

5  
6 Whereas, An estimated 26% of all pregnancies and 10% of clinically recognized pregnancies  
7 end in miscarriage<sup>1</sup>; and

8  
9 Whereas, An estimated 24,000 stillbirths occur each year in the United States<sup>2</sup>; and

10  
11 Whereas, It takes at least two weeks to physically recover from a miscarriage and the World  
12 Health Organization (WHO) recommends waiting 6 months after a miscarriage to try again to  
13 get pregnant<sup>3,4</sup>; and

14  
15 Whereas, The risk of severe maternal morbidity is more than four times higher for stillbirths  
16 compared with live birth deliveries<sup>5,6</sup>; and

17  
18 Whereas, In multiple studies, PTSD prevalence ranged from 33.3% to 60% after pregnancy  
19 loss, and the prevalence of anxiety was 20%, the prevalence of depression ranged from 5% to  
20 54% respectively, and 77% of parents experienced emotional and psychological distress  
21 following a stillbirth<sup>7,8,9,10</sup>; and

22  
23 Whereas, Black women and women of lower socioeconomic status are twice as likely to  
24 experience late miscarriage and stillbirth, have limited access to bereavement support, and are  
25 less likely to have access to paid leave time after miscarriage or stillbirth<sup>11</sup>; and

26  
27 Whereas, Paid sick leave has been shown to lead to an increase in employment, reduction in  
28 workforce turnover, and increases in household incomes<sup>12</sup>; and

29  
30 Whereas, The District of Columbia recently expanded bereavement leave to include leave for  
31 loss of a pregnancy, several states, including Illinois, Maryland, Oregon, and Washington, have  
32 bereavement of family leave policies but do not specify if pregnancy loss meets criteria for such  
33 leave, and multiple countries, including New Zealand and South Korea, mandate paid leave for  
34 miscarriages and similar legislation, such as the Support through Loss Act, has been introduced  
35 in the United States<sup>13, 14, 15, 16, 17, 18</sup>; and

36  
37 Whereas, Our AMA supports medical and family leave (H-420.979 and H-405.960) but we do  
38 not have policy that explicitly notes that this should include leave for pregnancy loss; therefore  
39 be it

1 RESOLVED, That our American Medical Association amend Policy H-405.960, "Policies for  
2 Parental, Family, and Medical Necessity Leave," by addition and deletion to read as follows:  
3

4 **Policies for Parental, Family and Medical Necessity Leave H-405.960**

5 AMA adopts as policy the following guidelines for, and encourages the implementation  
6 of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

7 1. Our AMA urges medical schools, residency training programs, medical specialty  
8 boards, the Accreditation Council for Graduate Medical Education, and medical group  
9 practices to incorporate and/or encourage development of leave policies, including  
10 parental, family, and medical leave policies, as part of the physician's standard benefit  
11 agreement.

12 2. Recommended components of parental leave policies for medical students and  
13 physicians include: (a) duration of leave allowed before and after delivery; (b) category  
14 of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for  
15 continuation of insurance benefits during leave, and who pays the premium; (e) whether  
16 sick leave and vacation time may be accrued from year to year or used in advance; (f)  
17 how much time must be made up in order to be considered board eligible; (g) whether  
18 make-up time will be paid; (h) whether schedule accommodations are allowed; ~~and~~ (i)  
19 leave policy for adoption; and (j) leave policy for miscarriage or stillbirth.

20 3. AMA policy is expanded to include physicians in practice, reading as follows: (a)  
21 residency program directors and group practice administrators should review federal law  
22 concerning maternity leave for guidance in developing policies to assure that pregnant  
23 physicians are allowed the same sick leave or disability benefits as those physicians  
24 who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible  
25 enough to allow for coverage without creating intolerable increases in other physicians'  
26 workloads, particularly in residency programs; and (c) physicians should be able to  
27 return to their practices or training programs after taking parental leave without the loss  
28 of status.

29 4. Our AMA encourages medical schools, residency programs, specialty boards, and  
30 medical group practices to incorporate into their parental leave policies a six-week  
31 minimum leave allowance, with the understanding that no parent should be required to  
32 take a minimum leave.

33 5. Residency program directors should review federal and state law for guidance in  
34 developing policies for parental, family, and medical leave.

35 6. Medical students and physicians who are unable to work because of pregnancy,  
36 childbirth, and other related medical conditions should be entitled to such leave and  
37 other benefits on the same basis as other physicians who are temporarily unable to work  
38 for other medical reasons.

39 7. Residency programs should develop written policies on parental leave, family leave,  
40 and medical leave for physicians. Such written policies should include the following  
41 elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and  
42 after delivery; (c) duration of leave allowed after miscarriage or stillbirth; ~~(e)~~(d) category  
43 of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); ~~(d)~~(e)  
44 whether leave is paid or unpaid; ~~(e)~~(f) whether provision is made for continuation of  
45 insurance benefits during leave and who pays for premiums; ~~(f)~~(g) whether sick leave  
46 and vacation time may be accrued from year to year or used in advance; ~~(g)~~(h) extended  
47 leave for resident physicians with extraordinary and long-term personal or family medical  
48 tragedies for periods of up to one year, without loss of previously accepted residency  
49 positions, for devastating conditions such as terminal illness, permanent disability, or  
50 complications of pregnancy that threaten maternal or fetal life; ~~(h)~~(i) how time can be  
51 made up in order for a resident physician to be considered board eligible; ~~(i)~~(j) what  
52 period of leave would result in a resident physician being required to complete an extra

1 or delayed year of training; ~~(j)~~(k) whether time spent in making up a leave will be paid;  
2 and ~~(k)~~(l) whether schedule accommodations are allowed, such as reduced hours, no  
3 night call, modified rotation schedules, and permanent part-time scheduling.

4 8. Our AMA endorses the concept of equal parental leave for birth, stillbirth, miscarriage,  
5 and adoption as a benefit for resident physicians, medical students, and physicians in  
6 practice regardless of gender or gender identity.

7 9. Staffing levels and scheduling are encouraged to be flexible enough to allow for  
8 coverage without creating intolerable increases in the workloads of other physicians,  
9 particularly those in residency programs.

10 10. Physicians should be able to return to their practices or training programs after  
11 taking parental leave, family leave, or medical leave without the loss of status.

12 11. Residency program directors must assist residents in identifying their specific  
13 requirements (for example, the number of months to be made up) because of leave for  
14 eligibility for board certification and must notify residents on leave if they are in danger of  
15 falling below minimal requirements for board eligibility. Program directors must give  
16 these residents a complete list of requirements to be completed in order to retain board  
17 eligibility.

18 12. Our AMA encourages flexibility in residency training programs, incorporating parental  
19 leave and alternative schedules for pregnant house staff.

20 13. In order to accommodate leave protected by the federal Family and Medical Leave  
21 Act, our AMA encourages all specialties within the American Board of Medical  
22 Specialties to allow graduating residents to extend training up to 12 weeks after the  
23 traditional residency completion date while still maintaining board eligibility in that year.

24 14. These policies as above should be freely available online and in writing to all  
25 applicants to medical school, residency or fellowship. (Modify Current HOD Policy); and  
26 be it further  
27

28 RESOLVED, That due to the prevalence of miscarriage and stillbirth and the need for physical  
29 and psychological healing afterwards, our AMA amend Policy H-420.979 "AMA Statement on  
30 Family and Medical Leave," by addition to read as follows:  
31

32 **AMA Statement on Family and Medical Leave H-420.979**

33 Our AMA supports policies that provide employees with reasonable job security and  
34 continued availability of health plan benefits in the event leave by an employee  
35 becomes necessary due to documented medical conditions. Such policies should  
36 provide for reasonable periods of paid or unpaid:

37 (1) medical leave for the employee, including pregnancy; miscarriage, and stillbirth;

38 (2) maternity leave for the employee-mother;

39 (3) leave if medically appropriate to care for a member of the employee's immediate  
40 family, i.e., a spouse or children; and

41 (4) leave for adoption or for foster care leading to adoption. Such periods of leave may  
42 differ with respect to each of the foregoing classifications, and may vary with  
43 reasonable categories of employers. Such policies should encourage voluntary  
44 programs by employers and may provide for appropriate legislation (with or without  
45 financial assistance from government). Any legislative proposals will be reviewed  
46 through the Association's normal legislative process for appropriateness, taking into  
47 consideration all elements therein, including classifications of employees and  
48 employers, reasons for the leave, periods of leave recognized (whether paid or  
49 unpaid), obligations on return from leave, and other factors involved in order to achieve  
50 reasonable objectives recognizing the legitimate needs of employees and employers.

51 (Modify Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 09/20/22

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**RELEVANT AMA POLICY**

**Policies for Parental, Family and Medical Necessity Leave H-405.960**

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity

leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.

4. Our AMA encourages medical schools, residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.

5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.

6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.

7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.

11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.

13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

CCB/CLRPD Rep. 4, A-13, Modified: Res. 305, A-14, Modified: Res. 904, I-14, Modified: Res. 307, A-22

### **AMA Statement on Family and Medical Leave H-420.979**

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy; (2) maternity leave for the employee-mother; (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and (4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.

BOT Rep. A, A-88, Reaffirmed: Sunset Report, I-98, Reaffirmed: CLRPD Rep. 1, A-08, Reaffirmation A-12, Reaffirmed: CMS Rep. 03, A-16

### **Parental Leave H-405.954**

1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.

2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.

3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members.

4. Our AMA: (a) encourages key stakeholders to implement policies and programs that help protect against parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare; and (b) urges key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of health and childcare.

Res. 215, I-16, Appended: BOT Rep. 11, A-19, Appended: Res. 403, A-22

### **Paid Sick Leave H-440.823**

Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; and (3) supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome.

CMS Rep. 03, A-16, Reaffirmed: BOT Rep. 11, A-19

### **FMLA Equivalence H-270.951**

Our AMA will advocate that Family and Medical Leave Act policies include any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship.

Res. 002, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303  
(I-22)

Introduced by: Medical Student Section

Subject: Medical Student Leave Policy

Referred to: Reference Committee C

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1 Whereas, The age of matriculation to medical school has been gradually increasing over the  
2 past several years resulting in an increase in trainees whose peak reproductive years now  
3 overlap partially or entirely with their medical school education<sup>1,2</sup>; and  
4

5 Whereas, As of 2021, over seven percent of graduating medical students had at least one non-  
6 spouse dependent, the majority of whom are likely children<sup>3</sup>; and  
7

8 Whereas, A 2017 single-institution study conducted at the University of South Dakota Sanford  
9 School of Medicine revealed that parenthood may affect an even larger proportion of the student  
10 body at some institutions, as they reported that 25 of 185 (13%) of surveyed students had  
11 become parents or were currently pregnant at the time of the study<sup>4</sup>; and  
12

13 Whereas, Further, more than half of matriculants to medical school now are female, meaning  
14 that these trainees bear the responsibility of coping with the physical, mental, and emotional  
15 changes of pregnancy, labor, and delivery, as well as infant- and child-care, in addition to the  
16 high-stakes, demanding, and often exhausting rigors of medical school<sup>1</sup>; and  
17

18 Whereas, Despite a growing number of medical students pursuing parenthood concomitantly  
19 with medical training, medical schools lag behind other levels of medical training—namely  
20 graduate medical education (GME), aka residency—in providing their trainee-parents supportive,  
21 accessible, and clear parental leave policies; and  
22

23 Whereas, For many medical students, even locating the parental leave policy for their school  
24 can be time-consuming and ultimately fruitless, as many medical schools fail to publish or do  
25 not have—a parental leave policy for their students and a 2019 study sifted through the websites  
26 and student-handbooks of 199 allopathic and osteopathic medical schools in the US<sup>5</sup>; and  
27

28 Whereas, The researchers found that only 65 of 199 (33%) of schools had parental leave  
29 policies available on their website or in their handbook and the policies located were far from  
30 standardized; and  
31

32 Whereas, Only 38 of the 65 (58%) available policies specifically included maternity AND  
33 paternity leave; 23 (35%) policies allowed for maternity leave only; of the 65 available policies,  
34 only 21 (32%) included an option to maintain the student's original graduation date following the  
35 leave; and only 3 (5%) school policies included parental leave for adoption<sup>5</sup>; and  
36

37 Whereas, The stress of having to locate parental leave policies, request and/or advocate for  
38 time off at a school which does not have a published parental leave policy, and, at most  
39 institutions, face the financial and psychological barriers of delay of graduation, and can be  
40 prohibitive to students wanting to begin families during their training; and

1 Whereas, The American Board of Medical Specialties (ABMS), recently recognized the need for  
2 parental leave policies and standardized requirements among all GME institutions nationwide,  
3 citing issues of trainee mental and physical wellness and work-life balance as well as “helping to  
4 narrow the gender gap in [women’s] career advancement” as chief reasons for implementing  
5 such policies<sup>6</sup>; and  
6

7 Whereas, Like medical students, GME matriculants are becoming parents, and having  
8 institutional support for the critical adjustment and bonding period of having a newborn is  
9 important to both mothers and fathers; and  
10

11 Whereas, As of July 2021, the ABMS required that all Accreditation Council for Graduate  
12 Medical Education (ACGME)-accredited residency programs “allow for a minimum of six weeks  
13 away once during training for purposes of parental, caregiver, and medical leave, without  
14 exhausting time allowed for vacation or sick leave and without requiring an extension in training”  
15 <sup>6</sup>; and  
16

17 Whereas, This new requirement indicates a recognition among the medical community that a  
18 visible and non-negotiable parental leave policy is important for the health and well-being of  
19 medical trainees and should be in place at all institutions with graduate medical learners; and  
20

21 Whereas, In fact, the American College of Obstetricians and Gynecologists (ACOG), the leading  
22 experts in pregnancy and transition to parenthood, agree with the ABMS policy, and endorse a  
23 6-week minimum parental leave, which they note has several benefits, including improving  
24 maternal health and decreasing infant mortality, as well as increasing worker morale,  
25 productivity, and likelihood to return to work<sup>7</sup>; and  
26

27 Whereas, Evidence supports the statements made by ABMS and ACOG that parental leave  
28 contributes to the overall health and wellness of new parents and studies have demonstrated  
29 that returning to work too early after childbearing is associated with negative mental health  
30 outcomes for mothers, including an increase in the rate of postpartum depression<sup>8</sup>; and  
31

32 Whereas, Further, a 2018 study found that each additional week of maternity leave (for leaves  
33 totaling <12 weeks) proportionally decreased the risk of experiencing postpartum depression<sup>9</sup>;  
34 and  
35

36 Whereas, In another 2018 study, specifically focused on medical residents, early return to work  
37 translated to a decreased length of breastfeeding (impacting maternal-infant bonding and infant  
38 health), decreased perceived support, and overall decreased satisfaction with parenthood<sup>10,11</sup>;  
39 and  
40

41 Whereas, Although the challenges presented by taking parental leave in medical school are  
42 different than those presented in residency and fellowship, the costs to families—parents and  
43 their children— of being denied parental leave of adequate length and/or being denied the peace  
44 of mind of having an easily accessible, comprehensive parental leave policy available from their  
45 institution, are the same; and  
46

47 Whereas, Thus, it is of paramount importance that our AMA have policies to support them in  
48 advocating on behalf of current and future medical student parents, that they receive the  
49 equitable, appropriate, and visible parental leave policies and benefits already guaranteed to  
50 their trainee counterparts in GME; and

1 Whereas, While current AMA policy (H-405.960) demonstrates a clear intent to include medical  
2 students in these leave protections, a large proportion of the policies which address this  
3 population are not applicable and thus do not offer any true protections to them; therefore be it  
4

5 RESOLVED, That our American Medical Association amend policy H-405.960 "Policies for  
6 Parental, Family and Medical Necessity Leave" by addition and deletion to read as follows:  
7

8 **Policies for Parental, Family and Medical Necessity Leave, H-405.960**

9 AMA adopts as policy the following guidelines for, and encourages the  
10 implementation of, Parental, Family and Medical Necessity Leave for Medical  
11 Students and Physicians:

12 1. Our AMA urges ~~medical schools,~~ residency training programs, medical specialty  
13 boards, the Accreditation Council for Graduate Medical Education, and medical group  
14 practices to incorporate and/or encourage development of leave policies, including  
15 parental, family, and medical leave policies, as part of the physician's standard benefit  
16 agreement.

17 2. Recommended components of parental leave policies for ~~medical students and~~  
18 physicians include: (a) duration of leave allowed before and after delivery; (b)  
19 category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision  
20 is made for continuation of insurance benefits during leave, and who pays the  
21 premium; (e) whether sick leave and vacation time may be accrued from year to year  
22 or used in advance; (f) how much time must be made up in order to be considered  
23 board eligible; (g) whether make-up time will be paid; (h) whether schedule  
24 accommodations are allowed; and (i) leave policy for adoption.

25 3. AMA policy is expanded to include physicians in practice, reading as follows: (a)  
26 residency program directors and group practice administrators should review federal  
27 law concerning maternity leave for guidance in developing policies to assure that  
28 pregnant physicians are allowed the same sick leave or disability benefits as those  
29 physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged  
30 to be flexible enough to allow for coverage without creating intolerable increases in  
31 other physicians' workloads, particularly in residency programs; and (c) physicians  
32 should be able to return to their practices or training programs after taking parental  
33 leave without the loss of status.

34 4. Our AMA encourages medical schools, residency programs, specialty boards, and  
35 medical group practices to incorporate into their parental leave policies a six-week  
36 minimum leave allowance, with the understanding that no parent should be required  
37 to take a minimum leave.

38 5. Residency program directors should review federal and state law for guidance in  
39 developing policies for parental, family, and medical leave.

40 6. Medical students and physicians who are unable to work because of pregnancy,  
41 childbirth, and other related medical conditions should be entitled to such leave and  
42 other benefits on the same basis as other physicians who are temporarily unable to  
43 work for other medical reasons.

44 7. Residency programs should develop written policies on parental leave, family  
45 leave, and medical leave for physicians. Such written policies should include the  
46 following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed  
47 before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental,  
48 unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether  
49 provision is made for continuation of insurance benefits during leave and who pays for  
50 premiums; (f) whether sick leave and vacation time may be accrued from year to year  
51 or used in advance; (g) extended leave for resident physicians with extraordinary and  
52 long-term personal or family medical tragedies for periods of up to one year, without

1 loss of previously accepted residency positions, for devastating conditions such as  
2 terminal illness, permanent disability, or complications of pregnancy that threaten  
3 maternal or fetal life; (h) how time can be made up in order for a resident physician to  
4 be considered board eligible; (i) what period of leave would result in a resident  
5 physician being required to complete an extra or delayed year of training; (j) whether  
6 time spent in making up a leave will be paid; and (k) whether schedule  
7 accommodations are allowed, such as reduced hours, no night call, modified rotation  
8 schedules, and permanent part-time scheduling.

9 8. Medical schools should develop written policies on parental leave, family leave,  
10 and medical leave for medical students. Such written policies should include the  
11 following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed  
12 before and after delivery; (c) extended leave for medical students with extraordinary  
13 and long-term personal or family medical tragedies, without loss of previously  
14 accepted medical school seats, for devastating conditions such as terminal illness,  
15 permanent disability, or complications of pregnancy that threaten maternal or fetal life;  
16 (d) how time can be made up in order for a medical students to be eligible for  
17 graduation without delays; (e) what period of leave would result in a medical student  
18 being required to complete an extra or delayed year of training; and (f) whether  
19 schedule accommodations are allowed, such as modified rotation schedules, no night  
20 duties, and flexibility with academic testing schedules.

21 ~~8- 9.~~ Our AMA endorses the concept of equal parental leave for birth and adoption as  
22 a benefit for resident physicians, medical students, and physicians in practice  
23 regardless of gender or gender identity.

24 ~~9- 10.~~ Staffing levels and scheduling are encouraged to be flexible enough to allow for  
25 coverage without creating intolerable increases in the workloads of other physicians,  
26 particularly those in residency programs.

27 ~~10- 11.~~ Physicians should be able to return to their practices or training programs after  
28 taking parental leave, family leave, or medical leave without the loss of status.

29 ~~11- 12.~~ Residency program directors must assist residents in identifying their specific  
30 requirements (for example, the number of months to be made up) because of leave  
31 for eligibility for board certification and must notify residents on leave if they are in  
32 danger of falling below minimal requirements for board eligibility. Program directors  
33 must give these residents a complete list of requirements to be completed in order to  
34 retain board eligibility.

35 ~~12- 13.~~ Our AMA encourages flexibility in residency training programs and medical  
36 schools incorporating parental leave and alternative schedules for pregnant trainees  
37 house staff.

38 ~~13- 14.~~ In order to accommodate leave protected by the federal Family and Medical  
39 Leave Act, our AMA encourages all specialties within the American Board of Medical  
40 Specialties to allow graduating residents to extend training up to 12 weeks after the  
41 traditional residency completion date while still maintaining board eligibility in that  
42 year.

43 ~~14- 15.~~ These policies as above should be freely available online and in writing to all  
44 current trainees and applicants to medical school, residency or fellowship. (Modify  
45 Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000

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The topic of this resolution is currently under study by the Council on Medical Education.

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**RELEVANT AMA POLICY**

**Policies for Parental, Family and Medical Necessity Leave H-405.960**

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA encourages medical schools, residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on parental leave, family leave, and medical leave

for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.

11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.

13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

Citation: CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22

#### **AMA Statement on Family and Medical Leave H-420.979**

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:

(1) medical leave for the employee, including pregnancy;

(2) maternity leave for the employee-mother;

(3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and

(4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.

BOT Rep. A, A-88, Reaffirmed: Sunset Report, I-98, Reaffirmed: CLRPD Rep. 1, A-08, Reaffirmation A-12, Reaffirmed: CMS Rep. 03, A-16

#### **Parental Leave H-405.954**

1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in

the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.

2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.

3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members.

4. Our AMA: (a) encourages key stakeholders to implement policies and programs that help protect against parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare; and (b) urges key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of health and childcare.

Res. 215, I-16, Appended: BOT Rep. 11, A-19, Appended: Res. 403, A-22

#### **Support for Residents and Fellows During Family and Medical Leave Time H-310.908**

Our AMA encourages specialty boards, the Accreditation Council for Graduate Medical Education and residency review committees to study alternative mechanisms and pathways based on competency evaluation to ensure that individuals who have taken family and medical leave graduate as close to their original completion date as possible.

Res. 307, A-13

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304  
(I-22)

Introduced by: New York

Subject: Protecting State Medical Licensing Boards from External Political Influence

Referred to: Reference Committee C

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1 Whereas, The US and world populations are in the midst of a COVID pandemic; and  
2  
3 Whereas, Hospitals, physicians and other healthcare workers are strained to contain the  
4 outbreak and treat individuals who have contracted COVID; and  
5  
6 Whereas, There has been progress in prevention through means of social isolation, mask  
7 wearing and vaccine prophylaxis; and  
8  
9 Whereas, Medical boards and other regulators across the country are scrambling to penalize  
10 doctors who spread misinformation about vaccines, and promote unproven cures for COVID–  
11 19; and  
12  
13 Whereas, In Idaho, local GOP officials appointed a pathologist who promoted unproven virus  
14 treatments to a local public health board, despite complaints from his peers to state regulators;  
15 and  
16  
17 Whereas, As of this date, Politico reports that medical boards have sanctioned eight physicians  
18 since January 2021 for spreading coronavirus–related misinformation, according to the  
19 Federation of State Medical Boards, which has recommended that health officials consider  
20 action against medical professionals who dispense false medical claims in public forums; and  
21  
22 Whereas, In some cases the responses from some medical boards and state officials have  
23 been stymied by political backlash, including in Tennessee and North Dakota; and  
24  
25 Whereas, Some state boards also lack the legal tools to discipline doctors for sharing unreliable  
26 information via social media, and “With the click of a mouse button, two million people can get  
27 information that's incorrect,” and legal structures developed for the 20th century are, in many  
28 states, not suited to discipline doctors who broadcast misinformation on social media because  
29 the physicians are not directly treating patients, Federation of State Medical Boards CEO  
30 Humayun Chaudhry said; and  
31  
32 Whereas, Misinformation distorts the public debate over vaccines, and has helped create a  
33 market for unproven drugs and treatment against COVID–19, sometimes with harmful side  
34 effects; and  
35  
36 Whereas, Poison centers have recorded [increased numbers of calls related to ivermectin](#) and  
37 [oleandrins](#), with some patients requiring hospitalizations; and

1 Whereas, A recent study in *The New England Journal of Medicine* projected nearly \$2.5 million  
2 in wasteful insurance spending on ivermectin in a single week; and

3  
4 Whereas, When the Medical Board of California started to crack down last year on doctors  
5 spreading misinformation about the coronavirus vaccines, the head of the Board began getting  
6 threats; and

7  
8 Whereas, The federation said that two-thirds of their members had seen an increased number  
9 of complaints related to disinformation in a December 2021 survey; therefore be it

10  
11 RESOLVED, That our American Medical Association work with the Federation of State Medical  
12 Boards and other interested parties to minimize external interference with the independent  
13 functioning of state medical disciplinary and licensing boards. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 09/20/22

**REFERENCES:**

[Medical boards get pushback as they try to punish doctors for Covid misinformation - POLITICO](#)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305  
(I-22)

Introduced by: Illinois

Subject: Encouraging Medical Schools to Sponsor Pipeline Programs to Medicine for Underrepresented Groups

Referred to: Reference Committee C

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1 Whereas, Structural inequities and system-level biases amongst members of admission  
2 committees contribute to non-inclusive environments and result in unequal opportunities for  
3 potential underrepresented minority (URM) applicants to enter the field of medicine; and  
4

5 Whereas, The racial injustices, social tragedies, and health care inequities particularly  
6 highlighted throughout the COVID-19 pandemic reinforce the demand for the implementation of  
7 strategies to support diversity, equity, and inclusion; and  
8

9 Whereas, Middle and high school pipeline programs providing comprehensive educational  
10 support and enrichment have improved test scores and raised school graduation and college  
11 matriculation rates; and  
12

13 Whereas, A study examining undergraduate students found that lower grade achievement of  
14 URM students in pre-health courses may not be fully attributable to the precollege educational  
15 pipeline, and can potentially be improved by academic and social supports during college; and  
16

17 Whereas, Nascent pipeline programs that have connected medical students and high school  
18 students in context specific and culturally relevant manner have the potential to help  
19 underrepresented students with identity formation and perceived achievement goals; and  
20

21 Whereas, Outreach and pipeline programs targeting students underrepresented in medicine are  
22 beneficial to the participants and the community by 1) exposing underserved and  
23 underrepresented youth to medicine, 2) improving their candidacy by providing opportunities for  
24 research, shadowing, and volunteering, and 3) increasing diversity in healthcare; and  
25

26 Whereas, Engaging with such programs provides value to the medical schools by 1) fulfilling  
27 accreditation requirements, 2) granting medical students the opportunity to interact with the  
28 surrounding community, and 3) serving as a source of qualified applicants who are  
29 underrepresented in medicine; therefore be it  
30

31 RESOLVED, That our American Medical Association urge medical schools to develop or  
32 expand the reach of existing pipeline programs for underrepresented middle school, high school  
33 and college aged students to motivate them to pursue and prepare them for a career in  
34 medicine (New HOD Policy); and be it further  
35

36 RESOLVED, That our AMA encourage collegiate programs to establish criteria by which  
37 completion of such programs will secure an interview for admission to the sponsoring medical  
38 school (New HOD Policy); and be it further

1 RESOLVED, That our AMA recommend that medical school pipeline programs for  
2 underrepresented students be free-of-charge or provide financial support with need-based  
3 scholarships and grants (New HOD Policy); and be it further  
4

5 RESOLVED, That our AMA encourage all physicians to actively participate in programs and  
6 mentorship opportunities that help expose underrepresented students to potential careers in  
7 medicine. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 09/27/22

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#### RELEVANT AMA POLICY

##### **Underrepresented Student Access to US Medical Schools H-350.960**

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students; (3) recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; and (5) recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations. Citation: Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15; Appended: CME Rep. 5, A-21

##### **Strategies for Enhancing Diversity in the Physician Workforce D-200.985**

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.

4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

Citation: CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21

#### **Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979**

Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.

- (2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.
- (3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.
- (4) Increasing the supply of minority health professionals.
- (5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.
- (6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.
- (7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.
- (8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.

Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306  
(I-22)

Introduced by: New York

Subject: Increased Credit for Continuing Medical Education Preparation

Referred to: Reference Committee C

1 Whereas, Our American Medical Association offers a maximum of only two hours of Category 2  
2 credit for the preparation and presentation of a one-hour continuing medical education (CME)  
3 program for physicians; and  
4

5 Whereas, A physician may need many more hours — often as many as 50 — to create a one-  
6 hour CME program of acceptable quality and utility for his or her peers; and  
7

8 Whereas, The small number (just two hours) of Category 2 credits dissuades many physicians  
9 from taking on the task of preparing and presenting CME programs; therefore be it  
10

11 RESOLVED, That our American Medical Association collaborate with the Accreditation Council  
12 on Continuing Medical Education (ACCME), to allow physicians to claim an amount of Category  
13 1 CME credits that more accurately reflects the hours they spend on preparing and presenting  
14 CME programs to a maximum of four (4) Category 1 CME hours. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 09/27/22

**RELEVANT AMA POLICY**

**Support for Development of Continuing Education Programs for Primary Care Physicians in Non-Academic Settings H-295.926**

The AMA: (1) supports development, where appropriate, of programs of education for medical students and faculty in non-academic settings, making use of telecommunications as needed; (2) encourages that medical schools provide faculty development programs that are designated for *AMA PRA Category 1 Credit*"; and (3) encourages that teaching continue to be accepted for *AMA PRA Category 2 Credit*" when not designated for *AMA PRA Category 1 Credit*" .

Citation: (CME Rep. 3, A-94; Reaffirmed: CME Rep. 2, A-05; Modified: CME Rep. 1, A-15)

**Unification of Education Credits H-300.976**

It is the policy of the AMA to develop, in cooperation with national specialty organizations and state medical associations, uniform nationwide standards for continuing medical education credits recognized by all medical associations and specialty societies.

Citation: Res. 102, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 01, A-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307  
(1-22)

Introduced by: Arkansas

Subject: Fair Compensation of Residents and Fellows

Referred to: Reference Committee C

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- 1 Whereas, Residents and Fellows form the backbone and the future of our healthcare system (1,  
2 2); and  
3  
4 Whereas, Residents and Fellows are usually under heavy financial debt of student loans  
5 accumulated over eight years of intense college and medical school education (3, 4); and  
6  
7 Whereas, Residents and Fellows, having to be employed for 3-7 years, who are dependent on  
8 their salary for those years for daily living and payment of student debt (5); and  
9  
10 Whereas, The Centers for Medicare & Medicaid Services (CMS) provides direct and indirect  
11 compensation for Residents and Fellows to cover their cost to the institution, and usually in  
12 excess (6, 7, 8, 9); and  
13  
14 Whereas, CMS payments per resident/fellow vary widely exacerbating financial strain for some  
15 training institutions (8, 9); and  
16  
17 Whereas, Residents and Fellows provide patient care services that are mission critical and an  
18 important source of revenue for their institutions (10, 11, 12, 13); and  
19  
20 Whereas, Current Resident and Fellow compensation, approaching minimum wage, is  
21 inadequate and unfair from all reasonable perspectives (14, 15, 16, 17); and  
22  
23 Whereas, The Arkansas Delegation believes that our AMA must advocate on behalf of its most  
24 vulnerable and most important constituency; therefore be it  
25  
26 RESOLVED, That our American Medical Association advocate for increasing the Resident and  
27 Fellow salary substantially (by at least 50% of current levels or better), along with all benefits  
28 including retirement benefits with institutional match as available to institutional administration,  
29 and peg yearly salary increase thereafter to COLA (Directive to Take Action); and be it further  
30  
31 RESOLVED, That our AMA advocate for enhanced and uniform payment per resident and  
32 fellow for all educational and training institutions across the country (Directive to Take Action);  
33 and be it further  
34  
35 RESOLVED, That our AMA amend the Residents and Fellows Bill of Rights: H-310.912 (last  
36 modified 2022) accordingly. (Modify Current HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 09/27/22

References:

1. <https://www.ama-assn.org/medical-residents/residency-life/vital-role-residents-play-health-care-during-pandemic>);
2. van der Leeuw et al. BMC Medicine 2012, 10:65 <http://www.biomedcentral.com/1741-7015/10/65>
3. <https://educationdata.org/average-medical-school-debt>
4. <https://www.nerdwallet.com/article/loans/student-loans/average-medical-school-debt>
5. <https://mededits.com/residency-admissions/timeline-length/>
6. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME>
7. <https://www.fiercehealthcare.com/practices/study-suggests-medicare-overpaying-1-28b-annually-to-support-residency-programs#:~:text=The%20study%20found%20GME%20payment,the%20%24150%2C000%20per%20resident%20rate.>
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9. Physician Workforce: Caps on Medicare-Funded Graduate Medical Education at Teaching Hospitals. GAO-21-391. Published: May 21, 2021. Publicly Released: Jun 21, 2021.
10. <https://doi.org/10.1371/journal.pone.0258633>
11. <https://thejns.org/downloadpdf/journals/j-neurosurg/135/1/article-p164.pdf>
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13. <https://link.springer.com/article/10.1007/s10198-021-01368-z>
14. <https://www.beckershospitalreview.com/leadership/how-medical-resident-salaries-compare-to-other-entry-level-pay.html>
15. <https://www.beckershospitalreview.com/compensation-issues/physician-assistant-salary-by-state-alaska-is-no-1-at-150-430.html>
16. <https://www.beckershospitalreview.com/compensation-issues/nurse-practitioner-salary-by-state-california-is-no-1-at-145-970.html>
17. <https://www.beckershospitalreview.com/compensation-issues/rn-average-hourly-wage-salary-for-all-50-states-calif-tops-list-at-120k.html>

## RELEVANT AMA POLICY

### Residents and Fellows' Bill of Rights H-310.912

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.
8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:

## **RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS**

Residents and fellows have a right to:

### **A. An education that fosters professional development, takes priority over service, and leads to independent practice.**

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

### **B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.**

With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.

### **C. Regular and timely feedback and evaluation based on valid assessments of resident performance.**

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

### **D. A safe and supportive workplace with appropriate facilities.**

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

### **E. Adequate compensation and benefits that provide for resident well-being and health.**

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their

training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

**F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.**

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

**G. Due process in cases of allegations of misconduct or poor performance.**

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

**H. Access to and protection by institutional and accreditation authorities when reporting violations.**

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.

10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).

11. The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.

12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles.

Citation: CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19; Modified: Res. 304, A-21; Modified: Res. 305, A-21; Modified: BOT Rep. 18, I-21; Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308  
(1-22)

Introduced by: American College of Radiology, American Academy of Pediatrics, Maryland, Radiological Society of North America, Society of Interventional Radiology, American Society for Radiation Oncology, American Institute of Ultrasound in Medicine, American Roentgen Ray Society, American College of Radiation Oncology, Association of University Radiologists, American College of Nuclear Medicine, American Society of Neuroradiology, Society of Nuclear Medicine and Molecular Imaging, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Paid Family/Medical Leave in Medicine

Referred to: Reference Committee C

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- 1 Whereas, The mission of the American Medical Association is “to promote the art and science  
2 of medicine and the betterment of public health...by representing physicians with a unified voice  
3 in courts and legislative bodies across the nation, removing obstacles that interfere with patient  
4 care...and driving the future of medicine to tackle the biggest challenges in health care.” [1]; and  
5
- 6 Whereas, The federal Family Medical Leave Act (FMLA) of 1993 requires private employers  
7 with 50 or more employees within 75 miles of the eligible employee’s worksite and all public  
8 agencies to provide eligible employees\* up to 12 work weeks of unpaid leave in a 12-month  
9 period for the birth and care of a newborn, adopted child, or foster child, as well as for care of  
10 oneself or an immediate family member with a serious health condition [2]\*\*; and  
11
- 12 Whereas, “The American Academy of Pediatrics has publicly endorsed 12 weeks of paid family  
13 leave based upon the scientific evidence of benefits to the child.” [3]; and  
14
- 15 Whereas, Since April 2022, the American College of Radiology (ACR) “recommends that  
16 diagnostic radiology, interventional radiology, radiation oncology, medical physics, and nuclear  
17 medicine practices, departments and training programs strive to provide 12 weeks of paid  
18 family/medical leave in a 12-month period for its attending physicians, medical physicists, and  
19 members in training as needed.” [4]; and  
20
- 21 Whereas, The business case for paid family/medical leave is compelling, with “significant  
22 rewards that outweigh the costs: improved employee retention; better talent attraction;  
23 reinforced values; improved engagement, morale, and productivity; and enhanced brand  
24 equity.” [5]. For instance, research has shown that the average time to fill a vacant position is 42  
25 days, and the average cost of a hire is at least 21% of annual salary [6]; and  
26
- 27 Whereas, While the most frequent argument against paid family/parental leave is “we can’t  
28 afford it,” there are ways to mitigate the cost of paid leave. Some states offer a paid leave  
29 program that can be used to offset the cost to a practice [7]. Short-term disability insurance for  
30 all practice members can also protect a practice from unexpected medical issues. Lastly,  
31 practices can consider creating an account that is funded annually for circumstances requiring  
32 family/medical leave [6]; therefore be it

1 RESOLVED, That our American Medical Association policy H-405.960 "Policies for Parental  
2 Family and Medical Necessity Leave" be amended by addition and deletion to read as follows:  
3

4 AMA adopts as policy the following guidelines for, and encourages the  
5 implementation of, Parental, Family and Medical Necessity Leave for Medical  
6 Students and Physicians:

7 1. Our AMA urges medical schools, residency training programs, medical specialty  
8 boards, the Accreditation Council for Graduate Medical Education, and medical group  
9 practices to incorporate and/or encourage development of leave policies, including  
10 parental, family, and medical leave policies, as part of the physician's standard benefit  
11 agreement.

12 2. Recommended components of parental leave policies for medical students and  
13 physicians include: (a) duration of leave allowed before and after delivery; (b)  
14 category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision  
15 is made for continuation of insurance benefits during leave, and who pays the  
16 premium; (e) whether sick leave and vacation time may be accrued from year to year  
17 or used in advance; (f) how much time must be made up in order to be considered  
18 board eligible; (g) whether make-up time will be paid; (h) whether schedule  
19 accommodations are allowed; and (i) leave policy for adoption.

20 3. AMA policy is expanded to include physicians in practice, reading as follows: (a)  
21 residency program directors and group practice administrators should review federal  
22 law concerning maternity leave for guidance in developing policies to assure that  
23 pregnant physicians are allowed the same sick leave or disability benefits as those  
24 physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged  
25 to be flexible enough to allow for coverage without creating intolerable increases in  
26 other physicians' workloads, particularly in residency programs; and (c) physicians  
27 should be able to return to their practices or training programs after taking parental  
28 leave without the loss of status.

29 4. Our AMA encourages medical schools, residency programs, specialty boards, and  
30 medical group practices to incorporate into their parental, family, and medical  
31 necessity leave policies a ~~six~~-twelve-week minimum leave allowance, with the  
32 understanding that no ~~parent~~ individual should be required to take a minimum leave.

33 5. Our AMA recommends that medical practices, departments and training programs  
34 strive to provide 12 weeks of paid parental, family and medical necessity leave in a  
35 12-month period for their attending and trainee physicians as needed.

36 ~~56.~~ Residency program directors should review federal and state law for guidance in  
37 developing policies for parental, family, and medical leave.

38 ~~67.~~ Medical students and physicians who are unable to work because of pregnancy,  
39 childbirth, and other related medical conditions should be entitled to such leave and  
40 other benefits on the same basis as other physicians who are temporarily unable to  
41 work for other medical reasons.

42 ~~78.~~ Residency programs should develop written policies on parental leave, family  
43 leave, and medical leave for physicians. Such written policies should include the  
44 following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed  
45 before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental,  
46 unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether  
47 provision is made for continuation of insurance benefits during leave and who pays for  
48 premiums; (f) whether sick leave and vacation time may be accrued from year to year  
49 or used in advance; (g) extended leave for resident physicians with extraordinary and  
50 long-term personal or family medical tragedies for periods of up to one year, without  
51 loss of previously accepted residency positions, for devastating conditions such as  
52 terminal illness, permanent disability, or complications of pregnancy that threaten

1 maternal or fetal life; (h) how time can be made up in order for a resident physician to  
2 be considered board eligible; (i) what period of leave would result in a resident  
3 physician being required to complete an extra or delayed year of training; (j) whether  
4 time spent in making up a leave will be paid; and (k) whether schedule  
5 accommodations are allowed, such as reduced hours, no night call, modified rotation  
6 schedules, and permanent part-time scheduling.

7 ~~89.~~ Our AMA endorses the concept of equal parental leave for birth and adoption as a  
8 benefit for resident physicians, medical students, and physicians in practice  
9 regardless of gender or gender identity.

10 ~~910.~~ Staffing levels and scheduling are encouraged to be flexible enough to allow for  
11 coverage without creating intolerable increases in the workloads of other physicians,  
12 particularly those in residency programs.

13 ~~4011.~~ Physicians should be able to return to their practices or training programs after  
14 taking parental leave, family leave, or medical leave without the loss of status.

15 ~~4412.~~ Residency program directors must assist residents in identifying their specific  
16 requirements (for example, the number of months to be made up) because of leave  
17 for eligibility for board certification and must notify residents on leave if they are in  
18 danger of falling below minimal requirements for board eligibility. Program directors  
19 must give these residents a complete list of requirements to be completed in order to  
20 retain board eligibility.

21 ~~4213.~~ Our AMA encourages flexibility in residency training programs, incorporating  
22 parental leave and alternative schedules for pregnant house staff.

23 ~~4314.~~ In order to accommodate leave protected by the federal Family and Medical  
24 Leave Act, our AMA encourages all specialties within the American Board of Medical  
25 Specialties to allow graduating residents to extend training up to 12 weeks after the  
26 traditional residency completion date while still maintaining board eligibility in that  
27 year.

28 ~~4415.~~ These policies as above should be freely available online and in writing to all  
29 applicants to medical school, residency or fellowship. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 09/30/22

The topic of this resolution is currently under study by the Council on Medical Education

**REFERENCES:**

- (1) American Medical Association. About. Accessed June 14, 2022. <https://www.ama-assn.org/about>
- (2) US Department of Labor. Wage and Hour Division (WHD). Family and Medical Leave Act. Accessed February 25, 2019. <https://www.dol.gov/whd/fmla/>
- (3) Riano NS, Linos E, Accurso EC, Sung D, Linos E, Simard JF, Mangurian C. Paid Family and Childbearing Leave Policies at Top US Medical Schools. *JAMA*. 2018 Feb 13;319(6):611-614. doi: 10.1001/jama.2017.19519. PMID: 29450516; PMCID: PMC5838606.
- (4) Resolution#13: Paid family/medical leave in radiology, interventional radiology and radiation oncology. Accessed May 6, 2022. [https://www.aawr.org/Portals/10/Focus/Spring%202022/AAWR.ResolutionPaidFamilyMedicalLeaveFor2022.FINAL\\_%20\(1\).pdf?ver=dptncUDp-LiVfKBSp7XrZw%3d%3d](https://www.aawr.org/Portals/10/Focus/Spring%202022/AAWR.ResolutionPaidFamilyMedicalLeaveFor2022.FINAL_%20(1).pdf?ver=dptncUDp-LiVfKBSp7XrZw%3d%3d)
- (5) Huang G. The business case for paid leave at your company. *Forbes*. Available at: <https://www.forbes.com/sites/georgenehuang/2017/02/28/the-business-case-for-paid-family-leave-at-your-company/#2c14371e4eae>. Published February 28, 2017. Accessed August 13, 2018.
- (6) Arleo EK. Paid family/medical leave: That's great - What's next? *Clin Imaging*. 2020 May;61:A1-A3. doi: 10.1016/j.clinimag.2020.02.004. Epub 2020 Feb 20. PMID: 32115344.
- (7) State Paid Family and Medical Leave Insurance Laws, as of January 2021: California, New Jersey, Rhode Island, New York, District of Columbia, Washington, Massachusetts, Connecticut, Oregon. <https://www.nationalpartnership.org/our-work/resources/economic-justice/paid-leave/state-paid-family-leave-laws.pdf>. Accessed July 14, 2021.

\*Defined, per FMLA, as “Employees are eligible for leave if they have worked for their employer at least 12 months, at least 1,250 hours over the past 12 months, and work at a location where the company employs 50 or more employees within 75 miles.” [3]

\*\*Additional reasons under the FMLA include:

- any qualifying exigency arising out of the fact that the employee’s spouse, son, daughter, or parent is a covered military member on “covered active duty”; and
- to care for a covered service member with a serious injury or illness if the eligible employee is the service member’s spouse, son, daughter, parent, or next of kin (leave entitlement is up to 26 weeks in a 12-month period). [2]

\*\*\*Defined, as “the problem of employees who are not fully functioning in the workplace because of an illness, injury or other condition. Even though the employee may be physically at work, he may not be able to fully perform his duties and is more likely to make mistakes on the job.” [12]

## RELEVANT AMA POLICY

### **Policies for Parental, Family and Medical Necessity Leave H-405.960**

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA encourages medical schools, residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without

creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.

11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.

13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

Citation: CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22

#### **AMA Statement on Family and Medical Leave H-420.979**

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy;

(2) maternity leave for the employee-mother;

(3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and

(4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.

Citation: BOT Rep. A, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: CMS Rep. 03, A-16;

#### **Parental Leave H-405.954**

1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.

2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.

3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members.

4. Our AMA: (a) encourages key stakeholders to implement policies and programs that help protect against parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare; and (b) urges key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of health and childcare.

Citation: Res. 215, I-16; Appended: BOT Rep. 11, A-19; Appended: Res. 403, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309  
(I-22)

Introduced by: Resident and Fellow Section

Subject: Bereavement Leave for Medical Students and Physicians

Referred to: Reference Committee C

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- 1 Whereas, The aging of the U.S. population stands to increase the number of senior citizens  
2 dying every year, and the bereavement felt by their loved ones in all sectors, including medical  
3 students and physicians; and<sup>1</sup>  
4
- 5 Whereas, Medical students and physicians also suffer emotional trauma related to reproductive  
6 complications such as pregnancy loss, as 10% of known pregnancies end in miscarriage or  
7 stillbirth,<sup>2</sup> and many students and physicians suffer failure of assisted reproductive technology  
8 and adoption; and  
9
- 10 Whereas, States of mental and emotional distress have been associated with unsafe patient  
11 care, as demonstrated in a 2016 systematic review that found poor wellbeing and moderate to  
12 high levels of burnout in healthcare staff were associated, in the majority of studies reviewed,  
13 with poor patient safety outcomes such as medical errors; and<sup>3</sup>  
14
- 15 Whereas, The Fair Labor Standards Act and the Family and Medical Leave Act do not require a  
16 U.S. employer to provide an employee with paid leave to attend a funeral, grieve a family  
17 member, or grieve a pregnancy loss; and<sup>4</sup>  
18
- 19 Whereas, Only 60% of private-sector workers were granted paid bereavement leave in 2012,  
20 per a report from the Bureau of Labor Statistics; and<sup>5</sup>  
21
- 22 Whereas, Other countries have instituted bereavement leave policies, such as Canada and  
23 France which guarantee three to five days of bereavement leave to employees suffering the  
24 loss of a close family member,<sup>6</sup> and India and New Zealand which have pregnancy loss laws  
25 entitling Indian women to 6 weeks of paid leave and New Zealand women and their partners to  
26 3 days of paid leave; and<sup>7</sup>  
27
- 28 Whereas, AMA policy H-405.960, "Policies for Parental, Family and Medical Necessity Leave,"  
29 sets precedent for the AMA providing detailed recommendations for medical schools, residency  
30 programs, medical specialty boards, the ACGME, and medical group practices to provide leave  
31 benefits to their medical students and physicians; therefore be it

1 RESOLVED, That our American Medical Association support bereavement leave for medical  
2 students and physicians:

- 3 1. Our AMA urges medical schools, residency and fellowship training  
4 programs, medical specialty boards, the Accreditation Council for  
5 Graduate Medical Education, and medical group practices to incorporate and/or  
6 encourage development of bereavement leave policies as part of the physician's  
7 standard benefit agreement.
- 8 2. Recommended components of bereavement leave policies for medical students and  
9 physicians include:
  - 10 a. whether cases requiring extensive travel qualify for additional days of leave  
11 and, if so, how many days;
  - 12 b. policy and duration of leave for an event impacting pregnancy or fertility  
13 including pregnancy loss, an unsuccessful round of intrauterine insemination or of  
14 an assisted reproductive technology procedure, a failed adoption arrangement, a  
15 failed surrogacy arrangement, or an event that impacts pregnancy or fertility;
  - 16 c. whether leave is paid or unpaid;
  - 17 d. whether obligations and time must be made up; and
  - 18 e. whether make-up time will be paid.
- 19 3. Our AMA encourages medical schools, residency and fellowship programs,  
20 specialty boards, specialty societies and medical group practices to incorporate into  
21 their bereavement leave policies a three-day minimum leave, with the understanding  
22 that no physician or medical student should be required to take a minimum leave.
- 23 4. Medical students and physicians who are unable to work beyond the defined  
24 bereavement leave period because of physical or psychological stress, medical  
25 complications of pregnancy loss, or another related reason should refer to their  
26 institution's sick leave policy, family and medical leave policy, and other benefits on the  
27 same basis as other physicians who are temporarily unable to work for other reasons.
- 28 5. Our AMA supports the concept of equal bereavement leave for pregnancy loss and  
29 other such events impacting fertility in a physician or their partner as a benefit for  
30 medical students and physicians regardless of gender or gender identity.
- 31 6. Staffing levels and scheduling are encouraged to be flexible enough to allow for  
32 coverage without creating intolerable increases in the workloads of other physicians,  
33 particularly those in residency programs.
- 34 7. These guidelines as above should be freely available online and in writing to all  
35 applicants to medical school, residency, or fellowship. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000

Received: 09/30/22

The topic of this resolution is currently under study by the Council on Medical Education

**References:**

1. Jordan J. (2020, June 25). 65 and Older Population Grows Rapidly as Baby Boomers Age. United States Census Bureau. <https://www.census.gov/newsroom/press-releases/2020/65-older-population-grows.html>. Retrieved September 10, 2021.
2. Wilcox AJ, Weinberg CR, O'Connor JF, et al. Incidence of early loss of pregnancy. *N Engl J Med.* 1988 Jul 28;319(4):189-94.
3. Hall LH, Johnson J, Watt I, et al. Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review. *PLoS One.* 2016;11(7):e0159015. doi:10.1371/journal.pone.0159015. Published July 8, 2016. Retrieved September 10, 2021
4. Funeral leave. United States Department of Labor. <https://www.dol.gov/general/topic/benefits-leave/funeral-leave>. Accessed September 10, 2021.
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6. Tveten J. When it comes to bereavement leave, the U.S. is unspeakably cruel. *Salon.* [https://www.salon.com/2019/09/30/when-it-comes-to-bereavement-leave-the-u-s-is-unspeakably-cruel\\_partner/](https://www.salon.com/2019/09/30/when-it-comes-to-bereavement-leave-the-u-s-is-unspeakably-cruel_partner/). Published August 12, 2020. Accessed September 17, 2021.
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## RELEVANT AMA POLICY

### H-405.960 Policies for Parental, Family and Medical Necessity Leave

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3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
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## **Reference Committee F**

### **BOT Report(s)**

- 02 Further Action to Respond to the Gun Violence Public Health Crisis
- 07 Transparency of Resolution Fiscal Notes
- 08 The Resolution Committee as a Standing Committee of the House
- 09 Employed Physicians

### **CLRPD Report(s)**

- 01 Senior Physicians Section Five-Year Review

### **HOD Comm on Compensation of the Officers**

- 01 Report of the HOD Committee on Compensation of the Officers

### **Report of the Speakers**

- 01 Election Committee - Interim Report

### **Resolution(s)**

- 601 AMA Withdraw its Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity
- 602 Finding Cities for Future AMA Conventions/Meetings

REPORT OF THE BOARD OF TRUSTEES

B of T Report 2-I-22

Subject: Further Action to Respond to the Gun Violence Public Health Crisis  
(Resolution 246-A-22)

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee F

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1 At the 2022 Annual Meeting, the House of Delegates (HOD) referred Resolution 246, “Further  
2 Action to Respond to the Gun Violence Public Health Crisis,” to the Board of Trustees (Board) for  
3 a report back to the HOD at 2022 Interim Meeting. Resolution 246, introduced by the Medical  
4 Student Section, asked that our American Medical Association (AMA) convene a task force for the  
5 purposes of: “working with advocacy groups and other relevant stakeholders to advocate for  
6 federal, state, and local efforts to end the gun violence public health crisis; identifying and  
7 supporting evidence-based community interventions to prevent gun injury, trauma, and death;  
8 monitoring federal, state, and local legislation, regulation, and litigation relating to gun violence;  
9 and reporting annually to the HOD on the AMA’s efforts to reduce gun violence.” The reference  
10 committee heard mixed testimony on whether a task force was necessary to develop actionable  
11 recommendations for our AMA to be a leader in responding to the firearm violence crisis; similar  
12 testimony was offered during the HOD floor debate. This report therefore addresses recent AMA  
13 activities on preventing firearm violence and makes a recommendation about creating a task force.  
14

15 BACKGROUND

16  
17 The AMA declared firearm violence a public health crisis at the 2016 Annual Meeting, which  
18 convened in the aftermath of the mass shooting at the Pulse nightclub in Orlando where 49 people  
19 were killed. Immediately before the 2022 Annual Meeting, two mass shootings occurred within 10  
20 days at an elementary school in Uvalde, Texas and a grocery store in Buffalo, New York. In the  
21 AMA’s press statement after the Uvalde shooting, then AMA President Gerald Harmon, MD,  
22 stated, “The shooting yesterday at an elementary school is horrific and sadly—and unacceptably—  
23 all too familiar in the United States. A week after Buffalo, 10 years after Sandy Hook, 23 years  
24 after Columbine; the places and cities change, but the story is the same—too-easy access to  
25 firearms, inaction on wildly popular, common-sense safety measures like background checks, and  
26 countless lives lost or changed forever.” Dr. Harmon further stated, “More and more it is clear no  
27 place is safe—malls, schools, movie theaters, places of worship, and grocery stores have all been  
28 targeted.... We call on lawmakers, leaders, and advocates to say enough is enough. No more  
29 Americans should die of firearm violence. No more people should lose loved ones.”  
30

31 In remarks at the 2022 Annual Meeting, Dr. Harmon declared that “Gun violence is a plague on our  
32 nation. It is a public health crisis, and much of it is preventable.” Also at the Annual Meeting, then  
33 AMA Board Chair Bobby Mukkamala, MD, addressed the HOD to reaffirm that the Board is fully  
34 committed to continuing to work on preventing firearm violence as a top AMA advocacy priority.  
35 With over 45,000 firearm-related deaths in 2020 and a continuing string of mass shootings, the  
36 Board recognizes this public health crisis needs heightened efforts and new strategies. According to  
37 the Gun Violence Archive—an independent, non-profit data collection and research group that

1 provides free online public access to accurate information about gun-related violence in the U.S.—  
2 there have been 393 mass shootings in 2022 (as of August 4, 2022) and a total of 26,300 deaths  
3 from firearm violence from all causes. Recent data from the Centers for Disease Control and  
4 Prevention (CDC) indicate that firearm deaths are increasing, and disparities are widening, with  
5 young people, males, and Black people experiencing the highest firearm homicide rates. These  
6 statistics are clearly unacceptable, especially since firearm injuries and deaths are preventable.

7  
8 RECENT AMA ADVOCACY ACTIVITIES

9  
10 During the 117th Congress, our AMA has advocated for evidence-based, commonsense legislative  
11 proposals to address firearm violence. The AMA expressed support for H.R. 8, the “Bipartisan  
12 Background Checks Act of 2021,” (Thompson, D-CA/Upton, R-MI), which would expand the  
13 existing background check system to cover all firearm sales, including those at gun shows, over the  
14 internet and through classified ads, while providing reasonable exceptions for law enforcement and  
15 family and friend transfers. This bill was passed by the U.S. House of Representatives on  
16 March 11, 2021, but has not been considered by the U.S. Senate. The AMA also supported  
17 H.R. 7910, the “Protecting Our Kids Act,” (Nadler, D-NY), an omnibus package of eight  
18 previously introduced bills focused on preventing firearm violence. This bill was passed by the  
19 House of Representatives on June 22, 2022, but also was not considered by the Senate.

20  
21 However, Congress succeeded in passing the first major firearm legislation in over 30 years with  
22 S. 2938, the “Bipartisan Safer Communities Act” (Murphy, D-CT/Cornyn, R-TX), which the AMA  
23 supported. President Biden signed this bill into law on June 25, 2022, and AMA Board Chair  
24 Sandra Fryhofer, MD, attended the signing ceremony. Key provisions of the bill include:

- 25
- 26 • Providing grants for states to establish or strengthen extreme risk protection orders;
  - 27 • Adding convicted domestic violence abusers in dating relationships to the National Instant  
28 Criminal Background Check System (NICS);
  - 29 • Requiring the NICS to contact authorities to see whether an individual under the age of 21 has  
30 a “disqualifying” juvenile record for buying a firearm;
  - 31 • Making it a federal crime to buy a firearm on behalf of an individual who is prohibited from  
32 doing so; and
  - 33 • Including new spending for school security and mental health treatment.
- 34

35 In the AMA’s statement following the Act’s enactment into law, AMA President Jack Resneck, Jr.,  
36 MD, noted that this law will save lives, and stated “The measures in this law—funding for red flag  
37 programs, closing the so-called ‘boyfriend loophole,’ and expanding background checks on people  
38 between the ages of 18 and 21 seeking to buy a gun—will keep weapons out of the hands of people  
39 wishing to do harm. This law isn’t a panacea, and more work remains to prevent firearm violence,  
40 but it is an important, critical step in the right direction.” Our AMA is now focused on advocating  
41 to ensure that the new funding authorized in the new law is actually appropriated, advocating for  
42 states to establish or strengthen extreme risk protection orders, and ensuring that the other  
43 provisions are properly and quickly implemented.

44  
45 The AMA is also working to ensure that Congress appropriates increased funding for research to  
46 prevent firearm violence. The AMA is working with medical specialty societies, including the  
47 American Academy of Pediatrics (AAP), to support \$60 million in funding for the CDC and the  
48 National Institutes of Health (NIH) to conduct public health research on firearm morbidity and  
49 mortality prevention. This would double the amount of funding provided last year. Our efforts have  
50 been successful so far: the House 2023 Labor-HHS Appropriations bill that passed out of the  
51 Appropriations Committee on June 30 includes the \$60 million for the NIH and CDC firearm

1 injury and prevention programs funding. The Senate Appropriations Committee released the  
2 Chairman’s mark of all 2023 appropriations bills on July 28; the summary document listed the  
3 same \$60 million for firearm injury and mortality prevention research at NIH and CDC. Our AMA  
4 will continue to monitor appropriations developments and advocate to ensure that this funding is  
5 approved by Congress.

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

26  
27 In addition, our AMA will work to implement the new policies approved by the HOD at the recent  
28 2022 Annual Meeting. With the rising availability of homemade “ghost guns,” the AMA called on  
29 state legislatures and Congress to subject these weapons to the same regulations and licensing  
30 requirements as traditional firearms (Policy H-145.967, “Regulation of Homemade Firearms”).  
31 New policy was also adopted that our AMA support legislation requiring that packaging for any  
32 firearm ammunition produced in, sold in, or exported from the United States carry a boxed  
33 warning. At a minimum, the warning should be text-based statistics and/or graphic warning labels  
34 related to the risks, harms, and mortality associated with firearm ownership and use. It also should  
35 include an explicit recommendation that ammunition be stored securely and separately from  
36 firearms (Policy H-145.968, “Support for Warning Labels on Firearm Ammunition Packaging”).

37  
38 Another policy adopted is focused on ensuring that active-shooter and live-crisis drills consider the  
39 mental health of children (Directive D-145.993, “Addressing Adverse Effects of Active-Shooter  
40 and Live-Crisis Drills on Children's Health”). With school shootings continuing at a troubling pace  
41 and few regulations in place to address the country’s firearm crisis, some schools prepare faculty  
42 and children to respond. While well-intentioned, there are concerns that the style of drill may have  
43 unintended harmful effects on children’s mental health. To address these concerns, the policy  
44 adopted encourages active-shooter and live-crisis drills to be conducted in an evidence-based and  
45 trauma-informed way that takes children’s physical and mental wellness into account, considers  
46 prior experiences that might affect children's response to a simulation, avoids creating additional  
47 traumatic experiences for children, and provides support for students who may be adversely  
48 affected. Our AMA will work with relevant stakeholders to raise awareness of ways to conduct  
49 active-shooter or live-crisis drills that are safe for children and developmentally appropriate. The  
50 AMA will also advocate for research into the impact of live-crisis exercises and drills on the

1 physical and mental health and well-being of children, including the goals, efficacy, and potential  
2 unintended consequences of crisis-preparedness activities involving children.

3  
4 COLLABORATIONS

5  
6 Our AMA is a partner organization of AFFIRM at The Aspen Institute, which is a non-profit  
7 dedicated to ending the American firearm injury epidemic using a health-based approach. AFFIRM  
8 combines health expertise with the knowledge and traditions of responsible firearm stewardship to  
9 achieve consensus recommendations. AFFIRM is committed to reducing the rate of firearm injuries  
10 and deaths. AFFIRM also builds partnerships with non-medical organizations that are equally  
11 committed to preventing firearm injury, including groups committed to firearm safety and shooting  
12 sports.

13  
14 The AMA has joined the American College of Physicians (ACP), American Academy of Family  
15 Physicians, AAP, American College of Surgeons (ACS), American Psychiatric Association (APA),  
16 and American Public Health Association in calling for policies to help stem firearm-related injuries  
17 and deaths in the United States. The organizations endorsed the article, Firearm-Related Injury and  
18 Death in the United States: A Call to Action From the Nation's Leading Physician and Public  
19 Health Professional Organizations, published online in *Annals of Internal Medicine* on August 7,  
20 2019.

21  
22 Our AMA is actively participating in monthly meetings convened by the AAP on advocacy related  
23 to doubling last year's appropriations funding for research on preventing firearm violence. The  
24 AMA also participated in a 2019 meeting on firearm violence organized by ACS and will be  
25 actively participating in a follow-up Medical Summit on Firearm Injury Prevention being  
26 sponsored by ACS in collaboration with the ACP, the American College of Emergency Physicians,  
27 and the Council of Medical Specialty Societies. The objectives of the 2022 summit are to use a  
28 consensus-based, non-partisan approach to selecting recommendations for executive action and/or  
29 legislation at the federal, state, and municipal levels that would decrease firearm-related injuries  
30 and identify elements of the most effective programs that can be implemented by physician  
31 practices/clinics/hospitals/health systems in partnership with their communities to effectively lower  
32 the risk of violence, with an emphasis on marginalized communities that are disproportionately  
33 impacted by violence.

34  
35 The AMA is also scheduling meetings with representatives of law enforcement and education  
36 organizations to see where consensus might be reached on possible solutions to reducing firearm  
37 violence and preventing firearm injuries and deaths. Our AMA is also planning federation calls to  
38 follow-up on the Medical Summit on Firearm Injury Prevention and plans to convene an informal  
39 advisory group of physicians to brainstorm additional ideas on how to prevent and reduce injuries  
40 and deaths from firearm violence.

41  
42 EDUCATION

43  
44 In 2017, the AMA and the American Bar Association held a joint conference in Chicago,  
45 "Preventing Gun Violence: Moving from Crisis to Action." This conference led the Council on  
46 Science and Public Health to initiate a report on "The Physician's Role in Firearm Safety," which  
47 was adopted by the House of Delegates at the 2018 Annual Meeting. At that meeting, the Council  
48 also co-sponsored an educational session with the AMA's Advocacy Resource Center focused on  
49 "Preventing Gun Violence: What Physicians Can do Now." The session focused on describing the  
50 trends in morbidity and mortality associated with firearm violence in the U.S., identifying  
51 evidenced-based strategies available to reduce firearm morbidity and mortality, and defining the

1 physician's unique role in promoting firearm safety and preventing firearm violence. Featured  
2 speakers included Marian "Emmy" Betz, MD, MPH, MPH, University of Colorado School of  
3 Medicine; Garen Wintemute, MD, MPH, University of California-Davis School of Medicine; and  
4 Megan Ranney, MD, MPH, Warren Alpert Medical School, Brown University. Dr. Betz,  
5 Dr. Wintemute and Dr. Ranney then collaborated with the AMA to develop an enduring CME  
6 module, "The Physician's Role in Promoting Firearm Safety," which was published on the AMA  
7 Ed Hub in December of 2018.

8  
9 The AMA also recognizes the need for state-specific guidance for physicians on how to counsel  
10 patients to reduce their risk for firearm-related injury or death, including when and how to ask  
11 sensitive questions about firearm ownership, access and use, and clarification on the circumstances  
12 under which physicians are permitted or may be required to disclose the content of such  
13 conversations to family members, law enforcement, or other third parties. To inform this work the  
14 AMA conducted research to: (1) understand physician's barriers and emotions related to firearm  
15 safety discussion with patients; (2) co-create with physicians and partners on relevant tools or  
16 methods to help improve firearm safety; and (3) recommend a path forward for the AMA to aid  
17 physicians in having firearm safety conversations. Six interviews were conducted with subject  
18 matter experts working in the field of firearm safety and violence prevention and four two-hour  
19 co-creation groups were held exploring current barriers to firearm safety conversations, physicians'  
20 emotions, and functional and emotional design needs. The four co-creation groups were convened  
21 by specialty (pediatrics, primary care (adult), psychiatry, and emergency physicians). Each group  
22 included four physicians.

23  
24 The findings of this research have informed the development of a resource to help physicians  
25 effectively screen and counsel patients at risk of firearm related injury and mortality. The resource  
26 is an online tool containing guidance on when and how to ask sensitive questions about firearm  
27 ownership, access, and use, as well as state-specific legal information about discrete legal topics  
28 related to firearms, such as laws governing physician speech about firearms, physicians'  
29 obligations to disclose confidential patient information, safe storage and child access prevention  
30 laws, and laws governing the possession and transfer of firearms. The tool is expected to be  
31 launched by the end of 2022.

### 32 33 EXISTING AMA POLICY

34  
35 In addition to the newly adopted policies noted above, the AMA has developed and adopted over  
36 [30 policy recommendations](#) over the past two decades to reduce firearm trauma, injury, and death.  
37 These include:

- 38  
39 • [A waiting period for firearm availability, and](#)
- 40 • [Background checks for all firearm purchasers, Policy H-145.996](#)
- 41 • [Firearm safety and research and enhancing access to mental health care, Policy H-145.975](#)
- 42 • [Gun safety education and regulation of interstate traffic of guns, Policy H-145.997](#)
- 43 • [Distribution of firearm safety materials in the clinical setting, Policy D-145.996](#)
- 44 • [Limit and control the possession and storage of weapons on school property, Policy H-](#)
- 45 • [145.983](#)
- 46 • [Firearm safety counseling with patients, Policy H-145.976](#)
- 47 • [Trigger locks and gun cabinets to improve firearm safety, Policy H-145.978](#)
- 48 • [Data on firearm deaths and injuries, Policy H-145.984](#)
- 49 • [Prevention of unintentional shooting deaths among children, Policy H-145.979](#)
- 50 • [Ban on handguns and automatic repeating weapons, Policy H-145.985](#)
- 51 • [Prevention of firearm accidents in children, Policy H-145.990](#)

- 1 • [Waiting period before gun purchase, Policy H-145.992](#)
- 2 • [Restriction of assault weapons, Policy H-145.993](#)
- 3 • [Mandated penalties for crimes committed with firearms, Policy H-145.999](#)
- 4 • [Public health policy approach for preventing violence in America, Policy H-515.971](#)

5  
6 DISCUSSION

7  
8 The Board believes that the above policies and additional policies that have been adopted by the  
9 HOD provide abundant opportunity to advocate at the federal, state, and local levels and with other  
10 stakeholders for evidence-based policy solutions to respond to the current public health crisis of  
11 firearm violence. The challenge in achieving legislative success, especially at the federal level, is  
12 not the lack of sufficient or adequate AMA policy but rather the political realities in the current  
13 Congress, especially advancing specific legislation through the U.S. Senate. Congress regards the  
14 passage and enactment of the Bipartisan Safer Communities Act as the high bar on what firearm  
15 related laws can be achieved at the federal level in the current political environment. Therefore,  
16 while seeking opportunities at the federal level to further advance comprehensive legislation,  
17 including expanding background checks to all firearm purchasers or restricting assault weapons  
18 and large capacity magazines, the AMA will continue to advocate for timely implementation and  
19 adequate funding of the recently enacted Bipartisan Safer Communities Act, with a particular focus  
20 at the state level in expanding Extreme Risk Protection Order (ERPO) laws.

21  
22 The Board acknowledges the impassioned testimony expressed during reference committee and on  
23 the floor of the HOD about the need to create an AMA task force to develop actionable  
24 recommendations for the AMA to be a leader in responding to the gun violence crisis. As  
25 summarized in this report, however, our AMA is already engaged in the advocacy, litigation, and  
26 coalition activities similarly called for in Resolution 246 and in accord with existing AMA policy.  
27 The Board concludes, therefore, that a task force, as called for in Resolution 246, is not necessary  
28 for the AMA to remain a leader and strong advocate for state and federal legislation and  
29 regulations to reduce firearm violence. Furthermore, the Board remains committed to seeking new  
30 solutions (through advocacy, litigation, education, and coalition activities) to reduce firearm  
31 violence, and can accomplish this in a more responsive and nimble manner than through a new task  
32 force. Accordingly, the Board recommends that Resolution 246 not be adopted. However, in order  
33 to keep the Federation of Medicine and the HOD up-to-date on developments in this space, the  
34 AMA will make readily available on the AMA website the comprehensive summary of AMA  
35 policies, activities, and progress regarding the public health crisis of firearm violence.

36  
37 RECOMMENDATION

38  
39 The Board of Trustees recommends that the following be adopted in lieu of Resolution 246 and  
40 that the remainder of the report be filed:

41  
42 Our AMA will make readily accessible on the AMA website the comprehensive summary of AMA  
43 policies, plans, current activities, and progress regarding the public health crisis of firearm  
44 violence. (New HOD Policy)

Fiscal note: None.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 7-I-22

Subject: Transparency of Resolution Fiscal Notes  
(Resolution 608-A-22)

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee F

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

4  
5 RESOLVED, That our American Medical Association amend current Policy G-600.061,  
6 “Guidelines for Drafting a Resolution or Report,” by addition and deletion to read as follows:

7  
8 (d) A fiscal note setting forth the estimated resource implications (expense increase,  
9 expense reduction, or change in revenue) of ~~the any~~ proposed ~~policy, program, study~~ or  
10 ~~directive to take action~~ shall be generated and published by AMA staff in consultation with  
11 the sponsor: prior to its acceptance as business of the AMA House of Delegates. Estimated  
12 changes in expenses will include direct outlays by the AMA as well as the value of the  
13 time of AMA’s elected leaders and staff. A succinct description of the assumptions used to  
14 estimate the resource implications must be included in the AMA House of Delegates  
15 Handbook to justify each fiscal note. ~~When the resolution or report is estimated to have a~~  
16 ~~resource implication of \$50,000 or more, the AMA shall publish and distribute a document~~  
17 ~~explaining the major financial components or cost centers~~ (such as travel, consulting fees,  
18 meeting costs, or mailing). No resolution or report that proposes ~~policies, programs, studies~~  
19 or actions that require financial support by the AMA shall be considered without a fiscal  
20 note that meets the criteria set forth in this policy.

21  
22 In its report, the reference committee, stated:

23  
24 Your Reference Committee heard mixed testimony on Resolution 608. Testimony noted that  
25 standardizing the fiscal note process will be beneficial for both the resolution author and the  
26 House of Delegates. It was stated that a process for developing fiscal notes was previously  
27 established through current AMA policy. Additionally, a concern was raised the proposed  
28 process could hinder the timely generation of fiscal notes for emergency resolutions. Due to  
29 issues raised during testimony, your Reference Committee believes that an exploration of all  
30 concerns related to fiscal note development is merited and recommends referral.

31  
32 The resolution was not discussed in the House, as the reference committee recommendation was  
33 adopted on the consent calendar. The full text of the policy in its current form is below in  
34 Appendix A. Appendix B provides the text of Resolution 608.

1 BACKGROUND

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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.\* Fiscal notes can only rarely be

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\* 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.”

1 calculated precisely, so current practice characterizes the fiscal note for most items within one of  
2 three ranges:

- 3  
4 • Minimal – less than \$1,000  
5 • Modest – between \$1,000 - \$5,000  
6 • Moderate – between \$5,000 - \$10,000  
7

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

11  
12 In fact, the fiscal notes for all items of business having a fiscal note appear in the “Summary of  
13 Fiscal Notes,” including those items that did not directly incorporate the figure when initially  
14 released. For those items where the note exceeds \$10,000, additional information is included for  
15 most, with exceptions largely from section-sponsored resolutions transmitted for immediate  
16 consideration by the House of Delegates and for which only a gross figure is available, but  
17 otherwise, a breakdown of the fiscal note is provided using broad categories (e.g., consultant fees).  
18 For example, the document included the following fiscal notes in June:

- 19  
20 • Res 242, Public Awareness and Advocacy Campaign to Reform the Medicare Physician  
21 Payment System: Est btwn \$1M - \$25M to conduct a public awareness camp (incl. paid ads,  
22 social and earned media, patient and phys grassroots) to prevent/mitigate further Medicare  
23 payment cuts and lay the groundwork to pass fed legislation. Incl prof. fees and promotion  
24 • Res 615, Anti-Harassment Training: Est cost approx. \$60K-\$65K to create 3 targeted  
25 eLearning modules. Incl end to end content design & devel costs to start from scratch, subj  
26 matter expert honorariums and staff time  
27

28 The summary document provides this additional information for all items for which the fiscal note  
29 exceeds \$10,000, not only those greater than \$50,000 as called for by existing Policy G-600.061.  
30 Also worth noting is that the resolution sponsor is contacted when the fiscal note exceeds \$5,000.  
31 That sometimes leads to a change in the resolution.  
32

### 33 *Limitations in the Current Fiscal Note Process*

34

35 As noted generating reliable estimates of the “estimated resource implications (expense increase,  
36 expense reduction, or change in revenue),” to use the language of the current policy, of an item of  
37 business, particularly resolutions, is difficult. Resolutions are most frequently submitted on or near  
38 deadlines, meaning time for processing—and preparing a fiscal note is only one facet of that  
39 process—must be accomplished relatively quickly and like any estimate, cannot be calculated with  
40 precision. Fiscal notes for reports are generally more reliable than those for resolutions because  
41 more time is available for their development, but even so, they should be considered qualified  
42 estimates rather than definitive.\*  
43

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

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\* 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.

1 particularly prone to interpretation. Does “study” simply mean that a report be prepared, or does it  
2 require more extensive effort, such as fielding a survey or soliciting members’ experiences?  
3

4 Finally, it should be borne in mind that the fiscal note is prepared based on the item of business as  
5 written. Changes by the reference committee and amendments in the House can significantly alter  
6 the item, potentially decreasing confidence and increasing error in the fiscal note. Routine  
7 informational reports to the House that are attributable to existing policy (e.g., the annual tobacco  
8 report, the annual demographic report, the update on the ACA at every HOD meeting) incur costs  
9 that are not captured by fiscal notes at all, even though their genesis is found in resolutions adopted  
10 by the House. The expense related to reports that stem from referred resolutions is similarly not  
11 captured in a fiscal note. Based on observations over multiple House meetings, it seems that  
12 “small” fiscal notes—small by whatever definition—concern few people, while “large” fiscal  
13 notes—probably defined as in excess of \$500,000—however accurate, seemingly cause concern  
14 that the dollars are used as a barrier against doing the work, rather than acceptance that the work  
15 can be and often times is costly.  
16

17 Lost in the discussion of fiscal notes is the fact that every item of business incurs various expenses.  
18 Those expenses begin with the sponsoring organization and extend to our AMA for processing,  
19 distribution, and implementation, even if implementation is little more than recording the statement  
20 in PolicyFinder. Similarly, items of business indirectly add to expenses for members of the House  
21 who leave their practices to attend House of Delegates meetings. To be clear, these observations  
22 are not criticisms, only an acknowledgement that fiscal notes do not cover all associated costs,  
23 much as various regulatory schemes or insurance practices impose costs on physicians even if  
24 unintended and unacknowledged.  
25

#### 26 RESOLUTION 608-A-22

27  
28 The declared intent underlying Resolution 608-A-22 is found in the whereas clause that states,  
29 “Providing the rationale behind the fiscal note to the House of Delegates would promote  
30 understanding, transparency, standardization and enable the House to utilize the AMA’s resources  
31 more judiciously.” (The full text of the resolution, including the whereas clauses, is found in  
32 Appendix B.) The fiscal note for the resolution was just over \$5800 annually, or moderate using  
33 the standard terminology, assuming the submission of 280 resolutions per year.  
34

35 The resolution proposes changes to three elements of the existing policy regarding fiscal notes,  
36 although the need for each change is not explicitly stated:  
37

- 38 • Removes proposed “policies and programs” from the requirement for a fiscal note while  
39 inserting “study or directive to take” before the word “action.”
- 40 • Requires that the fiscal note be generated and published “prior to acceptance as business.”
- 41 • Calls for including a succinct justification for each fiscal note to be included in the handbook.  
42

43 The rationale for the first change is unclear. If the intent is simply to propose alternative language  
44 for the existing policy, the change serves no real purpose. If the intent is to use the “directive to  
45 take action” terminology to cover any resolution calling for any sort of activity, the distinction with  
46 and inclusion of “study” is unnecessary. Given that the authors distinguish between “study” and  
47 “directive to take action,” it would be inconsistent to remove the word “program” from the policy.  
48

49 More problematic is the removal of the word “policy,” which is inconsistent with the author’s  
50 suggestion that the change will “enable the House to utilize the AMA’s resources more  
51 judiciously,” as it ignores the fact that every resolution incurs some cost, even if minimal. And it

1 should be reiterated that processing, distribution, and other meeting-related costs are not captured  
2 by fiscal notes. In addition, even purely philosophical statements of policy may carry costs  
3 associated with implementation and advocacy. For example, recent policies emphasizing the role of  
4 physicians on the health care team have led to considerable activity.

5  
6 Finally, the “policy, program, or action” language was developed by the Council on Long Range  
7 Planning and Development after careful consideration and presentation of its 1999 report  
8 mentioned above. Your Board cannot support the proposed change to this part of the policy.

9  
10 The second proposed change calls for preparing and publishing the fiscal note before accepting the  
11 item as business. Again the intent is unclear. Whenever possible, as noted above, fiscal notes are  
12 appended to the resolution before it is distributed in the handbook, addendum, or tote, and the  
13 summary of fiscal notes document appears in the handbook and in updated form in the tote. Thus it  
14 would seem that this is already accomplished.

15  
16 The policy already calls for the fiscal note to be developed in consultation with the authors, but  
17 given the usual timing of resolution submissions and the multiple processing steps, the Speakers  
18 have determined that this consultation is required only for those resolutions for which the fiscal  
19 note exceeds \$5000. To consult with the sponsor for every resolution would be problematic. First,  
20 it would likely add significantly to the processing time for resolutions. Most resolutions are  
21 submitted by medical society staff, but the person sending the resolutions to the House Office is not  
22 necessarily the best contact for the resolution. Connecting with the proper individual may take  
23 time, and it is not uncommon that the most knowledgeable party is the physician who initially  
24 generated the idea that then came through the society. Relatedly, section-sponsored resolutions,  
25 particularly those sent for immediate consideration by the House, may require governing council  
26 input if questions arise about the fiscal note, a potentially time-consuming process. Second, such  
27 consultations seem largely unnecessary for resolutions that have minimal costs. The value added  
28 for the time invested is virtually nil, as fiscal notes under \$5,000 essentially represent staff time,  
29 meaning there is little to explicate. Finally, resolutions are technically not accepted as business  
30 until the House acts (usually as part of the second opening) by which time fiscal notes have been  
31 prepared and published for all items of business, with only a handful of exceptions. If the authors  
32 have in mind that the fiscal note should be made available before the resolution can be included in  
33 the handbook, they have effectively created an impossible task or need to suggest a workable  
34 mechanism that will allow timely publication of meeting materials.

35  
36 Not seeing how this change benefits the House and not seeing how this proposal could be  
37 implemented without disrupting or delaying HOD meeting preparations, your Board does not  
38 support this change.

39  
40 The last change proposed would include a “succinct description of the assumptions used to  
41 estimate the resource implications” of each resolution in the handbook. As noted, most resolutions  
42 with a fiscal note under \$5,000 reflect costs associated with staff time, and the same is true for  
43 fiscal notes up to \$10,000. Including assumptions on staff costs would involve adding the hours  
44 and salary rates for AMA employees that would be an inappropriate public disclosure of  
45 compensation in many cases. Insofar as fiscal notes over \$5000 are discussed with the sponsor and  
46 the summary of fiscal notes document includes elements of the costs associated with resolutions  
47 having fiscal notes in excess of \$10,000, your Board believes this change is unnecessary.

1 RECOMMENDATION

2

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

Fiscal Note: None other than preparing this report

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.

REPORT 8 OF THE BOARD OF TRUSTEES (I-22)  
The Resolution Committee as a Standing Committee of the House  
(Resolution 605-N-21 and Resolution 619-A-22)  
(Reference Committee F)

EXECUTIVE SUMMARY

At the November 2021 Special Meeting of the House of Delegates, Texas introduced Resolution 605 seeking the establishment of a resolution committee to review “resolutions submitted for consideration at all meetings of the American Medical Association House of Delegates” to ensure that the resolutions meet the purpose of the meeting. At the 2022 Annual Meeting, another resolution having multiple sponsors proposed establishing a resolution committee that would be operational for all House of Delegates meetings. Both resolutions were referred to the Board of Trustees, and this report addresses both.

While the Interim Meeting is to focus on advocacy matters and ethics concerns, along with matters that require urgent action, the Annual Meeting has no expressly stated purpose beyond serving as the setting for the legislative and policymaking activities of the House of Delegates as described in the AMA Constitution. The bylaws have established a Resolution Committee for the Interim Meeting (§2.13.3).

A fundamental element of parliamentary law is that a body can determine its agenda, but only the House of Delegates can decide whether a resolution committee is the means to set the agenda for its meetings. Your Board of Trustees is not empowered to set House procedures and offers this report to determine the will of the House with respect to establishing a resolution committee.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 8-I-22

Subject: The Resolution Committee as a Standing Committee of the House  
(Resolution 605-N-21 and Resolution 619-A-22)

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee F

---

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

3  
4 RESOLVED, That the Bylaws of the American Medical Association be amended to provide  
5 that the Resolution Committee be responsible for reviewing resolutions submitted for  
6 consideration at all meetings of the American Medical Association House of Delegates and  
7 determining compliance of the resolutions with the purpose of any such meeting; and be it  
8 further

9  
10 RESOLVED, That the membership of the Resolution Committee reflect the diversity of the  
11 House of Delegates; and be it further

12  
13 RESOLVED, That the Resolution Committee rules be written to produce impartial results and  
14 appropriate changes be made to the AMA Bylaws as necessary to empower the committee.

15  
16 The reference committee had recommended referral and characterized the testimony in the hearing  
17 as follows:

18  
19 Your Reference Committee heard robust, yet widely divided testimony on formalizing the  
20 Resolution Review Committee as a standing House of Delegates committee. Testimony  
21 reflected that the Resolution Review Committee was implemented as a temporary solution to  
22 address an unprecedented situation.

23  
24 Opposition to formalizing the Resolution Review Committee entailed concerns, such as  
25 inconsistencies with evaluating resolutions, limiting discussion on ideas and emergent issues,  
26 ineffective extraction process, lack of inclusivity in policy deliberations, and exclusion of the  
27 minority voice in the parliamentary process.

28  
29 Testimony favoring formalization of the resolution review process cited issues regarding  
30 members of our AMA House of Delegates not having sufficient time to review a growing  
31 volume of business and the need to triage priority items of business.

32  
33 The resolution was then debated in the House and referred, and much of that debate could be  
34 characterized like the testimony in the reference committee.

35  
36 At the 2022 Annual Meeting, Texas, South Carolina, Florida, Mississippi, New Jersey, and  
37 Pennsylvania introduced Resolution 619-A-22, which reads:

1 RESOLVED, That the Resolutions Committee be formed as a standing committee of the  
2 house, the purpose of which is to review and prioritize all submitted resolutions to be acted  
3 upon at the annual and interim meetings of the AMA House of Delegates; and be it further  
4

5 RESOLVED, That the membership of the Resolutions Committee be composed of one Medical  
6 Student Section (MSS) member, one Resident and Fellow Section (RFS) member, and one  
7 Young Physicians Section (YPS) member, all appointed by the speakers through nominations  
8 of the MSS, RFS, and YPS respectively; six regional members appointed by the speakers  
9 through nominations from the regional caucuses; six specialty members appointed by the  
10 speakers through nominations from the specialty caucuses; three section members appointed by  
11 the speakers through nominations from sections other than the MSS, RFS, and YPS; and one  
12 past president appointed by the speakers; and be it further  
13

14 RESOLVED, That the members of the Resolutions Committee serve staggered two-year terms  
15 except for the past president and the MSS and RFS members, who shall serve a one-year term;  
16 and be it further  
17

18 RESOLVED, That members of the Resolutions Committee cannot serve more than four years  
19 consecutively; and be it further  
20

21 RESOLVED, That if a Resolutions Committee member is unable or unwilling to complete his  
22 or her term, the speakers will replace that member with someone from a similar member group  
23 in consultation with that group the next year, and the new member will complete the unfulfilled  
24 term; and be it further  
25

26 RESOLVED, That each member of the Resolutions Committee confidentially rank resolutions  
27 using a 0-to-5 scale (0 – not a priority to 5 – top priority) based on scope (the number of  
28 physicians affected), urgency (the urgency of the resolution and the impact of not acting),  
29 appropriateness (whether AMA is the appropriate organization to lead on the issue), efficacy  
30 (whether an AMA stance would have a positive impact), history (whether the resolution has  
31 been submitted previously and not accepted), and existing policy (whether an AMA policy  
32 already effectively covers the issue). Resolutions would not have to meet all of these  
33 parameters nor would these parameters have to be considered equally; and be it further  
34

35 RESOLVED, That the composite (or average) score of all members of the Resolutions  
36 Committee be used to numerically rank the proposed resolutions. No resolution with a  
37 composite average score of less than 2 would be recommended for consideration. The  
38 Resolutions Committee would further determine the cutoff score above which resolutions  
39 would be considered by the house based on the available time for reference committee and  
40 house discussion, and the list of resolutions ranked available for consideration would be titled  
41 “Resolutions Recommended to be Heard by the HOD”; and be it further  
42

43 RESOLVED, That the Resolutions Committee also make recommendations on all resolutions  
44 submitted recommending reaffirmation of established AMA policy and create a list titled  
45 “Resolutions Recommended for Reaffirmation,” with both lists presented to the house for  
46 acceptance; and be it further  
47

48 RESOLVED, That the membership of the Resolutions Committee be published on the AMA  
49 website with a notice that the appointed members should not be contacted, lobbied, or coerced;  
50 any such activity must be reported to the AMA Grievance Committee for investigation; and

1 should the alleged violations be valid, disciplinary action of the offending person will follow;  
2 and be it further

3  
4 RESOLVED, That the bylaws be amended to add the Resolution Committee as a standing  
5 Committee with the defined charge, composition, and functions as defined above for all AMA  
6 HOD meetings effective Interim 2022.

7  
8 Reference committee testimony on June's resolution echoed the comments that had been heard at  
9 the preceding November meeting and acknowledged the referral of the matter at that meeting. This  
10 resolution too was referred.

11  
12 At the outset your Board would note that a decision regarding a resolution committee rightly rests  
13 with the House. Your Board is not empowered to establish House procedures, so this report is  
14 intended to determine the will of the House in this matter.

## 15 16 BACKGROUND

17  
18 The House has never restricted the subject matter of resolutions. No subject is foreclosed at any  
19 HOD meeting, and aside from a few late resolutions, nearly all resolutions have been accepted over  
20 the years. The Annual Meeting has no defined focus. The Interim Meeting, however, is to focus on  
21 advocacy-related matters, and when that decision was made, a resolution committee was  
22 implemented to ensure that focus. The special meetings of 2020 and 2021 employed resolutions  
23 committees to limit the business to urgent or priority issues. Thus the limitations that have been  
24 imposed were based not on the subject matter but on the focus (i.e., advocacy) or need for action  
25 (i.e., urgency and priority).

### 26 27 *Resolution Committee – Interim Meetings*

28  
29 A committee tasked with the review of resolutions did not originate with the special meetings. It  
30 was just over twenty years ago that the House of Delegates determined that the Interim Meeting  
31 should be focused on advocacy matters, and while June's annual meetings would consider any  
32 business properly submitted, November's meetings should consider only resolutions that address  
33 advocacy and legislation. Matters concerning ethics were later added as an appropriate topic in  
34 November. It should be noted that the Interim Meetings are a full day shorter than our Annual  
35 Meetings further supporting a need for a narrow focus of business to be considered.

36  
37 To ensure the focus on advocacy, AMA bylaws were amended, and bylaw 2.12.1.1, "Business of  
38 Interim Meeting," reads:

39  
40 The business of an Interim Meeting shall be focused on advocacy and legislation. Resolutions  
41 pertaining to ethics, and opinions and reports of the Council on Ethical and Judicial Affairs,  
42 may also be considered at an Interim Meeting. Other business requiring action prior to the  
43 following Annual Meeting may also be considered at an Interim Meeting. In addition, any  
44 other business may be considered at an Interim Meeting by majority vote of delegates present  
45 and voting.

46  
47 Determining what business is appropriate for consideration at an Interim Meeting is the province of  
48 the Resolution Committee. That section of the bylaws reads:

1 2.13.3 Resolution Committee. The Resolution Committee is responsible for reviewing  
2 resolutions submitted for consideration at an Interim Meeting and determining compliance of  
3 the resolutions with the purpose of the Interim Meeting.  
4

5 The Resolution Committee for the Interim Meeting is appointed by the Speaker with broad  
6 representation from the House including members from all sections and councils. Our Bylaws  
7 restrict the committee to a maximum of 31 delegates. The committee does not meet, rather each  
8 member of the committee independently reviews the resolutions and sends their recommendations  
9 to the Office of House of Delegates Affairs, which tallies the individual votes. A “resolution shall  
10 be accepted for consideration at an Interim Meeting upon majority vote of committee members  
11 voting.” Items recommended against consideration by the committee are subject to appeal to the  
12 House, which can accept the resolution by majority vote as noted above. Your Board is not aware  
13 of any objections to the way in which the Interim Meeting Resolution Committee has operated,  
14 including the fact that its members have traditionally not been identified.  
15

16 *Resolutions Committees – Special Meetings, 2020 & 2021*  
17

18 Health and safety concerns as well as government-imposed restrictions stemming from the SARS-  
19 CoV-19 pandemic disallowed holding in-person meetings of the House of Delegates for the 2020  
20 and 2021 calendar years.<sup>1</sup> Under AMA bylaws, your Board of Trustees can and did call for special  
21 meetings of the House of Delegates, with four such meetings in those two years.  
22

23 The bylaws for special meetings state that notice of the meeting “shall specify the time and place of  
24 meeting and the purpose for which it is called, and the House of Delegates shall consider no  
25 business except that for which the meeting is called” (§2.12.2). Your Board declared that the  
26 purposes of the special meetings included leadership transitions (for the June meetings) and the  
27 consideration of urgent or priority business of the Association. Determining what proposals met the  
28 defined purposes of the meetings was thought best left to the House, following the model of the  
29 Resolution Committee associated with the Interim Meeting. That course was adopted for the  
30 November 2020, June 2021, and November 2021 special meetings. The June 2020 special meeting  
31 was much more circumscribed, with only a handful of items required by the bylaws considered in a  
32 meeting that required only about three hours.  
33

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

---

<sup>1</sup> 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.

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

1 In addition to determining what proposals met the urgency or priority threshold, mechanisms had to  
2 be developed to allow debate and voting in accord with Illinois corporate law, AMA bylaws, and  
3 the House’s procedures. Although the available tools were relatively easy to use, AMA’s  
4 procedures such as limiting election votes to delegates, substituting alternate delegates for their  
5 delegates (and vice versa), and allowing any member to testify in a reference committee presented  
6 special challenges related to use and familiarity with new technology. Consequently, concerns  
7 arose about the ability of the House to address the usual volume of business in a virtual format,  
8 which led to the need to pare the business to a reasonable level. The model of the Interim Meeting  
9 Resolution Committee provided the best available solution. A similar mechanism is used by the  
10 British Medical Association and was used by some state and specialty societies during the  
11 pandemic.  
12

13 Aside from a different focus for the special meetings, namely urgency or priority as noted in the  
14 call to each meeting, the special meeting resolutions committees functioned like the Interim  
15 Meeting Resolution Committee, with each member making independent judgments about every  
16 resolution. Each resolution was rated on a five-point scale from “a top priority” to “not a priority at  
17 this time,” using a priority matrix that had been developed by a subcommittee of the initial  
18 committee.<sup>3</sup> The initial priority matrix was modified slightly and approved by the subsequent  
19 committees. The average score for each resolution was calculated, and every resolution that was  
20 collectively rated as at least a medium priority (a “3” on the five-point scale) along with a handful  
21 that scored slightly below medium priority was recommended for acceptance, with the remaining  
22 items recommended against acceptance. Recommendations were based on each item’s rating—at  
23 least medium priority, although a few items rated slightly less than medium priority were proposed  
24 for acceptance. It was thought better to err on the side of inclusion. The committee’s  
25 recommendations were presented to the House as a consent calendar from which any delegate  
26 could extract an item, with the House determining whether to consider that item by a majority vote.  
27

28 The votes by the House were taken without oral debate, which is not ordinary practice in the  
29 House. This was intended to avoid debate about what would be debated, but the delegate requesting  
30 extraction could prepare a written statement on why the item should be considered, with that  
31 statement provided to the House in various ways: as part of the committee’s written report,  
32 appearing on screen before and during the vote, and at the November 2021 meeting appearing on  
33 screen while read aloud by the Speaker before the vote. In no case across the three meetings was a  
34 committee recommendation overturned, which has led some to call foul and argue that the process  
35 was unfair and dismissive of the minority view. Complying with AMA bylaws, which meant  
36 considering only the business for which the meetings had been called, was the reason for using  
37 resolutions committees across the special meetings.  
38

#### 39 VIEWS ON A RESOLUTION COMMITTEE

40

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

---

<sup>3</sup> 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.

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

4  
5 PROCESS FOUNDATION AND OUTCOMES OF THE SPECIAL RESOLUTIONS  
6 COMMITTEE

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

15  
16 Your Board believes that the resolutions committees employed for the special meetings were  
17 implemented in good faith to allow the House to exercise its legislative and policymaking authority  
18 cooperatively using tools and a format that are inherently less efficient than our AMA’s traditional  
19 in-person meetings while staying true to our parliamentary processes and House practices.

20  
21 A fundamental aspect of the deliberative process is that a legislative body has the right to  
22 determine its agenda. A full debate, discussion and vote on every proposal is not guaranteed.  
23 Indeed, House procedures provide two motions that preclude full consideration of specific items:  
24 the motion to object to consideration and the motion to table. Other House procedures, the  
25 reaffirmation calendar (initiated in 1991) and the Interim Meeting Resolution Committee,  
26 effectively operate to the same end. Insofar as these mechanisms generally become operable on the  
27 basis of a majority (or even supermajority) vote—extractions from the reaffirmation calendar being  
28 an exception—they fully comport with parliamentary procedure and, by inference, represent the  
29 majority’s view.

30  
31 That none of the items extracted from the resolution committee reports was successfully added to  
32 the agenda of one of the special meetings does not mean the process was ineffective or unfair. At  
33 the November 2021 meeting, 165 resolutions were submitted. From that pool, the resolutions  
34 committee had recommended that 39 be accepted, as those were of at least medium priority or  
35 nearly so. Of those recommended against acceptance, 98 were not extracted, and among the 28  
36 extracted items, three-fifths (i.e., 60%) or more of those voting supported the committee’s  
37 recommendation against consideration for 23 items, and the smallest margin was a four-point  
38 difference (52% to 48%).

39  
40 OPERATION OF THE HOUSE OF DELEGATES

41  
42 Commentary from both supporters and opponents of the resolutions committee noted the need for  
43 efficiency in the House of Delegates, although no concrete changes for improving efficiency were  
44 heard beyond the perceived pros or cons of a resolution committee. Efficiency in House of  
45 Delegates meetings has long been sought, and multiple changes have been implemented by various  
46 Speakers toward this goal. The previously mentioned reaffirmation calendar is one, and another is  
47 treating reference committee reports as a consent calendar from which items are extracted for  
48 debate in the House, which dates from the mid-1990s. The Interim Meeting Resolution Committee  
49 was instituted not as an efficiency measure but as a mechanism to allow the House to ensure the  
50 meeting is focused on advocacy.

1 The table below shows the number of resolutions submitted to each meeting since 2007, not  
 2 including memorial resolutions and without regard to whether each resolution was considered. The  
 3 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.

4 The number of items of business is inarguably correlated with the time required for reference  
 5 committee hearings and likely related to the duration of business sessions and debate in the House  
 6 as well.<sup>4</sup> Few would question the assertion that items considered late in a reference committee or  
 7 on the last day at the House of Delegates meeting typically get a less thorough hearing than items  
 8 considered earlier. Reference committees frequently rush through the last few items on their  
 9 agendas, and delegates' comments and testimony are not uncommonly constricted—forced into  
 10 60 second time slots—on the last day of the meeting. Prioritizing the business to be considered  
 11 would be better than the somewhat random consignment of items to late in the agenda, whereby  
 12 they receive foreshortened consideration.

13

14 CONCLUSION

15

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

22

23 Your Board believes a process that would allow the House of Delegates to focus on key concerns  
 24 of patients and our profession may merit a test. That decision, however, rests solely with the  
 25 House. Your Board is not empowered to set out House procedures, and this report should be  
 26 considered a vehicle to determine whether the House of Delegates wishes to implement a trial of a  
 27 standing resolution committee for future meetings. Should the House favor a test, your Board will  
 28 come back with a detailed proposal at the June 2023 House of Delegates Meeting (June 10-14,  
 29 2023) recommending both the parameters for a resolution committee and the necessary bylaws  
 30 changes.

31

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

37

38 The nature of the virtual format of the special meetings limited the volume of business that could  
 39 be considered. The limit was imposed, however, not primarily based on volume but on the  
 40 collective evaluation of a proposal's urgency or priority. In fact, the special meetings were called  
 41 by the Board to only handle urgent and priority business. For in-person meetings, the House has

---

<sup>4</sup> 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.

1 previously decided to focus the Interim Meeting on advocacy matters and not to restrict the  
2 business considered at the Annual Meeting.

3

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

7

8 RECOMMENDATION

9 Your Board of Trustees offers the following recommendation to be adopted in lieu of Resolutions  
10 605-N-21 and 619-A-22 and the remainder of the report filed.

11

12 That the Board of Trustees prepare a report for consideration at the 2023 Annual Meeting  
13 recommending a trial of a resolution committee, including the make-up and operation of the  
14 committee and create measures of fairness and effectiveness of the trial. (Directive to Take  
15 Action)

16

Fiscal Note: Within current budget

# REPORT OF THE BOARD OF TRUSTEES

B of T Report 9-I-22

Subject: Employed Physicians

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to Reference Committee F

---

## 1 INTRODUCTION

2  
3 At the November 2021 Special Meeting of the House of Delegates (HOD), Resolution 615,  
4 “Employed Physicians,” was introduced by the Oklahoma, Alabama, District of Columbia,  
5 Georgia, Mississippi, New Jersey, North Carolina, South Carolina, and Tennessee delegations and  
6 referred for report. In brief, Resolution 615 asks the AMA to:<sup>\*</sup>

- 7
- 8 1. dedicate full-time staff to address employed physician issues, which would include
- 9 providing legal assistance to physicians on contractual matters;
- 10 2. increase the representation of “employed physicians” (a term that would need to be
- 11 defined) in the HOD by allocating additional representation to the Organized Medical Staff
- 12 Section; and
- 13 3. increase representation of employed physicians in AMA leadership by adding OMSS
- 14 representatives (who would be employed physicians) to the Board of Trustees and to each
- 15 AMA council and committee.
- 16

17 Testimony on Resolution 615 reflected concern with the proposed representation scheme.  
18 Nevertheless, it was clear that the HOD seeks, in the words of the reference committee, “a  
19 workable plan for supporting employed physicians.” This report examines how the voice of  
20 employed physicians might best be heard within the organization.

## 21 22 BACKGROUND

23  
24 The AMA supports the needs of physicians in all modes of practice, including employed  
25 physicians. Moreover, the AMA has long recognized that employed physicians as a category have  
26 unique needs that can and should be met by the AMA. In particular, AMA Policy G-615.105,  
27 “Employed Physicians and the AMA,” states that the AMA will:

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

---

<sup>\*</sup> See Appendix A for full text of Resolution 615-N-21.

1 The AMA’s work on behalf of employed physicians has included the creation of model  
2 employment contracts, offering of multiple education opportunities on employment matters,  
3 development of the seminal “[AMA Principles for Physician Employment](#)” (AMA Policy H-  
4 225.950), and legislative, regulatory, and judicial advocacy on employment concerns such as non-  
5 compete agreements, due process rights, and so forth.

6  
7 *Defining “employed physician”*

8  
9 There is at present no universally acknowledged definition of what constitutes an employed  
10 physician relative to one that is not employed. While employed physicians could be understood to  
11 be physicians who are paid for their services by another party, the simple act of receiving a  
12 paycheck is not necessarily determinative of a physician’s employment status.

13  
14 For the purposes of this report, we propose the following working definition of what it means to be  
15 an employed physician:

16  
17 An employed physician is any non-resident, non-fellow physician who maintains a  
18 contractual relationship to provide medical services with an entity from which the  
19 physician receives a W-2 to report their income and in which the physician does not have a  
20 controlling interest, either individually or as part of a collective.

21  
22 *Trends in physician practice ownership and employment*

23  
24 For many years, physicians have been moving away from private practice and toward employment  
25 by health care entities. The AMA’s Physician Benchmark Survey found in 2020 that for the first  
26 time fewer than half (49.1 percent) of physicians surveyed reported that they worked in physician-  
27 owned private practice (as opposed to self-identifying as employees or contractors), which was  
28 down from 2018 when 54 percent of physicians surveyed worked in physician-owned practices.<sup>1</sup>  
29 As of May 2022, there are just under 1.1 million active primary care and specialist physicians  
30 working in the US,<sup>2</sup> implying that roughly 537,000 physicians are employed.

31  
32 The benchmark survey showed that the trend toward employment varied widely across specialties.  
33 Surgical subspecialties and radiology held the lowest percentages of employed physicians, both  
34 under 40 percent. At the other extreme, family medicine, pediatrics, internal medicine  
35 subspecialties, general surgery and emergency medicine physicians all reported that greater than 50  
36 percent of physicians were employed, with family medicine and pediatrics having the lowest rates  
37 of practice ownership.

38  
39 The Covid-19 pandemic potentially confounds the study of trends in physician employment during  
40 the last two years. During the pandemic, physician overhead costs increased while payments failed  
41 to keep pace,<sup>3</sup> which likely accelerated the trend toward physician employment and practice  
42 acquisition by health care entities. Indeed, a 2021 study examining growth trends in physician  
43 practice ownership and employment between January 1, 2019, and January 1, 2021, found that  
44 more than 48,000 physicians left independent practice to become employees of a health care entity  
45 during that time, a 12 percent increase in the number of employed physicians. At the same time,  
46 hospitals and other health care entities acquired 20,900 physician practices, a 25 percent increase in  
47 corporate-owned practices.<sup>4</sup>

1 DISCUSSION

2  
3 As the number of employed physicians continues to grow relative to the number who are in private  
4 practice, our AMA will continue to represent and otherwise meet the needs of employed  
5 physicians, as it does the needs of physicians in all practice settings. Resolution 615 proposes two  
6 key areas for AMA action, which we evaluate here before offering an alternative approach to  
7 ensure the voice of employed physicians continues to be heard within our organization.

8  
9 *Dedicated staffing to address employed physician issues*

10  
11 Resolution 615 asks the AMA to dedicate full-time staff to address issues of concern to employed  
12 physicians, with the authors going so far as to suggest in their Statement of Priority that AMA  
13 ought to establish a new stand-alone business unit (“office of the employed physicians”). We agree  
14 that employment relationships create unique challenges for physicians who choose this mode of  
15 practice and further, that AMA ought to be aware of these challenges and seek to address them.  
16 However, we do not believe that establishing a staffing entity dedicated to employed physicians is  
17 the correct approach.

18  
19 The needs of employed physicians are addressed across the existing staffing entities of the AMA.  
20 For example, AMA section staff, advocacy staff, and legal counsel form a center of expertise  
21 around physician-hospital relations, including contracting and medical staff bylaws protections for  
22 employed physicians. Similarly, in tackling physician burnout, the Professional Satisfaction and  
23 Practice Sustainability unit (“PS2”) considers how systemic deficiencies in healthcare  
24 organizations drive burnout among employed physicians. This pattern is borne out across the  
25 AMA, leading us to conclude that the needs of employed physicians would be better served by  
26 encouraging the various components of our organization to continue to consider the specific needs  
27 of physicians in all practice settings, including employed physicians, as they go about their work.

28  
29 Relatedly, Resolution 615 asks the AMA to provide a greater level of service to employed  
30 physicians in contracting matters—specifically, to provide legal opinions. AMA Policy G-615.105,  
31 which the resolution seeks to amend to achieve its goal, states explicitly that the AMA will not  
32 provide legal opinions or representation:

33  
34 As a benefit of membership our AMA will provide, through the Sections and Special Groups,  
35 assistance, such as information and advice, but not legal opinions or representation, as  
36 appropriate, to employed physicians, physicians in independent practice, and independent  
37 physician contractors in matters pertaining to their relationships with hospitals, health systems,  
38 and other entities, including, but not limited to, breach of contracts including medical staff  
39 bylaws, sham peer review, economic credentialing, and the denial of due process.

40  
41 While it is appropriate for our AMA to provide some level of guidance to physicians in contractual  
42 matters (e.g., AMA’s model annotated employment contracts for group practice employment and  
43 hospital employment, both of which are currently undergoing updates), AMA itself is not  
44 positioned to provide legal opinions or representation for individual physicians across U.S. states  
45 and territories, each with its own nuances of employment law. AMA has previously explored  
46 partnering with a third party to provide such services to physicians at a discounted rate but  
47 ultimately found such an arrangement to be cost prohibitive.

1 *Expanded representation of employed physicians across AMA governance*

2  
3 Resolution 615 asks the AMA to expand the representation of employed physicians across AMA  
4 governance, including in the House of Delegates, on the Board of Trustees, and on all AMA  
5 councils and committees. This expansion would be accomplished by granting OMSS proportional  
6 representation in the HOD and set-aside seats on the Board and councils/committees.

7  
8 The resolution purports to base this proposed structure on the proportional representation granted to  
9 medical students and residents/fellows in the HOD (i.e., regional and sectional delegates,  
10 respectively), and on the inclusion of medical students, residents/fellows, and young physicians on  
11 the Board and councils. However, the resolution misconstrues the nature of the relationship  
12 between these leaders and the sections of which they are members. Medical student regional  
13 delegates and resident/fellow sectional delegates do not represent the MSS or the RFS. Nor do the  
14 medical student, resident/fellow, and young physician members of the Board and councils  
15 represent the MSS, RFS, or YPS. Rather, they simply give voice to those particular segments of  
16 AMA membership. For this reason, it is inappropriate to route increased representation of  
17 employed physicians through OMSS, even if OMSS may be a logical home for employed  
18 physicians.

19  
20 More broadly than concerns with the proposed representation structure, we believe it is generally  
21 inadvisable to create additional governance set-asides. Medical students, residents/fellows, and  
22 young physicians are granted special representation because without dedicated positions, and  
23 owing to their relatively short AMA tenure, it is unlikely that there would be many of them in  
24 AMA leadership positions. Employed physicians, as individuals, do not face the same barrier.  
25 While they might not have been elected to explicitly represent the interests of employed physicians  
26 and while they might be proportionally underrepresented, there are in fact employed physicians at  
27 every level of AMA leadership. We fear that an additional carve-out for any group, including  
28 employed physicians, would spark an interest arms race wherein physicians in other practice  
29 arrangements seek proportional representation.

30  
31 *An alternative solution: employed physician caucus*

32  
33 AMA Policy G-615.002, “AMA Member Component Groups,” defines a “caucus” as “an informal  
34 group of physicians (from specialty and/or geographic medical groups or focused interest areas)  
35 who meet at the Annual and/or Interim meetings to discuss issues, pending resolutions and reports,  
36 candidates, and possible actions of the HOD.” Caucuses are a critical component of the AMA  
37 governance structure, giving voice in the AMA policymaking process to many groups that are not  
38 explicitly represented in the HOD. Examples of recently constituted caucuses include the obesity  
39 caucus and the mobility caucus.

40  
41 The creation of an employed physician caucus would validate the supposition that employed  
42 physicians as a category have unique needs and interests that should be heard within our AMA. But  
43 it would do so without creating problematic set-asides and while conforming to established  
44 pathways for recognition of viewpoints within our AMA.

45  
46 While it is beyond the scope of the Board to establish caucuses, the Board fully supports the  
47 creation of an employed physician caucus. It is our understanding that OMSS leadership has begun  
48 to engage other interested parties to convene an inaugural meeting of an employed physician  
49 caucus at the 2022 Interim Meeting. We are eager to see how this group will amplify the voice of  
50 employed physicians in our policymaking process and ultimately help our organization best meet  
51 the needs of the growing ranks of employed physicians. Additionally, while it is beyond the scope

1 of the Board to recommend the establishment of a new AMA section, we note that a caucus is an  
2 appropriate starting point for that level of representation, with multiple sections having originated  
3 as caucuses.

4  
5 RECOMMENDATIONS

6  
7 Your Board of Trustees recommends that the following recommendations be adopted in lieu of  
8 Resolution 615-N-21, and that the remainder of this report be filed:

9  
10 1. That our AMA adopt the following definition of “employed physician”:

11  
12 An employed physician is any non-resident, non-fellow physician who maintains a contractual  
13 relationship to provide medical services with an entity from which the physician receives a W-  
14 2 to report their income, and in which the physician does not have a controlling interest, either  
15 individually or as part of a collective. (New HOD Policy)

16  
17 2. That our AMA re-examine the representation of employed physicians within the organization  
18 and report back at the 2024 Annual Meeting. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 and \$5,000

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.

# REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-I-22

Subject: Senior Physicians Section Five-Year Review

Presented by: Edmond Cabbabe, MD, Chair

Referred to: Reference Committee F

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1 AMA Bylaw 7.0.9 states, “A delineated section must reconfirm its qualifications for continued  
2 delineated section status and associated representation in the House of Delegates by demonstrating  
3 at least every 5 years that it continues to meet the criteria adopted by the House of Delegates.”  
4 AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and  
5 Development (CLRPD) is “to evaluate and make recommendations to the House of Delegates,  
6 through the Board of Trustees, with respect to the formation and/or change in status of any section.  
7 The Council will apply criteria adopted by the House of Delegates.”

8  
9 The Council assessed information from the letter of application submitted by the Senior Physicians  
10 Section (SPS) for renewal of delineated section status, which is presented in the discussion section  
11 of this report.

## 12 APPLICATION OF CRITERIA TO THE SENIOR PHYSICIANS SECTION

13  
14  
15 Criterion 1: Issue of Concern – Focus will relate to concerns that are distinctive to the subset within  
16 the broader, general issues that face medicine. A demonstrated need exists to deal with these  
17 matters, as they are not currently being addressed through an existing AMA group.

18  
19 The SPS identified the following priority areas of concern as focal points of the last five years:  
20 healthy aging, transitioning to retirement/end-of-career practice patterns, physician re-entry,  
21 grassroots advocacy, and the *JAMA* Career Center. The Council asked the Section what actions  
22 have been taken on these issues, as well as the results of those activities. On the issue of healthy  
23 aging, the SPS Governing Council (GC) has offered educational programs at AMA HOD meetings  
24 on “how to keep your brain fit” and mindfulness workshops to help foster resiliency for senior  
25 physicians, as well as developing a guide of best health practices in senior independent living  
26 communities for publication on the AMA website. In 2018, the SPS assembled topics for a  
27 members-only, web-based toolkit, “How to Successfully Transition out of Medicine and into  
28 Retirement,” which included resources for transitioning to retirement as one leaves medical  
29 practice. The SPS presented educational programs on alternate licensure tracks for reentering  
30 physicians and created the State Licensure and Liability Laws grid for physicians, a state-by-state  
31 reference guide of liability laws for senior physician volunteers.

32  
33 The SPS has identified several issues of concern on which to focus for the coming years including  
34 senior physician competency, hearing screening/hearing aids and dementia, COVID-19 and  
35 seniors, advance care planning and health disparity relating to ageism.

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

3  
4 For the past five years, the SPS has convened a meeting in July or August to provide GC members  
5 with an introduction to the AMA Strategic Focus areas. The Section has engaged in regular  
6 activities related to the AMA strategic arcs. In collaboration with key staff in the Improving Health  
7 Outcomes (IHO) unit, the SPS GC promoted the Diabetes Prevention Program (DPP) shortly after  
8 it was approved as a Medicare benefit. The SPS began work three years ago to expand attendance  
9 at physician health care entrepreneurial events with innovation organizations with which the AMA  
10 has an affiliation (MATTER and Health2047). The SPS GC invited the AMA Chief Medical  
11 Information Officer to speak on electronic health record (EHR) adoption for older physicians who  
12 practice in rural or underserved communities, and SPS members provided feedback on EHR  
13 adoption and how it varies across practice specialty. In 2020, the SPS identified senior physicians  
14 to participate as Medical Student Section (MSS)/SPS mentors and role models to broaden the  
15 number of medical school campuses with an advisor. Staff worked to locate leaders at five  
16 campuses to participate as coaches in communities that may not be aware of the AMA SPS and/or  
17 the MSS.

18  
19 Criterion 3: Appropriateness – The structure of the group will be consistent with its objectives and  
20 activities.

21  
22 The SPS made changes to their internal operating procedures in 2018 and 2020, which included:

- 23  
24 • Clarification of continued service on the SPS GC for an Officer-at-Large member in  
25 his/her second term who is elected as SPS Chair-Elect.
- 26  
27 • Implementation of new criteria for the Officer-at-Large position that require demonstrated  
28 experience in organized medicine to help ensure that nominees are familiar with the  
29 functions of the AMA and the House of Delegates (HOD).
- 30  
31 • Development of a Candidate Review Committee that verifies all nominees are eligible to  
32 be placed on the general election ballot and validates election results. The SPS Immediate  
33 Past Chair leads the committee comprised of a diverse mix (specialty, geographic  
34 representation, gender, age and race/ethnicity) of volunteer members.
- 35  
36 • Establishment of a maximum tenure of 8 years from the current 6 years for SPS GC  
37 members. This is consistent with the maximum tenure for AMA Council and Board  
38 members as well as the governing councils of several other sections.
- 39  
40 • Expansion of criteria for the SPS delegate and alternate delegate that require attendance at  
41 two HOD meetings and participation in HOD reference committees. The GC determined  
42 that more specific and stringent criteria were needed given a large pool of candidates for  
43 these positions and for those applying with no prior HOD experience.
- 44

45 SPS meetings are held in conjunction with AMA HOD meetings. Each meeting includes a SPS  
46 Assembly Meeting followed by either a keynote speaker or an educational session. The SPS  
47 chooses to present CME programs, as most senior physicians who attend the meeting are still in  
48 active practice or wish to maintain their licensure. At the assembly meeting, most time is spent  
49 reviewing HOD resolutions of interest to the SPS, with a discussion of SPS positions on HOD  
50 reports and resolutions. Items are chosen in advance by the SPS delegate and alternate delegate and  
51 sent to those who register by email. Outcomes from these discussions help to identify gaps in

1 resources and policy as well as discussion of future program topics. Meeting evaluations ask  
2 participants to rank reasons they attend the meetings to understand what resonates most with them,  
3 and that information is used by leadership to inform agendas for future meetings.

4  
5 The SPS explores two signature issues with the SPS assembly at annual and interim meetings with  
6 discussion time for its members. In 2020, the SPS began a policy library, an institutional repository  
7 of current articles of interest to senior physicians published in major journals. Articles are posted to  
8 the SPS GC listserv weekly for comment. The policy committee regularly reviews the feedback to  
9 determine whether topics should become the next policy issues and to address future reports and  
10 proposals as part of its “signature issue pipeline.”

11  
12 Criterion 4: Representation Threshold – Members of the formal group would be based on  
13 identifiable segments of the physician population and AMA membership. The formal group would  
14 be a clearly identifiable segment of AMA membership and the general physician population. A  
15 substantial number of members would be represented by this formal group. At minimum, this  
16 group would be able to represent 1,000 AMA members.

17  
18 The qualifying criterion for membership in the SPS is to be an AMA member physician 65 years or  
19 above. Whether physicians are working full-time, part-time or retired, the SPS represents all  
20 physician members aged 65 and over.

21  
22 There are 61,895 physician AMA members aged 65 and above, according to AMA Masterfile 2020  
23 YE data. The SPS, by definition, represents 100% of these members. There are an additional  
24 317,181 senior physicians who are non-AMA members. Thus, SPS represented 16.3% of all senior  
25 physicians in 2020.

26  
27 Criterion 5: Stability – The group has a demonstrated history of continuity. This segment can  
28 demonstrate an ongoing and viable group of physicians will be represented by this section and both  
29 the segment and the AMA will benefit from an increased voice within the policymaking body.

30  
31 According to AMA Masterfile YE data, in 2015 there were 53,720 AMA senior physician  
32 members, and in 2020, there were 61,895 senior physician members. The 2020 YTD retention rate  
33 for senior physicians was 91.61%, and for retired physicians, the percentage was 89.09%. The  
34 retention rate for senior physicians, which includes dues exempt members, was the highest overall  
35 when compared to other AMA segments. The SPS works to extend physicians’ careers in clinical  
36 medicine and, in many cases, facilitate re-entry into medical practice. A 2015 retired physician  
37 survey revealed that 79% of retired physicians responded that they had been a member of the AMA  
38 for 20 years or longer.

39  
40 Attendance at SPS educational programs has ranged from ~100 attendees to ~200 attendees during  
41 each AMA HOD meeting and remained at those levels throughout the COVID-19 pandemic in  
42 virtual environments. The Section’s primary communication vehicle is a newsletter that keeps  
43 members apprised of SPS activities and relevant news/updates for senior physicians.  
44 Communications are sent approximately once per month for physicians who have an email address  
45 in the AIMS database and have opted in (~48K physicians in 2020, up from ~42K physicians in  
46 2018). Over the same period, both the open rate (28.3% in 2020, up from 23.5% in 2018) and click  
47 through rate (1.3% in 2020, up from 0.6% in 2018) of those communications have increased as  
48 well and the Section noted that the growth in engagement exceeds both AMA and industry  
49 standards.

1 The SPS described steps it has taken towards advancing membership engagement and growth:

- 2
- 3 • In 2018, the SPS participated in the AMA Members Move Medicine campaign, profiling  
4 senior physician leaders in advocacy, education, patient care and practice innovation in  
5 AMA marketing campaigns. Profiles were promoted in Morning Rounds, SPS newsletters  
6 and in banners at both the A-18 and I-18 Meetings.
- 7
- 8 • The SPS recruits AMA Ambassadors to champion the value of AMA membership and  
9 promote the work of the AMA. The Ambassador Program provides senior physicians with  
10 tools to share the impact of the AMA's work and the value of AMA membership to  
11 physicians at every stage of their career and life.
- 12
- 13 • SPS members serve as judges for the AMA's annual Research Symposium, which  
14 promotes collaboration between senior leaders and students during the meeting and  
15 facilitates mentorship opportunities.
- 16

17 Criterion 6: Accessibility - Provides opportunity for members of the constituency who are  
18 otherwise under-represented to introduce issues of concern and to be able to participate in the  
19 policymaking process within the AMA House of Delegates (HOD).

20

21 More than one-third of delegates (36.4%) and one-fifth of alternate delegates (19.4%) are senior  
22 physicians, according to CLRPD Report 1-June-21, "Demographic Characteristics of the House of  
23 Delegates and AMA Leadership." Based purely on delegate count, members of the senior physician  
24 demographic are not underrepresented in the HOD. However, as discussed in previous five-year  
25 reviews of the SPS, when serving on state and specialty delegations, physicians are obligated to  
26 represent the interests of their respective delegations, and not specifically the interests of senior  
27 physicians; the SPS, therefore, provides the appropriate structure to ensure that the concerns of  
28 senior physicians are adequately represented in the HOD.

29

30 To that end, the SPS regularly submits resolutions to the HOD and provides testimony on items of  
31 business that are of interest to the constituents of the SPS. The SPS implemented a resolution idea  
32 form to make it easier for senior physicians to introduce resolution topics, as well as a tutorial to  
33 help educate SPS members on the HOD processes and AMA PolicyFinder©. All resolution ideas  
34 are reviewed by the SPS delegate and alternate delegate and presented for the GC's approval.  
35 Resolutions are posted to an online member forum to allow viewing and comment. Senior  
36 physicians are then invited to provide testimony on the resolutions submitted. The SPS convenes a  
37 virtual teleconference twice a year to maintain open communications with SPS members across the  
38 country. Members can either submit a resolution idea or testify on behalf of items of concern to  
39 senior physicians. The testimony is then discussed on a virtual teleconference open to all SPS  
40 members to develop consensus opinions on SPS reports and resolutions. A majority vote of those  
41 present on the virtual conference call helps guide the actions of the SPS delegate when submitting  
42 items of business to the HOD for annual and interim meetings.

43

44 In conjunction with each HOD meeting, the SPS holds onsite business assembly meetings that  
45 generate an average of 60-150 people per meeting. This is open to all SPS members. The GC  
46 develops an agenda that provides an opportunity for SPS assembly members to discuss SPS-  
47 sponsored resolutions, business in the HOD Handbook relevant to the Section, educational  
48 sessions, internal operating issues, and other proposed items of interest. For any action of the  
49 assembly, a majority vote of those present constitutes an adopted action.

1 CLRPD DISCUSSION

2  
3 AMA Policy G-615.002, “AMA Member Component Groups,” states that “Delineated Sections  
4 will allow a voice in the house of medicine for large groups of physicians, who are connected  
5 through a unique perspective, but may be underrepresented. These sections will often be based on  
6 demographics or mode of practice.” The AMA is well positioned to represent and address the  
7 specific interests and needs of defined physician groups, with benefits to those groups and the  
8 Association as a whole.

9  
10 In the opinion of CLRPD, the SPS has created an effective structure that allows for the  
11 participation of senior physicians in the deliberations of the HOD and provides tools and  
12 educational opportunities that ensure the AMA maintains an appropriate focus on issues of concern  
13 to senior physicians. According to the U.S. Census Bureau, 16% of the U.S. population in 2021  
14 was 65 years of age or older, and that percentage is expected to grow to 21.6% of the population by  
15 2040. Additionally, according to 2018 CDC data, individuals who reach the age of 65 have an  
16 average life expectancy of 19.5 years; not only will senior physicians continue to represent a  
17 significant proportion of AMA membership, but that proportion is likely to grow. These data make  
18 it clear that to remain responsive to and effectively address the needs of the evolving physician  
19 demographics in the United States, the AMA must maintain a strong focus on the concerns and  
20 needs of senior physicians. The SPS provides the AMA with a centralized structure to ensure that  
21 focus, particularly in the areas of lifelong learning and healthy aging.

22  
23 Educational sessions hosted by the SPS, often in conjunction with other AMA sections and  
24 councils, have been consistently well-attended, including those held virtually during the COVID-19  
25 pandemic. Topics of these sessions in the past five years have demonstrated the Section’s  
26 commitment to addressing a variety of areas of concern relevant to senior physicians, including  
27 healthy aging (mindfulness, brain fitness, the impacts of vision and hearing loss), career issues  
28 (assessing competency of senior physicians, transitioning into retirement, understanding ageism  
29 and its impacts), and health equity (improving health outcomes for vulnerable patient populations,  
30 improving end-of-life care communication for seniors and LGBTQ elders).

31  
32 To facilitate senior physician contributions to HOD deliberations, the SPS has continued to refine  
33 its processes that allow any member of the constituency to submit ideas for resolutions and to  
34 provide input on items of business proposed by the SPS and/or of concern to the SPS constituency.  
35 Notably, the SPS provides a variety of avenues to allow any of its members to contribute insight on  
36 HOD items of business, leveraging virtual teleconferencing, online forums, and onsite business  
37 meetings, which are open to all SPS members. These practices demonstrate a strong commitment  
38 to accessibility, which is perhaps especially important for the senior demographic group, members  
39 of which may, for various reasons, find it undesirable or difficult to attend in-person AMA  
40 meetings.

41  
42 In the future, the Council looks forward to observing progress on newer initiatives being  
43 undertaken by the SPS. Among these are the nationwide mentorship program being piloted in  
44 conjunction with the MSS, as well as efforts to increase diversity of the SPS GC, which the SPS  
45 undertook with assistance from the AMA Center for Health Equity to recruit more diverse  
46 physicians by looking at racial and ethnic, socioeconomic, geographic, and academic/professional  
47 backgrounds. Additional initiatives include the implementation of a review mechanism to increase  
48 the scope and scale of resolution ideas for potential development, an improved format of its  
49 assembly to review SPS and HOD resolutions, and a SPS policy development committee that meets  
50 twice per year with AMA councils, sections and/or other constituencies to help educate authors  
51 about SPS positions.

1 In closing, the Council thanks SPS leadership, members and staff for their thoughtful work on the  
2 reapplication process, their continued contributions to ensure that the perspectives of senior  
3 physicians remain prominent in the AMA policymaking process, and all their efforts on behalf of  
4 senior physicians and patients in the United States.

5

6 RECOMMENDATION

7

8 The Council on Long Range Planning and Development recommends that our American Medical  
9 Association renew delineated section status for the Senior Physicians Section through 2027 with  
10 the next review no later than the 2027 Interim Meeting and that the remainder of this report be  
11 filed. (Directive to Take Action)

Fiscal Note: Within current budget

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

Compensation Committee Report, November 2022

Subject: Report of the House Of Delegates Committee on the Compensation of the Officers  
Presented by: Ray C. Hsiao, MD, Chair  
Referred to: Reference Committee F

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1 This report by the committee at the November 2022 Interim Meeting includes one recommendation  
2 and documents the compensation paid to Officers for the period July 1, 2021 through June 30,  
3 2022, including 2021 calendar year IRS reported taxable value of benefits, perquisites, services,  
4 and in-kind payments for all Officers.

5  
6 BACKGROUND

7  
8 At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on  
9 Trustee Compensation, currently named the Committee on Compensation of the Officers (the  
10 “Committee”). The Officers are defined in the American Medical Association’s (AMA)  
11 Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the  
12 HOD, Article V refers simply to “Officer,” which includes all 21 members of the Board among  
13 whom are the President, President-Elect, Immediate Past President, Secretary, Speaker and Vice  
14 Speaker of the HOD, collectively referred to in this report as Officers.) The composition,  
15 appointment, tenure, vacancy process and reporting requirements for the Committee are covered  
16 under the AMA Bylaws. Bylaws 2.13.4.5 provides:

17  
18 The Committee shall present an annual report to the House of Delegates recommending the  
19 level of total compensation for the Officers for the following year. The recommendations of the  
20 report may be adopted, not adopted, or referred back to the Committee, and may be amended  
21 for clarification only with the concurrence of the Committee.

22  
23 At A-00, the Committee and the Board jointly adopted the American Compensation Association’s  
24 definition of total compensation which was added to the Glossary of the AMA Constitution and  
25 Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an  
26 individual for work performance, including: (a) all forms of money or cash compensation; (b)  
27 benefits; (c) perquisites; (d) services; and (e) in-kind payments.

28  
29 Since the inception of this Committee, its reports document the process the Committee follows to  
30 ensure that current or recommended Officer compensation is based on sound, fair, cost-effective  
31 compensation practices as derived from research and use of independent external consultants,  
32 expert in Board compensation. Reports beginning in December 2002 documented the principles the  
33 Committee followed in creating its recommendations for Officer compensation.

34  
35 At A-08, the HOD approved changes that simplified compensation practices with increased  
36 transparency and consistency. At A-10, Reference Committee F requested that this Committee  
37 recommend that the HOD affirm a codification of the current compensation principle, which

1 occurred at I-10. At that time, the HOD affirmed that this Committee has and will continue to base  
2 its recommendations for Officer compensation on the principle of the value of work performed,  
3 consistent with IRS guidelines and best practices recommended by the Committee's external  
4 independent consultant, who is expert in Board compensation.

5  
6 At A-11, the HOD approved the alignment of Medical Student and Resident Officer compensation  
7 with that of all other Officers (excluding Presidents and Chair) because these positions perform  
8 comparable work.

9  
10 Immediately following A-11, the Committee retained Mr. Don Delves, founder of the Delves  
11 Group, to update his 2007 research by providing the Committee with comprehensive advice and  
12 counsel on Officer compensation. The updated compensation structure was presented and approved  
13 by the HOD at I-11 with an effective date of July 1, 2012.

14  
15 The Committee's I-13 report recommended and the HOD approved the Committee's  
16 recommendation to provide a travel allowance for each President to be used for upgrades because  
17 of the significant volume of travel representing our AMA.

18  
19 At I-16, based on results of a comprehensive compensation review conducted by Ms. Becky Glantz  
20 Huddleston, an expert in Board Compensation with Willis Towers Watson, the HOD approved the  
21 Committee's recommendation of modest increases to the Governance Honorarium and Per Diems  
22 for Officer Compensation, excluding the Presidents and Chair, effective July 1, 2017. At A-17 the  
23 HOD approved modifying the Governance Honorarium and Per Diem definition so that Internal  
24 Representation, greater than eleven days, receives a per diem.

25  
26 At A-18, based on comprehensive review of Board leadership compensation, the HOD approved  
27 the Committee's recommendation to increase the President, President-elect, Immediate Past-  
28 President, Chair, and Chair-elect honoraria by 4% effective July 1, 2018.

29  
30 At A-18 and A-19, the House approved the Committee's recommendation to provide a Health  
31 Insurance Stipend to President(s) who are under Medicare eligible age when the President(s) and  
32 his/her covered dependents, not Medicare eligible, lose the President's employer provided health  
33 insurance during his/her term as President. Should the President(s) become Medicare eligible while  
34 in office, he/she received an adjusted Stipend to provide insurance coverage to his/her dependents  
35 not Medicare eligible.

36  
37 The Committee's I-19 report recommended and the HOD approved the Committee's  
38 recommendation to increase the Governance Honorarium and Per Diem for Officers, excluding  
39 Presidents and Chair, by approximately 3% each effective July 1, 2020.

40  
41 The Committee's A-22 report recommended and the House approved increasing the travel upgrade  
42 allowance for President, President-Elect, and Immediate Past-President to \$5,000 and adding an  
43 upgrade allowance of \$2,500 for all other Officers to use as each deems appropriate, typically when  
44 traveling on an airline with non-preferred status.

#### 45 46 CASH COMPENSATION SUMMARY

47  
48 The cash compensation of the Officers shown in the following table will not be the same as  
49 compensation reported annually on the AMA's IRS Form 990s because Form 990s are based on a  
50 calendar year. The total cash compensation in the summary is compensation for the days these  
51 officers spent away from home on AMA business approved by the Board Chair. The total cash

1 compensation in the summary includes work as defined by the Governance Honorarium, Per Diem  
 2 for Representation and Telephone Per Diem for External Representation. Detailed definitions are in  
 3 the Appendix.  
 4  
 5 The summary covers July 1, 2021 to June 30, 2022.

AMA Officers	Position	Total Compensation	Total Days
David H. Aizuss, MD	Officer	\$ 67,000	42.5
Toluwalase A. Ajayi, MD	Officer	-	2.5
Susan R Bailey, MD	Immediate Past President	\$ 284,960	62
Madelyn E. Butler, MD	Officer	\$ 67,000	39
Alex Ding, MD, MS, MBA	Officer	-	2
Willarda V. Edwards, MD, MBA	Officer	\$ 74,700	49
Lisa Bohman Egbert, MD	Vice Speaker, House of Delegates	\$ 133,500	104
Jesse M. Ehrenfeld, MD, MPH	Officer	\$ 132,800	86
Scott Ferguson, MD	Secretary	\$ 69,100	46
Sandra Adamson Fryhofer, MD	Chair-Elect	\$ 210,280	69.5
Gerald E. Harmon, MD	President	\$ 290,160	112.5
Drayton Charles Harvey	Medical Student Officer	\$ 67,000	43.5
Marilyn Heine, MD	Officer	-	2.5
Pratistha Koirala, MD	Resident/Fellow Physician Officer	\$ 67,000	34.5
Russ Kridel, MD	Immediate Past Chair	\$ 69,800	46.5
Ilse R. Levin, DO, MPH & TM	Officer	\$ 67,000	36
Thomas J. Madejski, MD	Officer	\$ 78,900	45.5
Mario E. Motta, MD	Officer	\$ 80,300	49.5
Bobby Mukkamala, MD	Chair	\$ 282,380	65
Harris Pastides, PhD, MPH	Public Member Officer	\$ 67,000	35
Jack Resneck, Jr, MD	President-Elect	\$ 291,260	88
Bruce A. Scott, MD	Speaker, House of Delegates	\$ 142,600	96
Michael Suk, MD, JD, MPH, MBA	Officer	\$ 80,300	51.5
Willie Underwood, III, MD, MSc, MPH	Officer	\$ 81,700	61

6 President, President-Elect, Immediate Past President, and Chair  
 7 In 2021-2022, each of these positions received an annual Governance Honorarium which was paid  
 8 in monthly increments. These four positions spent a total of 327.5 days on approved Assignment  
 9 and Travel, or 81.9 days each on average.

10

11 Chair-Elect

12 This position received a Governance Honorarium of approximately 75% of the Governance  
 13 Honorarium provided to the Chair.

14

15 All other Officers

16 All other Officers received cash compensation, which included a Governance Honorarium of  
 17 \$67,000 paid in monthly installments. The remaining cash compensation is for Assignment and  
 18 Travel Days that are approved by the Board Chair to externally represent the AMA and for Internal  
 19 Representation days above 11. These days were compensated at a per diem rate of \$1,400.

1 *Note:* The Speaker and Vice Speaker had higher compensation than normal given how much extra  
2 time they devoted to planning the virtual and in-person House meetings in November 2021 and  
3 June 2022.

4  
5 **Assignment and Travel Days**

6 The total Assignment and Travel Days for all Officers (excluding the President, President-Elect,  
7 Immediate Past President and Chair) were 942.

8  
9 **EXPENSES**

10  
11 Total expenses paid for period, July 1, 2021 – June 30, 2022, was \$535,706, without use of upgrade  
12 allowance of \$5,000 for Presidents and \$2,500 all other Officers per position per term. Total  
13 upgrade allowances used for the period were \$10,763.95.

14  
15 **BENEFITS, PERQUISITES, SERVICES, AND IN-KIND PAYMENTS**

16  
17 Officers are able to request benefits, perquisites, services, and in-kind payments, as defined in the  
18 “AMA Board of Trustees Standing Rules on Travel Expenses.” These non-taxable business  
19 expense items are provided to assist the Officers in performing their duties.

- 20  
21
  - AMA Standard laptop computer or iPad
  - American Express card (for AMA business use)
  - Combination fax/printer/scanner (reimbursable up to \$250)
  - An annual membership to the airline club of choice offered each year during the Board member’s tenure
  - Personalized AMA stationery, business cards, and biographical data for official use

22  
23  
24  
25  
26  
27  
28 Additionally, all Officers are eligible for \$305,000 term life insurance and are covered under the  
29 AMA’s \$500,000 travel accident policy and \$10,000 individual policy for medical costs arising out  
30 of any accident while traveling on official business for the AMA. Life insurance premiums paid by  
31 the AMA are reported as taxable income. Also, travel assistance is available to all Officers when  
32 traveling more than 100 miles from home or internationally.

33  
34 Secretarial support, other than that provided by the AMA’s Board office, is available up to defined  
35 annual limits as follows: President, during the Presidential year, \$15,000, and \$5,000 each for the  
36 President-Elect, Chair, Chair-Elect, and Immediate Past President per year. Secretarial expenses  
37 incurred by other Officers in conjunction with their official duties are paid up to \$750 per year per  
38 Officer. This is reported as taxable income.

39  
40 Officers are also eligible to participate in a service provided to AMA employees by Care@Work  
41 through Care.com. This service offers referral services at no cost and back-up care for children and  
42 adults up to 10 days a calendar year at a subsidized rate. If a Board member uses back-up care, it  
43 will be reported to the IRS as taxable income.

44  
45 Calendar year taxable life insurance and taxable secretarial fee reported to the IRS totaled \$48,132  
46 and \$29,125 respectively for 2021. An additional \$10,500 was paid to third parties for secretarial  
47 services during 2021.

1 FINDINGS

2

3 The Cash Compensation Summary, travel expenses, and the suspension of tracking telephonic  
4 representation since most meetings were conducted virtually reflect the impact of the Coronavirus  
5 on the Officers in representing our AMA. Our AMA leadership quickly pivoted to continue  
6 representing the AMA, both internally and externally in virtual and in-person meetings. This pivot,  
7 while appearing seamless, required significant flexibility and behind-the-scenes planning of our  
8 Officers. As you know, the 2021 Interim Meeting was suspended.

9

10 This Committee commends and thanks our Officers for their representation of the AMA.

11

12 RECOMMENDATIONS

13

14 1. That there be no changes to the Officers' compensation for the period beginning July 1, 2022  
15 through June 30, 2023. (Directive to Take Action.)

16

17 2. That the remainder of the report be filed.

Fiscal Note: \$0

APPENDIX

POSITION	GOVERNANCE HONORARIUM
President	\$290,160
Immediate Past President	\$284,960
President-Elect	\$284,960
Chair	\$280,280
Chair-Elect	\$207,480
Officers	\$67,000

Definition of Governance Honorarium Effective July 1, 2017:

The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board Committee meetings, task forces, subcommittees, Board orientation, development and media training, Board calls, sections, councils, or other internal representation meetings or calls, and any associated review or preparatory work, and all travel days related to all meetings as noted up to eleven (11) Internal Representation days.

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

The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating, achievement of the respective organization goals such as the AMA Foundation, PCPI, etc. or for Internal Representation days above eleven (11). The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather-related travel delays. Per Diem for Chair-assigned representation and related travel is \$1,400 per day.

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

Officers, excluding the Board Chair and the President(s) who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation days above eleven (11), receive a per diem for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for those meetings would require approval of the Chair of the Board. The amount of the Telephonic Per Diem will be ½ of the full Per Diem which is \$700.

# REPORT OF THE SPEAKERS

Speakers' Report 1-I-22

Subject: Election Committee - Interim Report

Presented by: Bruce A. Scott, MD, Speaker; and Lisa Bohman Egbert, MD, Vice Speaker

Referred to Reference Committee F

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

## 8 9 BACKGROUND

10  
11 At the 2019 Annual Meeting of the House of Delegates the House adopted policy calling on the  
12 Speaker to appoint a task force for the purpose of recommending improvements to the AMA HOD  
13 election and campaign process. The task force, known as the Election Task Force or ETF, was  
14 given broad purview with a plan to report their recommendations back to the HOD for action. The  
15 ETF presented a preliminary report at I-19 and held an open forum to hear concerns.

16  
17 The task force presented their full report, Speakers Report 2: Report of the Election Task Force,  
18 with 41 recommendations at the June 2021 Special Meeting (the relevant portion from the report  
19 regarding the Election Committee is attached as Appendix A). 39 of the ETF recommendations  
20 were adopted by the HOD with broad support, including Recommendations 38 - 40 recommending  
21 the creation of an Election Committee (Note: A recommendation regarding interviews was  
22 referred, and a recommendation calling for the members of the Council on Constitution & Bylaws  
23 to be appointed was not adopted):

24  
25 Recommendation 38: In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election  
26 Committee of 7 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a  
27 lifetime maximum tenure of 8 terms) to report to the Speaker. These individuals would agree  
28 not to be directly involved in a campaign during their tenure and would be appointed from  
29 various regions, specialties, sections, and interest groups. The primary role of the committee  
30 would be to work with the Speakers to adjudicate any election complaint. Additional roles to  
31 be determined by the Speaker and could include monitoring election reforms, considering  
32 future campaign modifications and responding to requests from the Speaker for input on  
33 election issues that arise (New Policy).

34  
35 Recommendation 39: The Speaker in consultation with the Election Committee will consider a  
36 more defined process for complaint reporting, validation, resolution, and potential penalties.  
37 This process will be presented to the House for approval (New Policy).

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

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

10  
11 Also of note was Recommendation 41 calling for a review of the modified election processes after  
12 an interval of two years (after A-23).

13  
14 *The EC Report and Referral for Decision to the Board of Trustees*

15  
16 Pursuant to Recommendation 38 (Policy D-610.998) the Speaker appointed the initial House of  
17 Delegates Election Committee (EC) made up of 7 members of the House who volunteered to serve  
18 and agreed to not participate in campaigns during their tenure on the EC. As directed by the  
19 adopted policy (original recommendation 39), the EC presented a report ("Speakers' Report 2:  
20 Establishing an Election Committee," here forward referred to as the "EC Report," see Appendix  
21 B) at the November 2021 Special Meeting proposing a process by which the Speakers and the  
22 Election Committee would handle allegations of rules violations.

23  
24 The EC Report provided details regarding complaint reporting, validation, resolution, and potential  
25 penalties and further proposed that the Speakers would work with but not be actual members of the  
26 committee. In general, the report received positive comments, but during the HOD deliberations,  
27 questions about the role of the Speakers on the committee and the Speakers' role in adjudicating  
28 allegations led to the matter being referred for decision.

29  
30 Testimony heard at the House favored a more active role for the Speakers. The Board concluded  
31 because our policy (G-610.020) and tradition call for the Speaker to have oversight of elections, it  
32 was appropriate for the Speakers (unless conflicted) to serve as full voting members of the EC.

33  
34 Some testimony suggested that the Speaker should be the final arbiter of a complaint, while others  
35 pointed out that situations could arise where the Speaker may be conflicted. The Board concluded  
36 that no single individual, including the Speaker, should be the lone arbiter of a complaint. The  
37 responsibility and authority for validation of a complaint and determination of resolution should  
38 rest with the Election Committee, a cross section of the House, reflecting the fact that the House of  
39 Delegates determines its procedures, among which are election-related matters.

40  
41 In their review, the Board noted that while the body of the EC Report provided detailed  
42 information regarding complaint reporting, validation, and resolution for possible campaign  
43 violations, these details were not specified in the formal recommendations adopted by the House.  
44 The EC Report detailed that when a complaint was received, the Speaker would consult with the  
45 committee chair to form a subcommittee of three members to investigate the allegation. The  
46 subcommittee of the EC would be selected to avoid conflicts (e.g., being part of the same  
47 delegation as the alleged violator). Using necessary discretion, the subcommittee would investigate  
48 the complaint and when necessary, the Office of General Counsel or the HOD Office would assist.  
49 The subcommittee would report to the full EC the results of their investigation, with the final  
50 determination to be made by the full committee with any potentially conflicted members recused.  
51 No objections to these series of actions as presented in the EC Report were heard during testimony.

1 The Board concurred with the described process, with minor clarification, and determined that the  
2 process should be codified in policy.

3  
4 As discussed in the report (Appendix B), historically the only formal penalty for a campaign  
5 violation was announcement of the violation to the House by the Speaker. The report went on to  
6 state that this singular penalty may be excessive for some violations and thus the committee, in  
7 considering mitigating circumstances and the severity of the violation, should be allowed other  
8 options to resolve a validated violation. The EC also noted that an exhaustive list of potential  
9 violations would be an impossible task to compile and further that a list of associated penalties  
10 would be too rigid and ill advised. Consequently, the EC recommended that it be given discretion  
11 to determine the appropriate sanction for a validated complaint, with the option of announcement to  
12 the House remaining.

13  
14 The Board agreed that in many circumstances resolution may be accomplished by corrective  
15 action, short of announcement to the House, and that the EC be allowed discretion to determine the  
16 appropriate resolution of a given validated complaint with announcement to the House of a  
17 violation remaining an option for violations that are deemed to rise to that level. In these most  
18 significant violations the House of Delegates, through their vote in the election, would remain the  
19 final arbiter. In addition, a record of all filed complaints and the results of the validation and the  
20 resolution processes should be maintained by the General Counsel and kept confidential within the  
21 EC unless the committee determined that the violation should be reported to the House. Again, the  
22 Board determined these details should be specified in policy.

23  
24 No testimony was provided in the House regarding the process for reporting potential campaign  
25 violations. The Board concurred that individuals to whom potential campaign violations could be  
26 reported should include the Speakers who have traditionally been the recipients of such, but  
27 complainants should also have an option to report to the General Counsel. This third option of  
28 reporting might prevent awkward situations where one or both Speakers were potentially  
29 conflicted.

30  
31 *Action by the Board of Trustees*

32  
33 At their February 2022 meeting the Board officially adopted the following:

- 34  
35 1. That Paragraph 5 of Policy D-610.998, "Directives from the Election Task Force," be  
36 amended by addition to read as follows:  
37  
38 5. In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 7  
39 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime  
40 maximum tenure of 8 terms) to report to the Speaker. These individuals would agree not  
41 to be directly involved in a campaign during their tenure and would be appointed from  
42 various regions, specialties, sections, and interest groups. The primary role of the  
43 committee would be to work with the Speakers to adjudicate any election complaint.  
44 Additional roles to be determined by the Speaker and could include monitoring election  
45 reforms, considering future campaign modifications and responding to requests from the  
46 Speaker for input on election issues that arise. **The Speaker and Vice Speaker shall be**  
47 **full members of the Election Committee.** (*emphasis added*)  
48  
49 2. A Campaign Complaint Reporting, Validation and Resolution Process shall be established  
50 as follows:

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

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

- 8
- 9 3. Campaign violation complaints will be investigated by the Election Committee or a  
10 subcommittee thereof.
- 11 a. The Committee will collectively determine whether a campaign violation has occurred.
  - 12 b. For validated complaints, the Committee will determine appropriate penalties, which  
13 may include an announcement of the violation by the Speaker to the House.
  - 14 c. Committee members with a conflict of interest may participate in discussions but must  
15 recuse themselves from decisions regarding the merits of the complaint or penalties.
  - 16 d. Deliberations of the Election Committee shall be confidential.
  - 17 e. The Speaker shall include a summary of the Election Committee's activities in "Official  
18 Candidate Notifications" sent to the House. Details may be provided at the discretion of  
19 the Election Committee and must be provided when the penalty includes an  
20 announcement about the violator to the House.
- 21
- 22 4. A record of all complaints and the results of the validation and the resolution processes,  
23 including penalties, shall be maintained by the AMA Office of General Counsel and kept  
24 confidential.
- 25
- 26 5. The Election Committee will review the Campaign Complaint Reporting, Validation and  
27 Resolution Process as implemented and make further recommendations to the House as  
28 necessary.
- 29

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

31

## 32 REVIEW OF ELECTION COMMITTEE ACTIVITY

33

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

39

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

43

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

48

49 The EC has now completed a single campaign and election cycle. The Speaker reappointed 6  
50 members of the committee (a single member was unavailable for reappointment) and appointed a  
51 new member from volunteers who submitted applications. The newly constituted committee has

1 met to review the election process as implemented and discuss possible improvements. This report  
2 is the first report of the 2022-2023 Election Committee.

3  
4 DISCUSSION

5  
6 The EC reviewed the process for complaint reporting, validation, and resolution as established by  
7 the HOD and BOT. The committee believes the process, as defined by AMA policy, provides an  
8 appropriate matrix for handling reported campaign violations, and recommends additions and  
9 communication of the process.

10  
11 At A-22 the committee elected to involve the General Counsel and the Director of the Office of  
12 HOD Affairs in investigating a complaint, as was suggested in the EC Report. The EC believes the  
13 option of including the GC and Director should be added to the formal process specified in AMA  
14 policy.

15  
16 It has been suggested that due process demands that the accused be made aware of the accusations  
17 against them and given an opportunity to respond. While not specified in current policy, this  
18 suggestion comports with the process followed by the committee. The EC recommends that it be  
19 made explicit in policy given its inherent reasonableness and fundamental fairness.

20  
21 The EC Report from November 2021 (Appendix B) reviewed the option of specified penalties and  
22 concluded that creation of a "menu" of penalties would not be possible or prudent. The report  
23 discussed principles that would be applied in consideration of sanctions, including the timing of the  
24 offense, the advantage sought or gained, and the culpability of the candidate themselves. Policy  
25 D-610.998, paragraph 7b, codifies the role of the committee in determining appropriate penalties.  
26 Allowing some discretion for the EC, which is made up of a cross section of informed delegates,  
27 allows consideration of nuance and mitigating or extenuating circumstances.

28  
29 Current policy and precedent provide for announcement to the HOD of validated campaign  
30 violations that are deemed most serious. Neither AMA policy nor Bylaws provide for removal of a  
31 candidate from an election. Announcement to the House maintains the appropriate role of the HOD  
32 as the final arbiter by their vote in the associated or relevant election. The EC reviewed these issues  
33 and favors the current policy, allowing the House to remain the final arbiter of serious violations.  
34 The committee does not seek the authority to remove a candidate.

35  
36 Anonymity of complainants and confidentiality of deliberations is a basic tenet of claims of  
37 malfeasance and is specified in our rules. The desire for more information regarding serious  
38 accusations is understandable, but such disclosure would be problematic. It would seem unwieldy  
39 to expect complete disclosure. Any summary would invite accusations of bias or being misleading.  
40 In addition, disclosure could be embarrassing or even damaging to individuals interviewed solely  
41 to ensure a thorough and fair investigation. Knowing that such disclosure would be made would  
42 likely cause individuals to hesitate to cooperate in providing information, particularly if  
43 corroborating an allegation. While one would hope that ethics and professionalism alone would  
44 support truthful cooperation, the EC has no ability to compel individuals to cooperate with an  
45 investigation, and individuals do not testify under oath. Although not a jury, the EC is selected  
46 from experienced colleagues within the House who have agreed not to be involved in campaigns  
47 during their tenure on the committee and to recuse themselves if they have any potential conflict of  
48 interest in consideration of a complaint. The EC believes that while a record of all complaints and  
49 the results of the validation and the resolution processes should be maintained within the Office of  
50 the General Counsel, the committee deliberations should remain confidential and therefore,  
51 recommends no change to paragraph 8 of Policy D-610.998.

1 Prior to 2021 and the establishment of the Election Committee, election complaints were handled  
2 by a single individual, the Speaker, without any defined process. Our recently adopted House  
3 policy empowers the committee to “work with the Speakers to adjudicate any election complaint,”  
4 calling this the primary role of the committee. Further, AMA policy defines the process to be  
5 followed. Vesting such authority in the committee places trust that the individuals will carefully  
6 and fairly adjudicate any complaint.

7  
8 The policy that established the EC and our AMA campaign rules do not provide for oversight of  
9 delegations or caucuses beyond the fact that candidates themselves are held responsible for the  
10 actions of their campaign teams. In fact, our AMA has no clear authority over caucuses, which  
11 exist as independent entities and in some cases incorporated entities. The committee has heard that  
12 announcement of a violation may be perceived as damaging to a caucus or entire delegation, with  
13 or without their involvement. As such, it has been suggested that the leadership of a caucus or  
14 delegation be made aware whenever an allegation suggests the involvement of the group. While the  
15 EC does not seek broader oversight over delegations or caucuses, this request for notification and  
16 an opportunity to respond is considered reasonable and a recommended addition to policy.

17  
18 Paragraph 5 of Policy D-610.998 calls for the Speaker to appoint an Election Committee of 7  
19 individuals in accordance with Bylaw 2.13.7. The action of the Board in April making the speakers  
20 “full members” of the committee in effect expanded the EC to 9 members. This is allowed under  
21 Bylaw 2.13.7.2: “Size. Each committee shall consist of 7 members, **unless otherwise provided**”  
22 (*emphasis added*). Paragraph 7c of Policy D-610.998 requires committee members with a conflict  
23 of interest to recuse themselves. The EC notes that recusal of members may become a challenge,  
24 particularly in campaigns with multiple candidates from differing delegations, and recommends  
25 further expansion of the committee by two (2) additional members.

26  
27 The EC believes the process for reporting, validation and resolution of campaign violations as  
28 recommended here should be codified in policy and widely communicated. While this report will  
29 raise awareness, the EC believes the formal process established should be included in future  
30 editions of the Election Manual.

## 31 32 CONCLUSION

33  
34 The Election Committee was officially established in June 2021 and has been in place for a single  
35 campaign and election cycle. The EC intends this interim report to raise awareness of the current  
36 processes for campaign complaint reporting, validation, and resolution as codified by action of the  
37 HOD and the BOT. As per Policy D-610.998, paragraph 9, the committee will continue to review  
38 the processes as implemented and make further recommendations to the House as necessary. In  
39 addition, the House is reminded that a review of the entirety of the modified election processes will  
40 be conducted after the upcoming elections at A-23 as per adopted recommendation 41 of the  
41 Election Task Force Report. Any adopted recommendations will be subject to that review.

## 42 43 RECOMMENDATIONS

44  
45 It is recommended that the following recommendations be adopted and the remainder of the report  
46 filed.

- 47  
48 1. That Policy D-610.998, Paragraph 5, be amended by addition and deletion to read as follows:

49  
50 In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 7  
51 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime maximum

- 1 tenure of 8 terms) to report to the Speaker. These individuals would agree not to be directly  
2 involved in a campaign during their tenure and would be appointed from various regions,  
3 specialties, sections, and interest groups. The primary role of the committee would be to work  
4 with the Speakers to adjudicate any election complaint. Additional roles to be determined by  
5 the Speaker and could include monitoring election reforms, considering future campaign  
6 modifications and responding to requests from the Speaker for input on election issues that  
7 arise. The Speaker and Vice Speaker shall be full members of the Election Committee. (Modify  
8 Current HOD Policy)  
9
- 10 2. That Policy D-610.998, Paragraph 7, be amended by addition to read as follows:  
11  
12 Campaign violation complaints will be investigated by the Election Committee or a  
13 subcommittee thereof with the option of including the Office of General Counsel or the  
14 Director of the House of Delegates. (Modify Current HOD Policy)  
15
- 16 3. That Policy D-610.998, Paragraph 7(a), be amended by addition to read as follows:  
17  
18 7(a). The Committee will collectively determine whether a campaign violation has occurred.  
19 As part of the investigation process the Election Committee or its subcommittee shall  
20 inform the candidate of the complaint filed and give the candidate the opportunity to  
21 respond to the allegation. (Modify Current HOD Policy)  
22
- 23 4. That Paragraph 7 be amended by addition of a new sub point "b" to read as follows:  
24  
25 7(b) If the complaint implicates a delegation or caucus, the Election Committee or its  
26 subcommittee shall inform the chair of the implicated delegation or caucus of the  
27 complaint filed and give the implicated delegation or caucus chair(s) the opportunity to  
28 answer to the allegation as a part of the investigative process. (Modify Current HOD  
29 Policy)  
30
- 31 5. That amended Policy D-610.998 be widely communicated, including being published in the  
32 Election Manual. (Directive to Take Action)

Fiscal Note: Up to \$5000 annually; zero in the absence of a complaint.

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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601  
(I-22)

Introduced by: Louisiana, South Carolina

Subject: AMA Withdraw its Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity

Referred to: Reference Committee F

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1 Whereas, On May 11, 2021, the American Medical Association released to the public its  
2 *Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity* (hereinafter  
3 *the Equity Strategic Plan*), a work product developed by the AMA Center for Health Equity and  
4 approved by the AMA Board of Trustees; and

5  
6 Whereas, The Louisiana House of Delegates found the document to contain divisive and  
7 inflammatory language, terminology and racially characterizing statements that stand in polar  
8 opposition to our Louisiana State Medical Society Policies and to AMA Policies H-65.965,  
9 H-65.953, H-140.900, and the AMA Code of Medical Ethics; and

10  
11 Whereas, The Louisiana House of Delegates directed the Louisiana AMA Delegation to submit  
12 a resolution to the AMA HOD; therefore be it

13  
14 RESOLVED, That our American Medical Association withdraw its Organizational Strategic Plan  
15 to Embed Racial Justice and Advance Health Equity (Equity Strategic Plan) and rewrite the  
16 recommendations for correcting its past support for racially discriminating behavior with removal  
17 of the inflammatory rhetoric. (Directive to Take Action)

Fiscal Note: Estimated cost of \$415,000 to implement resolution.

Received: 06/16/22

**RELEVANT AMA POLICY**

**Support of Human Rights and Freedom H-65.965**

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.

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17; Modified: Res. 013, A-22

**Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice H-65.953**

1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.
2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.
3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category “race” can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.
4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.

Citation: Res. 11, I-20

**A Declaration of Professional Responsibility H-140.900**

Our AMA adopts the Declaration of Professional Responsibility

**DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE'S SOCIAL CONTRACT WITH HUMANITY**

**Preamble**

Never in the history of human civilization has the well being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets.

Advances in medical science and genetics, while promising to do great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

**Declaration**

We, the members of the world community of physicians, solemnly commit ourselves to:

- (1) Respect human life and the dignity of every individual.
- (2) Refrain from supporting or committing crimes against humanity and condemn any such acts.
- (3) Treat the sick and injured with competence and compassion and without prejudice.
- (4) Apply our knowledge and skills when needed, though doing so may put us at risk.
- (5) Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.
- (6) Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.
- (7) Educate the public and polity about present and future threats to the health of humanity.
- (8) Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.
- (9) Teach and mentor those who follow us for they are the future of our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor.

Citation: CEJA Rep. 5, I-01; Reaffirmation A-07; Reaffirmed: CEJA Rep. 04, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602  
(1-22)

Introduced by: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, New Jersey, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Virginia, West Virginia, Texas, American College of Radiology

Subject: Finding Cities for Future AMA Conventions/Meetings

Referred to: Reference Committee F

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- 1 Whereas, It appears that for at least the next five years or more the AMA Interim and Annual  
2 meetings are being limited to Chicago, Illinois, Orlando, Florida (but probably no more Orlando  
3 after 2026) and National Harbor, Maryland; and  
4
- 5 Whereas, There is political and financial benefit to both AMA and the AMA House of Delegates  
6 to move around the US as much as possible and visit in our states particularly for the Interim  
7 Meeting; and  
8
- 9 Whereas, There are convention centers in 47 states (see [List of convention centers in the](#)  
10 [United States - Wikipedia](#)) and with 36 of these centers over 300,000 sq ft of space; and  
11
- 12 Whereas, There are 19 other US cities with convention hotels with over 1500 rooms each (see  
13 [US Convention Hotels | Cvent Destination Guide](#)); and  
14
- 15 Whereas, About 20 US cities have over 4000 hotel rooms (from Costar: [Hotel News Now](#) and  
16 [Largest Hotels in USA \(United States\) by Most Number of Rooms \(rlist.io\)](#)); and  
17
- 18 Whereas, AMA Policy G-630.140 is vague and complex and has thus made AMA staff and  
19 consultants fearful of “doing the wrong thing” and thus forced us to the current limit on hotels or  
20 sites that AMA can “use”; and  
21
- 22 Whereas, Our sole intent is to amend Policy G- 630.140 to loosen up the sites and cities  
23 available to AMA meetings; therefore be it

1 RESOLVED, That our American Medical Association amend Policy G-630.140, "Lodging,  
2 Meeting Venues, and Social Functions," by addition and deletion to read as follows:

3  
4 AMA policy on lodging and accommodations includes the following:

5  
6 1. Our AMA supports choosing hotels for its meetings, conferences, and conventions  
7 based on size, service, location, cost, and similar factors.

8  
9 2. Our AMA shall attempt, when allocating meeting space, to locate the Section  
10 Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close  
11 proximity.

12  
13 3. All meetings and conferences organized and/or primarily sponsored by our AMA  
14 will be held in a town, city, county, or state that ~~has regulation or enacted~~  
15 ~~comprehensive~~ legislation requiring smoke-free worksites and public places (including  
16 restaurants and bars), unless intended or existing contracts or special circumstances  
17 justify an exception to this policy, and our AMA encourages state and local medical  
18 societies, national medical specialty societies, and other health organizations to adopt  
19 a similar policy.

20  
21 4. It is the policy of our AMA not to ~~hold meetings organized and/or primarily~~  
22 ~~sponsored by our AMA, in cities, counties, or states, or pay member, officer or~~  
23 ~~employee dues in any club, restaurant, or other institution, that has exclusionary~~  
24 ~~policies, including, but not limited to, policies based on, race, color, religion, national~~  
25 ~~origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity~~  
26 ~~and gender expression, disability, or age unless intended or existing contracts or~~  
27 ~~special circumstances justify an exception to this policy.~~

28  
29 5. Our AMA staff will work with facilities where AMA meetings are held to designate  
30 an area for breastfeeding and breast pumping.

31  
32 6. All future AMA meetings will be structured to provide accommodations for members  
33 and invited attendees who are able to physically attend, but who need assistance in  
34 order to meaningfully participate.

35  
36 7. Our AMA will revisit our criteria for selection of hotels and other venues in order to  
37 facilitate maximum participation by members and invited attendees with disabilities.

38  
39 8. Our AMA will report back to the HOD by no later than the 2023 Annual Meeting  
40 with a plan on how to maximize meeting participation for members and invited  
41 attendees with disabilities. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than \$1,000

Received: 09/27/22

## **RELEVANT AMA POLICY**

### **Lodging, Meeting Venues, and Social Functions G-630.140**

AMA policy on lodging and accommodations includes the following:

1. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors.
2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.
3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy.
4. It is the policy of our AMA not to hold meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.
5. Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping.
6. All future AMA meetings will be structured to provide accommodations for members and invited attendees who are able to physically attend, but who need assistance in order to meaningfully participate.
7. Our AMA will revisit our criteria for selection of hotels and other venues in order to facilitate maximum participation by members and invited attendees with disabilities.
8. Our AMA will report back to the HOD by no later than the 2023 Annual Meeting with a plan on how to maximize meeting participation for members and invited attendees with disabilities.

Citation: Res. 2, I-87; Reaffirmed: Sunset Report, I-97; Res. 512, I-98; Consolidated: CLRPD Rep. 3, I-01; Reaffirmation A-04; Modified: CCB/CLRPD Rep. 3, A-12; Modified: CCB/CLPRD Rep. 2, A-13; Modified: BOT Rep. 17, A-17; Appended: Res. 610, A-22

## Reference Committee J

### **CMS Report(s)**

- 01 Incentives to Encourage Efficient Use of Emergency Departments
- 02 Corporate Practice of Medicine

### **Resolution(s)**

- 801 Parity in Military Reproductive Health Insurance Coverage for All Service Members and Veterans
- 802 FAIR Health Database
- 803 Patient Centered Medical Home – Administrative Burdens
- 804 Centers for Medicare & Medicaid Innovation Projects
- 805 COVID Vaccine Administration Fee
- 806 Healthcare Marketplace Plan Selection
- 807 Medicare Advantage Record Requests
- 808 Reinstatement of Consultation Codes
- 809 Uniformity and Enforcement of Medicare Advantage Plans and Regulations
- 810 Medicare Drug Pricing and Pharmacy Costs
- 811 Covering Vaccinations for Seniors Through Medicare Part B
- 812 Implant-Associated Anaplastic Large Cell Lymphoma
- 813 Amending Policy on a Public Option to Maximize AMA Advocacy
- 814 Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?

REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (I-22)  
Incentives to Encourage Efficient Use of Emergency Departments  
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2022 Annual Meeting, the House of Delegates adopted Policy D-130.959, “Study of Incentives to Encourage Efficient Use of Emergency Departments,” which directs the American Medical Association (AMA) to study and report on the positive and negative experiences of programs in various states that provide Medicaid beneficiaries with incentives for choosing alternate sites of care, for physical and mental health conditions, when it is appropriate to their symptoms and/or conditions instead of hospital emergency departments (EDs).

Medicaid/Children’s Health Insurance Program (CHIP) enrollees have higher rates of ED visits than Medicare, privately insured, and even uninsured individuals, thereby utilizing higher-cost services than those provided in other ambulatory care settings. To address this issue, and contain costs, states—and managed care plans that enroll Medicaid patients—have long sought ways to incentivize more efficient ED use. Financial incentives, including increased patient cost-sharing and retrospective payment denials, are among the variety of strategies that have been employed across states to try to reduce ED visits perceived to be non-emergency, nonurgent, or avoidable. Consistent with Policy D-130.959, the Council reviewed the literature on these financial incentives and finds that: 1) modest cost-sharing requirements, on their own, may not be very effective at either reducing ED services or generating significant cost-savings; and 2) diagnosis-based payment and coverage denials for non-emergency ED services may potentially harm some patients—by dissuading them from seeking emergency care when needed—as well as physicians and hospitals, when payment is denied.

The Council believes that interventions aimed at reducing ED use for services that could be provided elsewhere, and at lower cost, are worthy of ongoing monitoring and testing by the Centers for Medicare & Medicaid Services and other stakeholders. Accordingly, the Council recommends support for continued monitoring and testing of strategies and best practices for reducing non-emergency ED use, particularly among patients with the highest number of ED visits. Given the abundance of AMA policy that is relevant to this report topic, and the need for state flexibility to design strategies well suited to a state’s Medicaid population, the Council also recommends support for state efforts to encourage appropriate ED use among Medicaid/CHIP enrollees that are consistent with the standards and safeguards outlined in AMA policy on ED services. Finally, the Council recommends reaffirmation of AMA policies supporting the prudent layperson standard of determining when to seek emergency care (Policy H-130.970); criteria to be used in Medicaid managed care monitoring and oversight (Policy H-290.985); and reasonable Medicaid payment (Policy H-290.959).

# REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-22

Subject: Incentives to Encourage Efficient Use of Emergency Departments

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee J

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1 At the 2022 Annual Meeting, the House of Delegates adopted Policy D-130.959, “Study of  
2 Incentives to Encourage Efficient Use of Emergency Departments,” which directs the American  
3 Medical Association (AMA) to study and report on the positive and negative experiences of  
4 programs in various states that provide Medicaid beneficiaries with incentives for choosing  
5 alternate sites of care, for physical and mental health conditions, when it is appropriate to their  
6 symptoms and/or conditions instead of hospital emergency departments (EDs). The Board of  
7 Trustees assigned this policy to the Council on Medical Service for a report back to the House of  
8 Delegates at the 2022 Interim Meeting. This report describes the positive and negative experiences  
9 of two commonly used incentives intended to reduce non-emergency ED use (increased patient  
10 cost-sharing and retrospective payment denials), summarizes relevant AMA policy, and makes  
11 policy recommendations.  
12

## 13 BACKGROUND

14  
15 Medicaid spending makes up an increasingly large share of most state budgets and continues to be  
16 a focus of policymakers seeking ways to contain costs without compromising care quality. EDs  
17 have been targeted for cost-savings in many states because, for a variety of complex reasons,  
18 Medicaid/Children’s Health Insurance Program (CHIP) enrollees have higher rates of ED use than  
19 Medicare, privately insured, and even uninsured individuals.<sup>1,2</sup> Because services cost significantly  
20 more when provided in EDs than in other ambulatory care settings (e.g., physician offices and  
21 outpatient clinics), states—and managed care plans that enroll Medicaid patients—have long  
22 prioritized incentivizing more efficient ED use by Medicaid enrollees. Financial incentives,  
23 including increased patient cost-sharing and retrospective payment denials, are among the variety  
24 of strategies employed to try to reduce ED visits perceived to be non-emergency, nonurgent, or  
25 avoidable. Although there is no standard definition of what constitutes non-emergency, nonurgent,  
26 avoidable ED care, it is generally described as that which can be appropriately provided in a  
27 primary care or other outpatient setting at reduced cost.  
28

29 Due to the lack of consensus around defining non-emergency, nonurgent, avoidable ED visits,  
30 researchers have employed an array of methodologies to assess the effectiveness of strategies to  
31 reduce those patient visits that could be effectively treated elsewhere. As a result, studies have  
32 produced a range of estimates of ED visits classified as non-emergency, nonurgent, or avoidable,  
33 depending on methodology and how these visits are defined. Importantly, a 2013 *JAMA* study  
34 revealed what many physicians already knew—that non-emergency visits cannot easily be  
35 discerned from patients’ presenting complaints and symptoms, since symptoms for many non-  
36 emergency conditions overlap with symptoms of conditions that require emergency care.<sup>3</sup> This  
37 suggests that, in many cases, decisions about emergency versus non-emergency care are far from  
38 clear-cut and may not be evident at triage. Although exact percentages are not known, most

1 estimates of non-emergency ED visits as a proportion of all ED visits are relatively small. Analyses  
 2 by the Centers for Disease Control and Prevention (CDC) of ED data from the National Hospital  
 3 Ambulatory Medical Care Survey found that 5.5 percent of all ED visits in 2015,<sup>4</sup> 3.9 percent in  
 4 2017,<sup>5</sup> and 3.1 percent in 2018,<sup>6</sup> were classified as nonurgent. A 2015 report of the Washington  
 5 Health Alliance found that nearly 12 percent of Medicaid enrollee ED visits in the Puget Sound  
 6 region could be described as avoidable, compared to 8.5 percent of ED visits by privately insured  
 7 individuals.<sup>7</sup>

8  
 9 Experts have long posited that a lack of regular access to primary care drives many patients to EDs  
 10 for nonurgent reasons. Furthermore, Medicaid enrollees, and individuals dually eligible for  
 11 Medicare and Medicaid, are known to experience added barriers to accessing health care, in part  
 12 because they are more likely to experience inequities in social determinants of health (SDOH) that  
 13 lead to complex and chronic health needs. Other factors that lower access to health care include a  
 14 lack of available transportation, the distance one must travel to obtain care (especially in rural  
 15 areas), an inability to get needed specialty care, difficulties taking time off to attend medical  
 16 appointments, cost concerns among patients, lack of community behavioral health resources, and  
 17 inadequate Medicaid physician payment rates.

18  
 19 **MEDICAID PAYMENT RATES AND ENROLLEE ACCESS TO CARE**

20  
 21 For decades, the AMA has highlighted the inadequacy of physician payment rates across state  
 22 Medicaid programs—rates that are substantially below Medicare and private insurance fees and  
 23 often do not come close to covering the cost of providing care. In enacting the equal access  
 24 provision in section 1902(a)(30)(A) of the Social Security Act, Congress recognized that, “without  
 25 adequate payment levels, it is simply unrealistic to expect physicians to participate in the  
 26 [Medicaid] program.”<sup>8</sup> While physicians have a strong sense of responsibility to provide care for  
 27 Medicaid patients, physician practices cannot remain economically viable if they lose money on  
 28 the care they provide. Without an adequate supply of participating physicians, Medicaid patients  
 29 have coverage but may lack access to care. And without access to needed primary and specialty  
 30 care, Medicaid enrollees tend to visit EDs more often for conditions that could be handled in  
 31 alternate sites of service.

32  
 33 Because physicians participating in Medicaid remain sparse in many areas of the country, enrollees  
 34 often experience lengthy wait times, travel long distances to access care, or may go without care  
 35 altogether. Medicaid payment rates have been shown to significantly impact patient access to care,  
 36 with increases in payments found to improve access to care.<sup>9</sup> Accordingly, the AMA has long  
 37 advocated at the federal and state levels that physicians be provided fair and reasonable Medicaid  
 38 payment, defined in AMA policy as a minimum of 100 percent of Medicare rates. The AMA  
 39 further advocates that the Centers for Medicare & Medicaid Services (CMS) ensure that states  
 40 maintain Medicaid rate structures at levels that ensure there is sufficient physician participation, so  
 41 that Medicaid patients can access care in a timely manner.

42  
 43 **FACTORS CONTRIBUTING TO NON-EMERGENCY ED USE**

44  
 45 EDs have historically served as an essential source of care for people struggling with economic  
 46 marginalization, and research has shown an association between socioeconomic variables and  
 47 potentially avoidable ED use.<sup>10</sup> Medicaid enrollees experiencing inequities in SDOH—such as  
 48 housing instability, food insecurity, or lack of transportation—may be more likely to use the ED for  
 49 non-emergency care.

1 As previously noted, patients who do not have an established relationship with a primary care  
 2 provider may be more likely to seek care at an ED for non-emergency conditions. Moreover, across  
 3 some states, and especially in rural areas, it can be difficult for some Medicaid enrollees to obtain  
 4 needed specialty care; in turn, these patients may visit EDs because alternative care sites are simply  
 5 not available. Lack of access to behavioral health and substance use disorder services may be an  
 6 additional barrier in some areas. Physician workforce shortages in certain specialties likely  
 7 compound these access barriers that contribute to higher ED use among Medicaid enrollees.

8  
 9 Although some people may seek non-emergency care at EDs out of convenience, or on weekends  
 10 or evenings when other outpatient care is not available, analyses have been mixed and some  
 11 hospitals have found that non-emergency visits predominantly occur during regular hours when  
 12 physician offices are open. A subset of Medicaid enrollees may turn to hospital EDs for services  
 13 that cannot be accessed at primary care offices, while others may be motivated to have multiple  
 14 health concerns addressed during a single ED visit. Patients who perceive that they cannot access  
 15 timely or needed care in another setting, including individuals with mental health needs and/or  
 16 substance use disorder, may also seek non-emergency ED care, as will patients who believe they  
 17 are experiencing emergencies requiring immediate attention.

18  
 19 Insurer prior authorization (PA) requirements are also important drivers of non-emergency ED use,  
 20 especially when they preclude patients from getting timely needed care. In some cases, patients  
 21 may resort to EDs for certain medically indicated services that would otherwise be delayed while  
 22 approval is sought from the patient’s insurer. PA rules that impede quick access to services ranging  
 23 from mental health and substance use disorder treatment to imaging may lead some patients to seek  
 24 care at EDs. According to one study, a new outpatient PA process for radiologic studies may have  
 25 led to an increase in ED visits for outpatient MRI scans.<sup>11</sup>

26  
 27 Lack of insurance, or limited insurance, also impacts ED use, although people with health  
 28 insurance still experience time and access barriers to receiving regular care. Although the  
 29 expansion of Medicaid under the Affordable Care Act has been found to reduce the number of  
 30 uninsured individuals and increase access to primary care,<sup>12</sup> research findings on the association  
 31 between Medicaid expansion and ED use have been mixed, in part because newly insured patients  
 32 may use more health care services.

33  
 34 **STRATEGIES TO REDUCE NON-EMERGENCY ED USE**

35  
 36 Beyond financial incentives, strategies to reduce non-emergency ED use are numerous and varied  
 37 and have produced mixed results in the literature in terms of their impact. One strategy that is  
 38 central to many state efforts is care coordination designed to connect Medicaid enrollees to services  
 39 that address their physical and mental health needs as well as non-medical issues such as housing,  
 40 nutrition, and transportation. To improve care coordination, many states have focused on enrolling  
 41 Medicaid patients in patient-centered medical homes that use a physician-led team approach to  
 42 coordinating and managing care for individuals. Consistent with value-based care, care  
 43 coordination and the use of patient-centered medical homes assist patients in getting the right care  
 44 at the right time in the appropriate setting. Many medical home programs have successfully  
 45 reduced hospitalizations and ED use including, for example, Community Care of North Carolina,  
 46 which was found to decrease ED visits among individuals enrolled compared to those not  
 47 enrolled.<sup>13</sup> In the Medicare population, enrollees with patient-centered medical homes have also  
 48 been found to have slower growth in ED use than those not treated by medical homes.<sup>14</sup>

49  
 50 Additional mechanisms employed to help reduce non-emergency ED use include integrating  
 51 behavioral health care into primary care and expanding access to after-hours primary care, which

1 have been implemented by some health systems along with expanded telehealth availability. In the  
 2 Netherlands, linkages between primary care physician cooperatives and EDs have significantly  
 3 reduced ED use.<sup>15</sup> Rural health clinics, community health centers, and federally qualified health  
 4 centers serving economically marginalized communities may also play a role in reducing non-  
 5 emergency ED visits by providing accessible and timely care that would otherwise not be available.  
 6 Research has shown that the availability of health centers lowers ED use, and that many centers  
 7 actively work with local hospitals to further reduce ED visits.<sup>16</sup>

8  
 9 Ensuring the availability of community mental health resources is also key to addressing ED use by  
 10 mental health and substance use disorder patients and enabling them to access treatment outside of  
 11 EDs. Crisis response services and same-day access to treatment in one’s community have also been  
 12 cited as important mechanisms for reducing the use of EDs.<sup>17</sup> Notably, some states, health plans,  
 13 hospitals and health systems pursue cost-savings opportunities by targeting high-need, high-cost  
 14 Medicaid patients who have the greatest number of ED visits. Case management/care management  
 15 interventions of varying designs are often employed to help meet these patients’ complex physical,  
 16 behavioral, and social needs, thereby reducing their use of EDs. Extensivist clinics, employed by  
 17 some hospitals and health systems to coordinate and manage care for patients with multiple  
 18 complex health needs, have also been found to incur cost-savings by decreasing ED utilization and  
 19 hospitalizations.<sup>18</sup> Consistent with Policy D-130.959, this report summarizes the literature on two  
 20 commonly used financial incentives—increased cost-sharing for non-emergency ED use and  
 21 retrospective payment denials for non-emergency diagnoses.

22  
 23 **INCREASED PATIENT COST-SHARING FOR NON-EMERGENCY ED VISITS**

24  
 25 Although federal law prohibits the imposition of cost-sharing for certain services in Medicaid,  
 26 including “emergency services,”<sup>19</sup> the Deficit Reduction Act of 2005 (DRA) gave states the option  
 27 to impose cost-sharing for “non-emergency services.”<sup>20</sup> In 2013, CMS established through  
 28 rulemaking that a maximum eight dollars in cost-sharing for non-emergency use of the ED could  
 29 be imposed by states without an approved waiver.<sup>21</sup> Accordingly, over the ensuing years, many  
 30 states have imposed limited cost-sharing amounts of eight dollars or less. Although the Kaiser  
 31 Family Foundation reported in 2020 that 21 states had mandated cost-sharing requirements for non-  
 32 emergency use of EDs,<sup>22</sup> it is unclear how many states have waived those requirements for the  
 33 duration of the COVID-19 public health emergency. Notably, South Dakota’s Medicaid program  
 34 informs enrollees that they will be responsible for paying the full cost of non-referred, non-  
 35 emergency ED services.<sup>23</sup>

36  
 37 A handful of states have used Section 1115 demonstration waivers to establish cost-sharing  
 38 amounts exceeding the eight-dollar maximum, although most of these waivers—including those  
 39 from Kentucky and New Mexico—are no longer in effect. Under Georgia’s current waiver, \$30  
 40 can be retroactively deducted from enrollees’ Member Rewards Accounts—used to deduct and  
 41 deposit non-monetary dollar-value equivalent credits for healthy behavior activities—for non-  
 42 emergency use of EDs. Because enrollees are not charged with any out-of-pocket costs, the \$30  
 43 deduction in Georgia is considered an incentive but is not true cost-sharing.<sup>24</sup> Other states have  
 44 provided prepaid cards to cover cost-sharing expenses that may allow enrollees to keep remaining  
 45 amounts on the card at the end of the year; however, no analyses of such programs were located  
 46 during the development of this report.

### 1 *Relevant Research*

2  
3 The landmark RAND Health Insurance Experiment, conducted between 1971 and 1982, is  
4 frequently cited as the benchmark study of cost-sharing and its effects on health care utilization,  
5 quality of care, and health. This experiment found that cost-sharing reduced utilization of almost all  
6 services, whether needed or not, and that the sickest and lowest-income people had better outcomes  
7 under free plans, suggesting that cost-sharing should not be applied to them.<sup>25</sup> Prior to enactment of  
8 the DRA, research had found that even minimal cost-sharing could lead Medicaid enrollees to use  
9 fewer health care services.<sup>26</sup>

10  
11 More recent studies of cost-sharing requirements for ED visits labeled non-emergency or  
12 nonurgent have produced mixed results. A study of state ED cost-sharing requirements in the five  
13 years following DRA enactment found no differences in ED use between states with and without  
14 those cost-sharing requirements, and no increases in the use of alternative outpatient settings.<sup>27</sup> A  
15 2010 study of data in nine states that had imposed cost-sharing for non-emergency ED visits also  
16 suggested that cost-sharing requirements did not reduce these visits and were therefore not  
17 effective.<sup>28</sup> However, a 2015 analysis of nine years of data (from 2001 to 2009) concluded that ED  
18 visits by Medicaid enrollees in states with cost-sharing requirements were less likely to be  
19 nonurgent.<sup>29</sup>

### 20 21 *Positive and Negative Experiences*

22  
23 Cost-sharing requirements are intended to incentivize appropriate health care utilization while  
24 discouraging unnecessary or inappropriate care. The DRA policy allowing limited cost-sharing  
25 requirements intended to incentivize Medicaid enrollees to reduce their reliance on EDs for  
26 services that can be provided in alternate settings at reduced costs. Cost-sharing requirements have  
27 also been touted for encouraging personal responsibility and incentivizing patients to make better  
28 health care choices, which could benefit both patients and the Medicaid program overall.

29  
30 However, increased cost-sharing in state Medicaid programs has been somewhat controversial  
31 because of the risks that imposing even limited cost-sharing amounts will dissuade economically  
32 marginalized enrollees from seeking ED care in emergency situations. Critics of these cost-sharing  
33 requirements maintain that most Medicaid enrollees use EDs for actual emergencies and, as  
34 discussed earlier in this report, a relatively small percentage of enrollees turn to EDs for non-  
35 emergency services that could be provided elsewhere. Accordingly, on their own, cost-sharing  
36 requirements may not incur much cost-savings and could lead some patients to avoid seeking or  
37 delay needed care.

38  
39 An additional drawback of cost-sharing increases for non-emergency ED visits is that it can be  
40 challenging for hospitals to administer since, in many cases, it is frequently not possible to  
41 determine at triage whether services will be considered non-emergency and thus subject to cost-  
42 sharing. Moreover, hospitals may be hesitant to request that cost-sharing be paid upfront due to  
43 potentially violating the Emergency Medical Treatment and Labor Act (EMTALA), which requires  
44 individuals to be stabilized and treated, regardless of insurance status or ability to pay. Lastly, the  
45 administrative burden on hospitals of collecting cost-sharing amounts after care is provided may be  
46 higher than any savings incurred from the minimal cost-sharing that is collected.<sup>30</sup>

### 47 48 RETROSPECTIVE PAYMENT DENIALS FOR NON-EMERGENCY ED SERVICES

49  
50 Some states and insurers have attempted to rein in Medicaid costs by reducing or denying payment  
51 and coverage for ED services when the diagnosis is retrospectively determined to be non-

1 emergency. One state using a variation of this incentive is Indiana, where the Indiana Health  
 2 Coverage Program (IHCP) will pay hospitals for emergency services only if a screening determines  
 3 that the patient has an emergency condition. Although the IHCP does not deny payment for non-  
 4 emergency services, a site-of-service payment reduction is applied to those services so that  
 5 payment is based on office visit rates.<sup>31</sup>

6  
 7 In 2011, the Washington State Health Care Authority made headlines by announcing its intention  
 8 to limit non-emergency ED visits to three per year and to deny payment to physicians and hospitals  
 9 for services related to a lengthy list of diagnoses labeled non-emergent.<sup>32</sup> Facing significant  
 10 opposition from physicians and hospitals, this policy was nixed at the last minute and replaced by  
 11 an alternative plan that arose from a partnership between the Washington State Medical  
 12 Association, the Washington Chapter of the American College of Emergency Physicians, the  
 13 Washington State Hospital Association, and the Health Care Authority. This multifaceted effort to  
 14 reduce nonurgent ED visits coalesced around a series of best practices that saved nearly \$34  
 15 million in the program’s first year, during which ED visits by Medicaid enrollees declined by 10  
 16 percent.<sup>33</sup> The following “ER is for Emergencies” best practices became integral to Washington  
 17 State’s efforts to reduce avoidable ED visits:

- 18
- 19 1. Adoption and use of an interoperable health information exchange;
- 20 2. Dissemination of materials intended to educate patients about appropriate care utilization
- 21 and the difference between emergencies and non-emergencies;
- 22 3. Identification by hospitals of frequent ED users;
- 23 4. Development of care management plans for frequent ED users that incorporate information
- 24 on social determinants of health;
- 25 5. Implementation of state guidelines for prescribing opioids;
- 26 6. Implementation of the state’s prescription monitoring program; and
- 27 7. Engaging ED and care management staff to track ED utilization data and provide
- 28 feedback.<sup>34</sup>
- 29

30 While not specifically targeting Medicaid, large private insurers have periodically proposed  
 31 coverage denials that limit payment for ED services retrospectively determined to have non-  
 32 emergency ED discharge diagnoses. The AMA has advocated against such policies, as it did in  
 33 2017, when Anthem implemented policies in several states that denied coverage for many ED  
 34 services and shifted the cost burden onto patients.<sup>35</sup>

### 35 36 *Relevant Research*

37  
 38 Some studies have questioned the accuracy of retrospective payment denial policies for nonurgent  
 39 ED services, which are based on claims data and assume there is a clear association between  
 40 presenting symptoms and discharge diagnoses. The findings from the 2013 *JAMA* study, cited  
 41 earlier in this report, cast doubt on this association and further suggest that policies that deny or  
 42 limit payment based on diagnosis at discharge are not appropriate and may put some patients at risk  
 43 of not getting emergency care that they need. According to the *JAMA* study:

44  
 45 Among ED visits with the same presenting complaint as those ultimately given a primary care-  
 46 treatable diagnosis based on ED discharge diagnosis, a substantial proportion required  
 47 immediate emergency care or hospital admission. The limited correspondence between  
 48 presenting complaint and ED discharge diagnosis suggests that these discharge diagnoses are  
 49 unable to accurately identify nonemergency ED visits.<sup>36</sup>

1 Similar results were found in a 2018 study of a large private insurer’s policy to deny coverage for  
 2 ED visits when the ED discharge diagnosis is determined to be nonurgent.<sup>37</sup> This analysis of ED  
 3 visits of privately insured patients between 2011 and 2015 found that nearly 40 percent of the more  
 4 than 15 percent of visits with non-emergency diagnoses were in fact urgent, as evidenced by the  
 5 fact that patients received emergency care. Furthermore, the presenting symptoms of patients in  
 6 nearly 90 percent of the ED visits were the same as symptoms of those patients with diagnoses  
 7 labeled nonemergent.<sup>38</sup>

8  
 9 *Positive and Negative Experiences*

10  
 11 Although retrospective payment denials are likely to save money, they also violate important  
 12 patient protections and undercut the practice of emergency medicine. Federal law requires  
 13 insurance coverage of emergency services as defined using a prudent layperson standard that is  
 14 based on symptoms, not eventual diagnoses.<sup>39</sup> Retrospective payment denial policies run the risk of  
 15 violating the prudent layperson standard and also disregard patients’ perceptions of their own  
 16 symptoms and whether they need emergency care. Patients make care decisions based on  
 17 symptoms and they should be neither encouraged to second guess their instincts that emergency  
 18 care is needed nor expected to self-diagnose to determine whether, for example, chest pain is a  
 19 heart attack or indigestion. Finally, the impact of policies that deny coverage and payment for  
 20 emergency services based on diagnoses risks leading Medicaid patients, who may be seriously ill,  
 21 to either not seek or delay seeking needed emergency medical care.

22  
 23 **AMA POLICY**

24  
 25 The AMA has long-standing policy supporting the prudent layperson standard (Policy H-130.970).  
 26 Accordingly, this policy states that emergency services should be defined as those services  
 27 provided in a hospital emergency facility after the sudden onset of a medical condition that  
 28 manifests itself by symptoms of sufficient severity, including severe pain, that the absence of  
 29 immediate medical attention could reasonably be expected by a prudent layperson, who possesses  
 30 an average knowledge of health and medicine, to result in: (1) placing the patient’s health in  
 31 serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any  
 32 bodily organ or part. Policy H-130.970 also directs the AMA to work with state insurance  
 33 regulators, insurance companies and other stakeholders to take action to halt the implementation of  
 34 policies that violate the prudent layperson standard of determining when to seek emergency care.  
 35 Policy H-290.965 supports the use of ED best practices that are evidence-based to reduce avoidable  
 36 ED visits.

37  
 38 Policy H-290.982 supports modest copays or income-adjusted premiums in Medicaid for non-  
 39 emergent, non-preventive services. Policy H-165.855 states that children qualified for Medicaid  
 40 should have no cost-sharing obligations. Under Policy H-290.985, the AMA advocates that  
 41 enrollees in Medicaid managed care plans be educated about appropriate use of services, including  
 42 at the emergency department, and availability of off-hours, walk-in primary care. This policy also  
 43 maintains that Medicaid managed care plans should be responsive to cultural, language and  
 44 transportation barriers to access, and provide intensive case management for high utilizers and  
 45 realistic financial disincentives for beneficiary misuse of services.

46  
 47 Policy H-450.941 supports initiatives that protect patient access and that do not contain  
 48 requirements that permit third-party interference in the patient-physician relationship, and it  
 49 strongly opposes attempts to steer patients towards certain physicians primarily based on cost.  
 50 Policy H-450.938 states that physicians should encourage their patients to participate in making  
 51 value-based health care decisions, while Policy H-155.960 supports value-based decision-making

1 and broad strategies for addressing rising health care costs. Policy H-155.960 also encourages  
2 third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are  
3 determined based on the clinical value of a health care service or treatment, and tailoring cost-  
4 sharing requirements to patient income and other factors known to impact compliance. Policy  
5 H-185.939 supports value-based insurance design (VBID), consistent with several principles  
6 including that coverage and cost-sharing policies must be transparent and that VBID should not  
7 restrict access to care. Policy D-185.979 encourages national medical specialty societies to  
8 collaborate with payers to promote alignment of patient financial incentives with utilization of  
9 high-value services.

10  
11 Under Policies H-385.921 and H-290.976, the AMA advocates for reasonable physician payments  
12 within Medicaid/CHIP, defined as a minimum of 100 percent of Medicare rates. Policy H-400.957  
13 encourages CMS to expand the extent and amount of payment for procedures performed in the  
14 physician's office, to shift more procedures from the hospital to the office setting, which is more  
15 cost effective. Policy D-240.994 advocates that third-party payers be required to assess equal or  
16 lower facility cost-sharing for lower-cost sites of service.

17  
18 The AMA has adopted principles for patient-centered medical homes, including that each patient  
19 has an ongoing relationship with a personal physician trained to provide first contact, continuous  
20 and comprehensive care (Policy H-160.919). These principles also maintain that enhanced access  
21 to care is available through systems such as open scheduling, expanded hours and new options for  
22 communication between patients, their personal physician, and practice staff. ED boarding and  
23 overcrowding are addressed by Policies H-130.940 and H-130.945. The latter policy encourages  
24 hospitals to use appropriate criteria to triage patients so those with simpler medical needs can be  
25 redirected to other appropriate ambulatory facilities. EMTALA is addressed by Policy D-130.982.

26  
27 Policy H-165.822 (1) encourages new and continued partnerships to address non-medical, yet  
28 critical health needs and the underlying social determinants of health; (2) supports continued efforts  
29 by public and private health plans to address social determinants of health in health insurance  
30 benefit designs; and (3) encourages public and private health plans to examine implicit bias and the  
31 role of racism and social determinants of health. Policy H-185.920 supports continuity of care  
32 principles for financial incentive programs, including that these programs never interfere with a  
33 patient-physician relationship, and that only treating physicians can determine whether a lower-cost  
34 care option is medically appropriate. This policy also supports objective studies of the impacts of  
35 financial incentive programs.

36  
37 Policy H-373.994 recognizes the increasing use of patient navigator and patient advocacy services  
38 to help improve access to care and help patients manage complex aspects of the health care system.  
39 Policy H-290.995 supports primary care case management programs for Medicaid enrollees: on a  
40 voluntary basis with incentives provided toward a prudent choice of care source; and on a  
41 mandatory basis only for those identified as overutilizers or mis-utilizers of services; and  
42 comparative analyses of these programs to determine their relative effectiveness regarding patient  
43 access, quality of and satisfaction with care, and cost reduction.

#### 44 45 DISCUSSION

46  
47 Policies aimed at reducing ED use for services that could be provided elsewhere, and at lower cost,  
48 have been debated for decades and are worthy of continued monitoring and testing. Since many  
49 states incorporate such policies into Section 1115 demonstration waivers and state Medicaid plan  
50 amendments, the Council recommends support for continued monitoring and pilot testing, by CMS  
51 and other stakeholders, of strategies and best practices for reducing non-emergency ED use among

1 Medicaid/CHIP enrollees, particularly among patients with the highest number of ED visits. The  
 2 Council believes that ongoing study of state approaches to reducing ED use, and dissemination of  
 3 study results, will greatly benefit state Medicaid programs as they strive to manage health care  
 4 costs without compromising care quality.

5  
 6 State Medicaid programs, hospitals and health systems have employed a variety of strategies to  
 7 reduce non-emergency ED use, and the Council supports state flexibility in this regard since best  
 8 practices will depend in part on the health needs of a state’s Medicaid population. Recognizing the  
 9 abundance of AMA policy that is relevant to this topic, the Council recommends support for state  
 10 efforts to encourage appropriate ED use among Medicaid/CHIP enrollees that are consistent with  
 11 the standards and safeguards outlined in AMA policy on ED services.

12  
 13 The Council understands that a complex mix of factors influences ED use and that the share of  
 14 visits that are non-emergency, while difficult to discern, is relatively low. We also recognize that  
 15 modest cost-sharing for non-emergency ED visits for adult Medicaid enrollees, but not for children,  
 16 is consistent with AMA policy (Policies H-290.982 and H-165.855) and may incentivize some  
 17 patients to make better health care choices. Although we do not recommend changes to existing  
 18 policy, we conclude from the literature that modest cost-sharing requirements, on their own, may  
 19 not be very effective at either reducing nonurgent ED services or generating significant cost-  
 20 savings. We further question whether the cost of administering nominal cost-sharing requirements  
 21 may, in some cases, be higher than any savings they generate.

22  
 23 Although diagnosis-based payment and coverage denials for non-emergency ED services may  
 24 effectively contain costs, the Council affirms that these policies risk violating important patient  
 25 protections and may potentially harm some patients—by dissuading them from seeking emergency  
 26 care when needed—as well as physicians and hospitals, when payment is denied. Accordingly, the  
 27 Council recommends reaffirming Policy H-130.970, which supports the prudent layperson standard  
 28 for determining the need for emergency services and directs the AMA to work with state insurance  
 29 regulators, insurers, and other stakeholders to halt the implementation of policies that violate this  
 30 standard.

31  
 32 The Council believes that most Medicaid enrollees turn to EDs when they do not have access to  
 33 primary care or needed specialty care—including mental health and substance use disorder  
 34 treatment—and when few or no other care options are available. We further believe that strategies  
 35 may be more effective if they specifically target individuals with the highest numbers of ED visits,  
 36 generally a small percentage of enrollees who account for a disproportionately high amount of ED  
 37 utilization. Facilitating these patients’ treatment for non-emergency services in alternate settings  
 38 and linking them with primary care, mental health care, and other needed services, are more likely  
 39 to significantly reduce ED use and incur some cost-savings. The Council emphasizes that strategies  
 40 targeting frequent ED users should be comprehensive and multifaceted, addressing not only  
 41 physical and mental health needs but also socioeconomic factors that could contribute to higher  
 42 rates of ED utilization. Such strategies should strive to ensure access to primary, preventive and  
 43 behavioral health care, as well as substance use disorder treatment, outside of EDs through the  
 44 availability of community providers and resources.

45  
 46 Before the COVID-19 pandemic, available state Medicaid data showed that more than 60 percent  
 47 of enrollees identified as Black, Latino/a, or other individuals of color, with studies finding that  
 48 enrollees of color experienced poorer outcomes and more barriers to care than whites.<sup>40</sup>  
 49 Accordingly, state Medicaid programs should consider the potential health equity implications of  
 50 strategies to reduce ED visits and address SDOH. Consistent with numerous AMA site-of-service  
 51 policies (i.e., Policies H-400.957 and D-240.994), state Medicaid program strategies should

1 focus—through patient education and empowerment, 24/7 telephone triage, and telehealth  
2 availability, among other efforts—on ensuring that all patients receive health care services in the  
3 outpatient setting most appropriate to their symptoms and needs. Accordingly, the Council  
4 recommends reaffirmation of Policy H-290.985, which advocates that a long list of criteria be used  
5 to monitor and oversee Medicaid managed care plans, including that enrollees are educated about  
6 appropriate use of services, including ED services; plans are responsive to cultural, language and  
7 transportation barriers to access; off-hours, walk-in primary care is available; there is geographic  
8 dispersion and accessibility of participating physicians and other providers; intensive case  
9 management is provided to high utilizers; and payment levels are realistic and based on costs of  
10 care and predicted utilization levels.

11  
12 Because increases in Medicaid payment rates have been found to increase enrollee access to care,  
13 the Council recommends reaffirming Policy H-290.976, which affirms the AMA’s commitment to  
14 advocating that Medicaid should pay physicians at minimum 100 percent of Medicare rates.  
15 Finally, the Council recommends rescinding Policy D-130.959, which called for the development  
16 of this report.

17  
18 RECOMMENDATIONS

19  
20 The Council on Medical Service recommends that the following be adopted and the remainder of  
21 the report be filed:

- 22  
23 1. That our American Medical Association (AMA) support continued monitoring, by the Centers  
24 for Medicare & Medicaid Services and other stakeholders, of strategies and best practices for  
25 reducing non-emergency emergency department (ED) use among Medicaid/Children’s Health  
26 Insurance Program (CHIP) enrollees, including frequent ED users. (New HOD Policy)  
27  
28 2. That our AMA support state efforts to encourage appropriate emergency department (ED) use  
29 among Medicaid/CHIP enrollees that are consistent with the standards and safeguards outlined  
30 in AMA policy on ED services. (New HOD Policy)  
31  
32 3. That our AMA reaffirm Policy H-130.970, which supports the prudent layperson standard and  
33 directs the AMA to work with state insurance regulators, insurers, and other stakeholders to  
34 halt the implementation of policies that violate the prudent layperson standard of determining  
35 when to seek emergency care. (Reaffirm HOD Policy)  
36  
37 4. That our AMA reaffirm Policy H-290.985, which advocates that numerous criteria be used in  
38 Medicaid managed care monitoring and oversight, including that enrollees are educated about  
39 appropriate use of services, including ED services; plans are responsive to cultural, language  
40 and transportation barriers to access; off-hours, walk-in primary care is available; and intensive  
41 case management is provided to high utilizers. (Reaffirm HOD Policy)  
42  
43 5. That our AMA reaffirm Policy H-290.976, which affirms the AMA’s commitment to  
44 advocating that Medicaid should pay physicians at minimum 100 percent of Medicare rates.  
45 (Reaffirm HOD Policy)  
46  
47 6. That our AMA rescind Policy D-130.959, which called for the development of this report.  
48 (Rescind HOD Policy)

Fiscal Note: Less than \$500.

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**Appendix**  
**AMA Policies Recommended for Reaffirmation**

**Policy H-130.970, “Access to Emergency Services”**

1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:

(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

(B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)

(C) All health plans should be prohibited from requiring prior authorization for emergency services.

(D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment.

(E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an “emergency medical condition” as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer.

(F) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third-party payer whether it is retrospectively determined that an emergency existed or not.

(G) States should be encouraged to enact legislation holding health plans and third-party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services.

(H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available.

(I) In instances in which no private or public third-party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services.

2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the “prudent layperson” standard of determining when to seek emergency care. (CMS Rep. A, A-89; Modified by CMS Rep. 6, I-95; Reaffirmation A-97; Reaffirmed by Sub. Res. 707, A-98; Reaffirmed: Res. 705, A-99; Reaffirmed: CMS Rep. 3, I-99; Reaffirmation A-00; Reaffirmed: Sub. Res. 706, I-00; Amended: Res. 229, A-01; Reaffirmation and Reaffirmed: Res. 708, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 07, A-16; Appended: Res. 128, A-17; Reaffirmation: A-18; Reaffirmed in lieu of: Res. 807, I-18)

**Policy H-290.985, “Monitoring Medicaid Managed Care”**

As managed care plans increasingly become the source of care for Medicaid beneficiaries, the AMA advocates the same policies for the conduct of Medicaid managed care that the AMA advocates for private sector managed care plans. In addition, the AMA advocates that the following criteria be used in federal and/or state oversight and evaluation of managed care plans serving

Medicaid beneficiaries, and insists upon their use by the Federation in monitoring the implementation of managed care for Medicaid beneficiaries:

- (1) Adequate and timely public disclosure of pending implementation of managed care under a state program, so as to allow meaningful public comment.
- (2) Phased implementation to ensure availability of an adequate, sufficiently capitalized managed care infrastructure and an orderly transition for beneficiaries and providers.
- (3) Geographic dispersion and accessibility of participating physicians and other providers.
- (4) Education of beneficiaries regarding appropriate use of services, including the emergency department.
- (5) Availability of off-hours, walk-in primary care.
- (6) Coverage for clinically effective preventive services.
- (7) Responsiveness to cultural, language and transportation barriers to access.
- (8) In programs where more than one plan is available, beneficiary freedom to choose his/her plan, enforcement of standards for marketing/enrollment practices, and clear and comparable disclosure of plan benefits and limitations including financial incentives on providers.
- (9) Beneficiary freedom to choose and retain a given primary physician within the plan, and to request a change in physicians when dissatisfied.
- (10) Significant participating physician involvement and influence in plan medical policies, including development and conduct of quality assurance, credentialing and utilization review programs.
- (11) Ability of plan participating physicians to determine how many beneficiaries and the type of medical problems they will care for under the program.
- (12) Adequate identification of plan beneficiaries and plan treatment restrictions to out-of-plan physicians and other providers.
- (13) Intensive case management for high utilizers and realistic financial disincentives for beneficiary misuse of services.
- (14) Treatment authorization requirements and referral protocols that promote continuity rather than fragment the process of care.
- (15) Preservation of private right of action for physicians and other providers and beneficiaries.
- (16) Ongoing evaluation and public reporting of patient outcomes, patient satisfaction and service utilization.
- (17) Full disclosure of plan physician and other provider selection criteria, and concerted efforts to qualify and enroll traditional community physicians and other existing providers in the plan.
- (18) Absence of gag rules.
- (19) Fairness in procedures for selection and deselection.
- (20) Realistic payment levels based on costs of care and predicted utilization levels.
- (21) Payment arrangements that do not expose practitioners to excessive financial risk for their own or referral services, and that tie any financial incentives to performance of the physician group over significant time periods rather than to individual treatment decisions.
- (22) Our AMA urges CMS to direct those state Medicaid agencies with Medicaid managed care programs to disseminate data and other relevant information to the state medical associations in their respective states on a timely and regular basis. (CMS Rep. 5 A-96; Reaffirmed and Appended: Sub. Res. 704, I-97; Reaffirmation A-00; Reaffirmation I-04; Reaffirmed: CMS Rep. 1, A-14)

**Policy H-290.976, “Enhanced SCHIP Enrollment, Outreach, and Reimbursement”**

1. It is the policy of our AMA that prior to or concomitant with states’ expansion of State Children’s Health Insurance Programs (SCHIP) to adult coverage, our AMA urge all states to maximize their efforts at outreach and enrollment of SCHIP eligible children, using all available state and federal funds.

2. Our AMA affirms its commitment to advocating for reasonable SCHIP and Medicaid reimbursement for its medical providers, defined as at minimum 100 percent of RBRVS Medicare allowable. (Res. 103, I-01; Reaffirmation A-07; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, I-14; Reaffirmation A-15; Reaffirmed: CMS Rep. 3, A-15; Reaffirmation: A-17; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 9, A-21; Reaffirmed: CMS Rep. 3, I-21)

## REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-I-22

Subject: Corporate Practice of Medicine  
(Resolution 721-A-22)

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee J

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1 At the 2022 Annual Meeting, the House of Delegates referred Resolution 721, “Amend Policy  
2 H-215.981, ‘Corporate Practice of Medicine’,” which was sponsored by the Resident and Fellow  
3 Section. Resolution 721-A-22 asked the American Medical Association (AMA) to “amend AMA  
4 Policy H-215.981, ‘Corporate Practice of Medicine,’ by addition of a fourth clause that reads: ‘4.  
5 Our AMA acknowledges that the corporate practice of medicine has led to the erosion of the  
6 physician-patient relationship, erosion of physician-driven care and created a conflict of interest  
7 between profit and training the next generation of physicians.’”  
8

9 The referral of Resolution 721-A-22 included specific concern that the study should include the  
10 impact of the corporate practice of medicine on all practice types. The Board of Trustees assigned  
11 this item to the Council on Medical Service for a report back to the House of Delegates. The  
12 Council notes that a related report is being presented by the Council on Medical Education at this  
13 meeting (CME Report 1-I-22 “The Impact of Private Equity on Medical Training”). The Council  
14 recognizes that private equity and corporate investors are becoming increasingly involved in  
15 graduate medical education, residencies, fellowships, and training of non-physician practitioner.  
16 We have chosen to focus this report on the general aspects of the corporate practice of medicine.  
17

### 18 BACKGROUND

19  
20 The Council recently prepared CMS Report 11 at the 2019 Annual Meeting which addressed a  
21 similar topic. The corporate practice of medicine is broadly defined as non-physician investment in  
22 medical practices. Two examples of corporate medicine include private equity investment funds  
23 and physician management groups. Private equity funds are pooled investments used to buy  
24 controlling shares of companies or other entities. After taking control, private equity funds  
25 typically streamline the business (which often includes cutting costs and reducing the ability for  
26 prior physician owners to make governance decisions) with the goal of selling the business for a  
27 profit in three to seven years. The types of investment range from venture capital (VC) firms that  
28 primarily invest in early-stage companies in exchange for minority ownership to more traditional  
29 private equity firms that borrow money to take a controlling stake in mature yet undervalued or  
30 underperforming companies through leveraged buyout deals.<sup>1</sup> Alternatively, a practice  
31 management company is a privately held or publicly traded for-profit company that manages the  
32 back-end administrative functions of medical practices, such as insurance contracting and billing.  
33 Many practice management companies, often referred to as staffing companies, also contract with  
34 hospitals and ambulatory surgical centers to provide professional staffing and management  
35 services. Investments in practice management companies by private equity funds have led to an  
36 increase in their utilization.<sup>2</sup>

1 While the extent of corporate investment in physician practices is not precisely known, a growing  
2 number of physicians are employed by corporations including hospitals, health systems, and  
3 insurers. Concerns regarding these partnerships have primarily centered on the potential for  
4 subsequent increases in prices, service volume, and internal referrals, as well as the use of  
5 unsupervised non-physician practitioners. An array of factors has led to these changes, including  
6 changes in payment and delivery models, physician payment challenges, high costs of new  
7 technology and equipment, and increased administrative and regulatory burdens.

8  
9 In addition to employment by hospitals, health systems, and insurers, private equity firms and  
10 publicly traded for-profit corporations may invest in physician practices. Increasingly, private  
11 equity firms have acquired majority and/or controlling interests in entities that manage physician  
12 practices. However, there is little peer-reviewed evidence regarding the impact of these  
13 arrangements on physicians, patients or health care prices, and physician opinions vary. Hospitals,  
14 health systems, academic medical centers, large multispecialty groups, and corporate buyers  
15 frequently compete with private equity investors for the same physician practice targets. Corporate  
16 buyers may also partner with private equity investors or form consortia of buyers to acquire highly  
17 sought-after practices. Increased competition for physician groups in some specialties has led price  
18 valuations of these practices to rise. Because many private equity transactions are not disclosed  
19 (non-disclosure agreements are commonly used), the degree of investment in physician practices,  
20 while believed to be relatively small overall, cannot be precisely determined. Incomplete data on  
21 corporate transactions involving physician practices is a significant impediment to determining the  
22 impact of corporate investors on physicians, patients, and the health care marketplace.<sup>3</sup>

#### 23 24 *State-by-State Differences*

25  
26 Generally, corporate practice of medicine doctrines prohibit corporations from practicing or  
27 interfering with the practice of medicine. The doctrines arise from state medical practice acts and  
28 are based on a number of public policy concerns, such as: (1) allowing corporations to practice  
29 medicine will result in the commercialization of the practice of medicine; (2) a corporation's  
30 obligation to its shareholders may not align with a physician's obligation to their patients; and  
31 (3) corporate interests may interfere with the physician's independent medical judgment.<sup>4</sup> It is  
32 important to note that while most states have a prohibition on the corporate practice of medicine,  
33 every state provides an exception for professional corporations and many states provide an  
34 exception for employment of physicians by certain entities. For example, some states explicitly  
35 permit hospitals to employ physicians, some states allow nonprofit hospitals to employ physicians,  
36 and other states recognize an unwritten exception to the corporate practice of medicine for  
37 hospitals employing physicians.<sup>5</sup> Many states that allow hospitals to employ physicians specifically  
38 prohibit the hospital from interfering with the independent medical judgment of the physician,  
39 thereby protecting the autonomy of the physician's clinical decision-making.<sup>6</sup> For example, in  
40 California and Indiana, clinics and hospitals may employ physicians as long as the entity does not  
41 direct or control independent medical acts, decisions or judgments of the licensed physician. On the  
42 other hand, in Colorado and Arkansas, all shareholders and officers of a medical corporation must  
43 be licensed physicians, consistent with each state's licensing laws. In Texas, state laws allow  
44 critical access hospitals, sole community hospitals, and hospitals in counties with fewer than  
45 50,000 people to employ physicians, with the requirement that physicians must "retain independent  
46 medical judgment in providing care to patients at the hospital or other health care facilities owned  
47 or operated by the hospital and may not be disciplined for reasonably advocating for patient care."<sup>7</sup>

48  
49 Recently, there have been complaints filed in state courts arguing that some of these firms have  
50 overstepped and are in violation of state corporate practice of medicine doctrines. One example of  
51 this is a lawsuit filed in California by the American Academy of Emergency Medicine Physician

1 Group (AAEM-PG) against Envision Healthcare Corporation. In its filing, AAEM-PG alleges that  
2 Envision is in violation of the state’s corporate practice of medicine doctrine, as Envision either  
3 forms new medical groups with non-physician officers or “installs Envision executives or officers  
4 in pre-existing medical groups.” Specifically, the lawsuit alleges that Envision: “decides how many  
5 and which physicians to hire, their compensation and work schedule...controls and influences  
6 advertising for physician vacancies, vetting physicians, establishing the terms of employment, the  
7 physician’s rate of pay, scheduling the hours physicians will work, staffing levels, the number of  
8 patient encounters and working conditions...when to terminate physicians and denies them rights  
9 to appeal via traditional medical staffing mechanisms...negotiates the groups’ contracts with third-  
10 party payers and health insurers and decides whether the group will agree to the terms...physicians  
11 are not made aware of the terms of their contracts with third-party payers.” The lawsuit was  
12 originally filed in December 2021. In May 2022, a judge for the United States District Court for the  
13 Northern District of California denied Envision Healthcare’s motion to dismiss the case; therefore,  
14 the case remains ongoing. The American College of Emergency Physicians and the California  
15 Medical Association have both filed amicus briefs in support of AAEM-PG.<sup>8</sup> Further details and  
16 copies of court documents can be found on <https://www.aem.org/envision-lawsuit>.

17  
18 As previously stated, there is limited data on the extent of physician practice acquisition by private  
19 equity firms; however, private equity acquisition of physician practices increased from 59 deals in  
20 2013 to 136 deals in 2016.<sup>9</sup> In April 2022, *JAMA Health Forum* published data on the geographic  
21 variations in private equity penetration of physician practices (defined as the share of physicians in  
22 private equity-acquired practices) across six specialties: dermatology, gastroenterology,  
23 ophthalmology, obstetrics/gynecology, orthopaedics, and urology. Private equity penetration was  
24 highest in the Northeast (6.8 percent) and lowest in the Midwest (3.8 percent). Twelve states and  
25 the District of Columbia (DC) have an above average share of physicians in private equity  
26 practices, while eleven states have no identified acquisitions. States with the highest private equity  
27 penetration are Washington, DC (18.2 percent), Arizona (17.5 percent), New Jersey (13.6 percent),  
28 Maryland (13.1 percent), Connecticut (12.6 percent), and Florida (10.8 percent). By specialty,  
29 private equity penetration was highest in dermatology, followed by gastroenterology,  
30 ophthalmology, obstetrics/gynecology, and orthopaedics.<sup>10</sup>

### 31 *Risks and Benefits*

32  
33  
34 As with any practice type, there are risks and benefits associated with entering into corporate  
35 partnerships. Risks include loss of control over the physician practice and future revenues, loss of  
36 autonomy in decision-making, an emphasis on profit or meeting financial goals, potential conflicts  
37 of interest, and potential uncertainties for non-owner early and mid-career physicians. Additionally,  
38 after a buyout there could be added layers of bureaucracy that could add burdens to physicians.  
39 Examples could be new checks and balances or updated workflows. Benefits include financially  
40 lucrative deals for physicians looking to exit ownership of their practices, access to capital for  
41 practice expenses or expansions (which may relieve physicians’ financial pressures), potentially  
42 fewer administrative and regulatory burdens on prior practice owners, and centralized resources for  
43 certain functions such as IT, marketing, and human resources.

44  
45 There can also be risks to patients when physicians enter into these agreements. Recent evidence  
46 has shown a 10 percent increase in short-term mortality in private equity-owned nursing homes  
47 compared to non-private equity owned nursing homes. This is possibly due to decreases in nursing  
48 staff and declines in compliance with federal and state standards of care.<sup>11</sup> Another study  
49 evaluating private equity acquisitions of US hospitals demonstrated increased charges, increased  
50 net income, and increased patient risk scores, along with fewer Medicaid patients admitted, after  
51 private equity acquisition relative to control groups.<sup>12</sup> A third study showed that private

1 equity-owned dermatology practices were associated with 3 percent-5 percent higher prices for  
 2 routine medical visits at 1.5 years after acquisition as compared with non-private equity-owned  
 3 practices. Other studies have shown increased rates of surprise billing, overutilization of high-  
 4 margin or low-value services, and pressure to up-code charges after private equity acquisition.<sup>13</sup>

5  
 6 *Impact on Patient-Physician Relationship*

7  
 8 Research is ongoing about the effects of corporate medicine investment on patient outcomes and  
 9 cost-savings. A study of 176 hospitals acquired by private equity firms during 2005-2014 was  
 10 conducted to compare financial performance to matched control hospitals.<sup>14</sup> Private equity  
 11 acquisition of short-term acute care hospitals was associated with decreased costs per discharge and  
 12 increased margins. The study highlights early findings on the impact private equity investment has  
 13 on the health care system. Preliminary data show that financial performance improved after  
 14 acquisition; however, patient utilization of services increased, and staffing decreased. Importantly,  
 15 the study found that the decline in total costs per discharge was not adjusted for total full time  
 16 hospital personnel, which suggests that hospitals cut costs in other dimensions, not only labor, after  
 17 private equity acquisition. The authors of the study note that although improved financial  
 18 performance occurred broadly, the findings are not evidence that gains in efficacy translate to  
 19 improved patient outcomes or clinical experiences in either the short or long term.<sup>15</sup>

20  
 21 Under private equity investment, maintaining physician autonomy and a physician-led care team is  
 22 crucial. Physicians should retain complete control of clinical decision making, as well as decisions  
 23 regarding who is a member of their care team. Care provided by non-physician practitioners has  
 24 been shown to be more costly than care provided by a physician-led team. An example of this is at  
 25 the Hattiesburg Clinic in Mississippi. An examination of cost data for the South Mississippi  
 26 system's accountable care organization (ACO) revealed that care provided by non-physician  
 27 practitioners working on their own patient panels was more expensive than care delivered by  
 28 physicians. The 2017-2019 Centers for Medicare & Medicaid Services (CMS) cost data on  
 29 Medicare patients without end-stage renal disease and who were not in a nursing home showed that  
 30 per-member, per-month spending was \$43 higher for patients whose primary health professional  
 31 was a nonphysician instead of a physician. This finding could translate to \$10.3 million more in  
 32 spending annually if all patients were followed by non-physician practitioners. Citing the results of  
 33 the clinic's study, researchers found that "the results are consistent and clear: By allowing  
 34 advanced practice providers to function with independent panels under physician supervision, we  
 35 failed to meet our goals in the primary care setting of providing patients with an equivalent value-  
 36 based experience." These findings underscore the importance of physician-led care teams,  
 37 regardless of business model or private equity investment, both to control costs and improve patient  
 38 outcomes.<sup>16</sup>

39  
 40 **AMA POLICY**

41  
 42 Long-standing AMA policy states that physicians are free to choose their mode of practice and  
 43 enter into contractual agreements as they see fit.

44  
 45 Policy H-215.981 opposes federal legislation preempting state laws prohibiting the corporate  
 46 practice of medicine; states that the AMA will continue monitoring the corporate practice of  
 47 medicine and its effect on the patient-physician relationship, financial conflicts of interest, and  
 48 patient-centered care; and directs the AMA to provide guidance, consultation, and model  
 49 legislation regarding the corporate practice of medicine, at the request of state medical associations,  
 50 to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings,  
 51 and physicians contracting with corporately-owned management service organizations.

1 Policy H-285.951 states that physicians should have the right to enter into whatever contractual  
2 arrangements they deem desirable and necessary but should be aware of potential conflicts of  
3 interest due to the use of financial incentives in the management of care.

4  
5 Policy H-215.968 supports and encourages competition between and among health facilities as a  
6 means of promoting the delivery of high-quality, cost-effective care.

7  
8 Policy H-225.947 encourages physicians who seek employment as their mode of practice to strive  
9 for employment arrangements consistent with a series of principles, including: (a) physician  
10 clinical autonomy is preserved; (b) physicians are included and actively involved in integrated  
11 leadership opportunities; (c) physicians are encouraged and guaranteed the ability to organize  
12 under a formal self-governance and management structure; (d) physicians are encouraged and  
13 expected to work with others to deliver effective, efficient, and appropriate care; (e) a mechanism  
14 is provided for the open and transparent sharing of clinical and business information by all parties  
15 to improve care; and (f) a clinical information system infrastructure exists that allows capture and  
16 reporting of key clinical quality and efficiency performance data for all participants accountability  
17 across the system to those measures.

18  
19 Policy H-160.960 states that when a private medical practice is purchased by corporate entities,  
20 patients shall be informed of the ownership arrangement by the corporate entities and/or  
21 physicians. Policy H-160.891 lists guidelines for physicians to consider when they are  
22 contemplating corporate investor partnerships. These guidelines include: (a) how the practice's  
23 current mission, vision, and long-term goals align with those of the corporate investor; (b) due  
24 diligence should be conducted that includes, at minimum, review of the corporate investor's  
25 business model, strategic plan, leadership and governance, and culture; (c) external legal,  
26 accounting and/or business counsels should be obtained to advise during the exploration and  
27 negotiation of corporate investor transactions; (d) retaining negotiators to advocate for best  
28 interests of the practice and its employees should be considered; (e) whether and how corporate  
29 investor partnerships may require physicians to cede varying degrees of control over practice  
30 decision-making and day-to-day management; (f) the potential impact of corporate investor  
31 partnerships on physician and practice employee satisfaction and future physician recruitment; (g)  
32 a clear understanding of compensation agreements, mechanisms for conflict resolution, processes  
33 for exiting corporate investor partnerships, and application of restrictive covenants; (h) corporate  
34 investor processes for medical staff representation on the board of directors and medical staff  
35 leadership selection; and (i) retain responsibility for clinical governance, patient welfare and  
36 outcomes, physician clinical autonomy, and physician due process under corporate investor  
37 partnerships. Additionally, Policy H-160.891 states that the AMA supports improved transparency  
38 regarding corporate investment in physician practices and subsequent changes in health care prices;  
39 encourages national medical specialty societies to research and develop tools and resources on the  
40 impact of corporate investor partnerships on patients and the physicians practicing in that specialty;  
41 and supports consideration of options for gathering information on the impact of private equity and  
42 corporate investors on the practice of medicine.

43  
44 **DISCUSSION**

45  
46 The Council recognizes that private equity investment and the corporate practice of medicine are  
47 continuing to change the health care landscape. This report describes various investment  
48 opportunities and their impact on medical practice. Anecdotally, there have been challenges  
49 associated with the corporate practice of medicine and evidence that some investment firms have  
50 overstepped and could be in violation of state corporate practice of medicine doctrines. It is clear

1 that in order to control spending and provide optimal care for patients, care teams should be  
2 physician-led.

3  
4 The AMA has long-standing policy that supports a physician's right to choose their mode of  
5 practice and type of employment, and we acknowledge that investor partnerships can be lucrative  
6 and successful. The AMA has published several resources and ethical opinions to guide physicians  
7 as they make the choice that is best for them.

8  
9 The Council recommends new policy to address the concerns outlined in this report, including the  
10 potential to erode the patient-physician relationship and create conflicts of interest in medical  
11 education. In addition, the Council recognizes that the nature of corporate investor relationships  
12 could potentially change in the future and recommends amending Policy H-160.891 regarding  
13 corporate investors to strengthen the physician's role in clinical decision-making, medical  
14 education, and determining the composition of the care team.

15  
16 RECOMMENDATIONS

17  
18 The Council on Medical Service recommends that the following be adopted in lieu of Resolution  
19 721-A-22, and the remainder of the report be filed:

- 20  
21 1. That our American Medical Association (AMA) acknowledge that the corporate practice of  
22 medicine has the potential to erode the patient-physician relationship. (New HOD Policy)  
23  
24 2. That our AMA acknowledge that the corporate practice of medicine may create a conflict of  
25 interest between profit and best practices in residency and fellowship training. (New HOD  
26 Policy)  
27  
28 3. That our AMA amend Policy H-160.891 by addition of two new clauses, as follows:  
29 j. Each individual physician should have the ultimate decision for medical judgment in patient  
30 care and medical care processes, including the use of mandated patient care algorithms or  
31 supervision of non-physician practitioners.  
32 k. Physicians should retain primary and final responsibility for structured medical education  
33 inclusive of undergraduate and graduate medical education including the structure of the  
34 program, program curriculum, selection of faculty and trainees, as well as educational and  
35 disciplinary issues related to these programs. (Modify Current HOD Policy)

Fiscal Note: Less than \$500.

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- <sup>11</sup> Ikram, *Supra* note 1.
- <sup>12</sup> Ikram, *Supra* note 1.
- <sup>13</sup> Ikram, *Supra* note 1.
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- <sup>15</sup> *Ibid.*
- <sup>16</sup> Robeznieks, A. “Amid doctor shortage, NPs and Pas seemed like a fix. Data’s in: Nope.” AMA News Story. March 17, 2022. Available at: <https://www.ama-assn.org/practice-management/scope-practice/amid-doctor-shortage-nps-and-pas-seemed-fix-data-s-nope>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 801  
(I-22)

Introduced by: Young Physicians Section

Subject: Parity in Military Reproductive Health Insurance Coverage for All Service Members and Veterans

Referred to: Reference Committee J

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- 1 Whereas, The World Health Organization (WHO) defines infertility as “the failure to achieve a  
2 pregnancy after 12 months or more of regular unprotected sexual intercourse;”<sup>1</sup> and  
3  
4 Whereas, Our AMA also recognizes infertility as a disease (AMA policy H-420.952);<sup>2</sup> and  
5  
6 Whereas, In an Ethics Committee Opinion, the American Society for Reproductive Medicine  
7 (ASRM) states that “individuals and couples should have access to fertility services irrespective  
8 of marital status, sexual orientation, or gender identity;”<sup>3</sup> and  
9  
10 Whereas, This ASRM Ethics Committee Opinion also states that “results of research suggested  
11 that the development, adjustment, and well-being of children are not markedly impacted by the  
12 marital status, sexual orientation, or gender identity of the parents;”<sup>3</sup> and  
13  
14 Whereas, This ASRM Ethics Committee Opinion also states that “programs should treat all  
15 requests for assisted reproduction equally without regard to marital status, sexual orientation, or  
16 gender identity;”<sup>3</sup> and  
17  
18 Whereas, “Compared to the general population, military families face unique challenges that  
19 can complicate family building and planning;”<sup>4</sup> and  
20  
21 Whereas, “During military service, active duty service members may experience exposures to  
22 potential chemical, physical, and environmental hazards such as jet fuel, burn pits, spent  
23 uranium, nuclear power plants, and exposures associated with submarines and aviation, all of  
24 which may be linked to negative effects on reproductive health;”<sup>4</sup> and  
25  
26 Whereas, “Exposure to endocrine-disrupting chemical agents including lead, mercury, or certain  
27 pesticides is shown to result in altered semen quality and sterility in men as well as menstrual  
28 cycle interference in women;”<sup>4</sup> and  
29  
30 Whereas, “Several studies demonstrate an association between military service and Post  
31 Traumatic Stress Disorder, depression, toxic exposures, and their negative impact on fertility;”<sup>4</sup>  
32 and  
33  
34 Whereas, “The Department of Defense (DOD) does not provide coverage for infertility services  
35 for most with military insurance, including artificial (intrauterine) inseminations, costs related to  
36 sperm or oocyte donation...;”<sup>4</sup> and

1 Whereas, For veterans, Veterans Health Administration Directive 1334 (12 February 2018)  
2 specifically excludes fertility coverage for single women or same-sex couples that would  
3 otherwise be covered;<sup>4,5</sup> and  
4

5 Whereas, For active duty servicemembers, the Department of Defense (DoD) Policy for  
6 Assisted Reproductive Services for the Benefit of Seriously or Severely Ill/Injured (Category II or  
7 III) Active Duty Service Members (ADSMs) specifically states that “Third party donations and  
8 surrogacy are not covered benefits;”<sup>6</sup> and  
9

10 Whereas, Our AMA also “supports: (1) insurance coverage for fertility treatments regardless of  
11 marital status or sexual orientation when insurance provides coverage for fertility treatments;  
12 and (2) local and state efforts to promote reproductive health insurance coverage regardless of  
13 marital status or sexual orientation when insurance provides coverage for fertility treatments  
14 (AMA policy H-185.926);”<sup>7</sup> therefore be it  
15

16 RESOLVED, That our American Medical Association support expansion of reproductive health  
17 insurance coverage to all active-duty service members and veterans eligible for medical care  
18 regardless of marital status, gender or sexual orientation. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 08/19/22

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7. AMA policy H-185.926 Reproductive Health Insurance Coverage, at <https://policysearch.ama-assn.org/policyfinder/detail/fertility?uri=%2FAMADoc%2FHOD-185.926.xml>, accessed 30 April 2022.

## RELEVANT AMA POLICY

### Reproductive Health Insurance Coverage H-185.926

Our AMA supports: (1) insurance coverage for fertility treatments regardless of marital status or sexual orientation when insurance provides coverage for fertility treatments; and (2) local and state efforts to promote reproductive health insurance coverage regardless of marital status or sexual orientation when insurance provides coverage for fertility treatments.

Citation: Res. 804, I-16

### Recognition of Infertility as a Disease H-420.952

Our AMA supports the World Health Organizations designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention.

Citation: Res. 518, A-17

**Health Care Disparities in Same-Sex Partner Households H-65.973**

Our American Medical Association: (1) recognizes that denying civil marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families; (2) recognizes that exclusion from civil marriage contributes to health care disparities affecting same-sex households; (3) will work to reduce health care disparities among members of same-sex households including minor children; and (4) will support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households.

Citation: CSAPH Rep. 1, I-09; BOT Action in response to referred for decision Res. 918, I-09; Reaffirmed in lieu of Res. 918, I-09; BOT Rep. 15, A-11; Reaffirmed in lieu of Res. 209, A-12; Reaffirmed: CSAPH Rep. 1, A-22

**Health Disparities Among Gay, Lesbian, Bisexual, Transgender and Queer Families D-65.995**

Our AMA supports reducing the health disparities suffered because of unequal treatment of minor children and same sex parents in same sex households by supporting equality in laws affecting health care of members in same sex partner households and their dependent children.

Citation: Res. 445, A-05; Modified: CSAPH Rep. 1, A-15; Res. 16, A-18

**Eliminating Health Disparities - Promoting Awareness and Education of Sexual Orientation and Gender Identity Health Issues in Medical Education H-295.878**

Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues related to sexual orientation and gender identity; and (3) encourages medical education accreditation bodies to both continue to encourage and periodically reassess education on health issues related to sexual orientation and gender identity in the basic science, clinical care, and cultural competency curricula in undergraduate and graduate medical education.

Citation: Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-16; Modified: Res. 16, A-18; Modified: Res. 302, I-19

**Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991**

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.  
Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 802  
(1-22)

Introduced by: New York  
Subject: FAIR Health Database  
Referred to: Reference Committee J

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1 Whereas, The FAIR Health database was created to bring independent accuracy and  
2 transparency to medical price data; and  
3  
4 Whereas, This database is now widely used, not just for charge data, but also for contracted  
5 rate data; and  
6  
7 Whereas, One important piece of information that has been included in these listings was the  
8 frequency of the Current Procedural Terminology (CPT) code's usage during the past 12-month  
9 period that was used to calculate the statistical data; and  
10  
11 Whereas, This "frequency" information was of great relevance in understanding how much data  
12 FAIR Health had obtained; and  
13  
14 Whereas, This "frequency" data was also useful for providers when they wanted to challenge  
15 the accuracy of various statistics provided by FAIR Health; and  
16  
17 Whereas, The FAIR Health database no longer reports the specific "frequency" of the data  
18 collected; therefore be it  
19  
20 RESOLVED, That our American Medical Association advocate to FAIR Health to ensure the  
21 continued identification of the frequency by which a particular CPT code is used. (New HOD  
22 Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 09/20/22

**RELEVANT AMA POLICY**

**Network Adequacy H-285.908**

1. Our AMA supports state regulators as the primary enforcer of network adequacy requirements.
2. Our AMA supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time.
3. Our AMA supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received.

4. Our AMA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
5. Our AMA advocates for regulation and legislation to require that out-of-network expenses count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies.
6. Our AMA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
7. Our AMA supports health insurers paying out-of-network physicians fairly and equitably for emergency and out-of-network bills in a hospital. AMA policy is that any legislation which addresses this issue should assure that insurer payment for such care be based upon a number of factors, including the physicians' usual charge, the usual and customary charge for such service, the circumstances of the care and the expertise of the particular physician.
8. Our AMA provides assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks.
9. Our AMA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities.
10. Our AMA advocates for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited.
11. Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible.
12. Our AMA supports requiring that health insurers that terminate in-network providers: (a) notify providers of pending termination at least 90 days prior to removal from network; (b) give to providers, at least 60 days prior to distribution, a copy of the health insurers letter notifying patients of the providers change in network status; and (c) allow the provider 30 days to respond to and contest if necessary the letter prior to its distribution.

Citation: CMS Rep. 4, I-14; Reaffirmation I-15; Reaffirmed in lieu of Res. 808, I-15; Modified: Sub. Res. 811, I-15; Reaffirmed: CMS Rep. 03, A-17; Reaffirmed: Res. 108, A-17; Appended: Res. 809, I-17; Reaffirmed: Res. 116, A-18; Reaffirmation: A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 803  
(I-22)

Introduced by: New York

Subject: Patient Centered Medical Home – Administrative Burdens

Referred to: Reference Committee J

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1 Whereas, The “Medical Home Model” provides increased care to homebound patients but  
2 increases the administrative burden on physicians and their office staff; and  
3

4 Whereas, The effects of these additional administrative burdens limits physician care to other  
5 patients in the office and hospital settings; and  
6

7 Whereas, Administrative burdens are a leading cause of physician “burnout”; and  
8

9 Whereas, The analytic data showing how the metrics which are required to be reported are  
10 actually helping quality patient care is not provided; and  
11

12 Whereas, Maintenance of Patient Centered Medical Home (PCMH) certification continually  
13 requires additional metrics and “paper work” that takes time away from direct patient care;  
14 therefore be it  
15

16 RESOLVED, That our American Medical Association seek regulations which would reduce the  
17 increasing strain that Patient Centered Medical Home (PCMH) metrics are placing on  
18 physicians and patient care. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 09/20/22

**RELEVANT AMA POLICY**

**Principles of the Patient-Centered Medical Home H-160.919**

1. Our AMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association "Joint Principles of the Patient-Centered Medical Home" as follows:

*Principles*

*Personal Physician* - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

*Physician Directed Medical Practice* - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

*Whole Person Orientation* - The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

*Care is coordinated and/or integrated* across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information

technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

*Quality and safety* are hallmarks of the medical home:

Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

Evidence-based medicine and clinical decision-support tools guide decision making.

Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.

Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

Patients and families participate in quality improvement activities at the practice level.

*Enhanced access* to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

*Payment* appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.

It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.

It should support adoption and use of health information technology for quality improvement.

It should support provision of enhanced communication access such as secure e-mail and telephone consultation.

It should recognize the value of physician work associated with remote monitoring of clinical data using technology.

It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).

It should recognize case mix differences in the patient population being treated within the practice.

It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.

It should allow for additional payments for achieving measurable and continuous quality improvements.

2. Our AMA supports the patient-centered medical home (as defined in Policy H-160.919) as a way to provide care to patients without restricting access to specialty care.
3. It is the policy of our AMA that medical home participation criteria allow any physician practice to qualify as a medical home, provided it can fulfill the principles of a patient-centered medical home.
4. Our AMA will work with The Joint Commission (TJC) to examine the structures of TJC-accredited medical homes and determine whether differences exist in patient satisfaction, quality, value, and patient safety, as reflected by morbidity and mortality outcomes, between physician-led (MD/DO) and non-physician-led medical homes.
5. Our AMA supports the physician-led patient-centered medical home and advocate for the public

reporting/notification of the professional status (education, training, experience) of the primary care clinician who leads the primary care medical home.

Citation: Res. 804, I-08; CMS Rep. 8, A-09; Reaffirmed: CME Rep. 15, A-10; Reaffirmed: Res. 723, A-11; Appended: Res. 723, A-11; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed in lieu of Res. 706, A-12; Reaffirmed: BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 03, I-18

#### **The Joint Commission Primary Care Home Initiative D-35.988**

1. Our AMA Commissioners to The Joint Commission will strongly advocate that the requirements for any primary care home or medical home initiative of The Joint Commission strictly meet the requirements of the *Joint Principles of the Patient-Centered Medical Home* and more specifically that (1) each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care and (2) that a personal physician lead a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. The *Joint Principles of the Patient-Centered Medical Home* were developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association and approved by the AMA.
2. Our AMA will continue to support the concept of physician-led teams within the patient centered medical home (PCMH) as outlined in the *Joint Principles of the Patient-Centered Medical Home*.
3. Our AMA will respond to The Joint Commission's interpretation of its primary care medical home certification standards addressing non-physician-led PCMHs.
4. Our AMA will oppose any interpretation by The Joint Commission, or any other entity, of primary care medical home or patient centered medical home (PCMH) as being anything other than MD/DO physician led.

Citation: (Res. 831, I-10; Reaffirmed: BOT Rep. 9, I-11; Appended: Res. 738, A-14)

#### **The Patient-Centered Medical Home H-160.918**

Our AMA:

1. will urge the Centers for Medicare and Medicaid Services (CMS) to work with our AMA and national medical specialty societies to design incentives to enhance care coordination among providers who provide medical care for patients outside the medical home;
2. will urge CMS to assist physician practices seeking to qualify for and sustain medical home status with financial and other resources;
3. will advocate that Medicare incentive payments associated with the medical home model be paid for through system-wide savings – such as reductions in hospital admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part D), and elimination of government subsidies for Medicare Advantage plans (Part C) – and not be subject to a budget neutrality offset in the Medicare physician payment schedule;
4. will advocate that all payers support and assist PCMH transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care recognizing that payer support is crucial to the long-term sustainability of delivery reform; and
5. encourages health agencies, health systems, and other stakeholders to support and assist patient-centered medical home transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care.

Citation: CMS Rep. 8, A-09; Modified: CMS Rep. 03, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 804  
(1-22)

Introduced by: New York

Subject: Centers for Medicare & Medicaid Innovation Projects

Referred to: Reference Committee J

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1 Whereas, Centers for Medicare & Medicaid Services' (CMS) Center for Medicare & Medicaid  
2 Innovation (CMMI), which has been developing proposals for new health care payment and  
3 service delivery models, was given broad authority by the Affordable Care Act to scale up any of  
4 these models for potential application to the entire Medicare program, without approval or  
5 oversight by Congress; and  
6

7 Whereas, Two of CMMI's models, the Direct Contracting Entities and Value-based Payment  
8 Models, are designed in such a way as to incentivize the rationing and restricting of care for  
9 senior patients and patients with disabilities; and  
10

11 Whereas, The Direct Contracting Entities and Value-based Payment Models have not been  
12 shown to improve quality of care or significantly reduce cost; therefore be it  
13

14 RESOLVED, That our American Medical Association advocate against mandatory participation  
15 in Centers for Medicare and Medicaid Innovation (CMMI) demonstration projects, and advocate  
16 for CMMI instead to focus on the development of voluntary pilot projects (Directive to Take  
17 Action); and be it further  
18

19 RESOLVED, That our AMA advocate to ensure that any CMMI project that requires physician  
20 and/or patient participation be required to be approved by Congress. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 09/20/22

**RELEVANT AMA POLICY**

**Medicare Physician Payment Reform D-390.961**

1. Our AMA will continue to advocate for adequate investment in comparative effectiveness research that is consistent with AMA Policy H-460.909, and in effective methods of translating research findings relating to quality of care into clinical practice.
2. Our AMA will advocate for better methods of data collection, development, reporting and dissemination of practical clinical decision-making tools for patients and physicians, and rapid, confidential feedback about comparative practice patterns to physicians to enable them to make the best use of the information at the local and specialty level.
3. Our AMA urges physician organizations, including state medical associations and national medical specialty societies, to develop and recruit groups of physicians to experiment with diverse ideas for achieving Medicare savings, including the development of organizational structures that maximize participation opportunities for physician practices.

4. Our AMA will continue to advocate for changes in antitrust and other laws that would facilitate shared-savings arrangements, and enable solo and small group practices to make innovations that could enhance care coordination and increase the value of health care delivery.

5. Our AMA supports local innovation and funding of demonstration projects that allow physicians to benefit from increased efficiencies based on practice changes that best fit local needs.

6. Our AMA will work with appropriate public and private officials and advisory bodies to ensure that bundled payments, if implemented, do not lead to hospital-controlled payments to physicians.

Citation: CMS 6, A-09; Reaffirmation A-10; Reaffirmation I-13; CMS Rep. 5, I-16; Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 805  
(I-22)

Introduced by: Utah

Subject: COVID Vaccine Administration Fee

Referred to: Reference Committee J

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- 1 Whereas, To assist the public health effort against SARS CoV2 virus in the US, health care  
2 providers have contracted with the CDC to administer COVID-19 vaccines to patients and  
3 community members; and  
4
- 5 Whereas, Contracted COVID-19 vaccine providers are required to administer vaccine equitably  
6 and to refrain from directly billing patients for the cost of administering the vaccine  
7 (administration fee); and  
8
- 9 Whereas, Providers previously billed the Health Resources and Services Administration (HRSA)  
10 for the administration fee for uninsured patients; and  
11
- 12 Whereas, Since the emergency funding appropriated by the HRSA was exhausted in April 2022,  
13 HRSA ceased reimbursing the administration fee for uninsured citizens; and  
14
- 15 Whereas, The US government has recently begun providing a reformulated bivalent COVID-19  
16 vaccine booster to the US population; and  
17
- 18 Whereas, A large portion of the US population is eligible for this bivalent COVID-19 booster; and  
19
- 20 Whereas, Contracted COVID-19 vaccine providers will be expected to use their resources to  
21 provide the bivalent booster; and  
22
- 23 Whereas, The uninsured patients of physician offices can comprise 5 to 10% of their practice  
24 and may be higher for those physician practices located in rural and underserved geographies;  
25 and  
26
- 27 Whereas, The lack of reimbursement from the federal government puts providers at financial  
28 risk and may cause providers to no longer contract to be access points for their patients and  
29 community members to receive COVID-19 vaccines; and  
30
- 31 Whereas, The lack of access to providers who offer COVID-19 vaccines to uninsured patients is  
32 an issue of health equity; therefore be it

1 RESOLVED, That American Medical Association policy D-440.981, “Appropriate  
2 Reimbursements and Carve-outs for Vaccines,” be amended by addition to read as follows:

3  
4 **Appropriate Reimbursements and Carve-outs for Vaccines D-440.981**

5 Our AMA will: (1) continue to work with the Centers for Medicare and Medicaid  
6 Services (CMS) and provide comment on the Medicare Program payment policy for  
7 vaccine services; (2) continue to pursue adequate reimbursement for vaccines and  
8 their administration from all public and private payers, including federal funds to  
9 reimburse for administration of the COVID-19 vaccine to uninsured patients; (3)  
10 encourage health plans to recognize that physicians incur costs associated with the  
11 procurement, storage and administration of vaccines that may be beyond the average  
12 wholesale price of any one particular vaccine; (4) seek legislation mandating that  
13 health insurance companies in applicable states either adequately pay for vaccines  
14 recommended by the Advisory Committee on Immunization Practices, or clearly state  
15 in large bold font in their notices to patients and businesses that they do not follow the  
16 federal advisory body on vaccine recommendations, the Advisory Committee on  
17 Immunization Practices; and (5) advocate that a physician’s office can bill Medicare for  
18 all vaccines administered to Medicare beneficiaries and that the patient shall only pay  
19 the applicable copay to prevent fragmentation of care. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than \$1,000

Received: 09/23/22

**RELEVANT AMA POLICY**

**Appropriate Reimbursements and Carve-outs for Vaccines D-440.981**

Our AMA will: (1) continue to work with the Centers for Medicare and Medicaid Services (CMS) and provide comment on the Medicare Program payment policy for vaccine services; (2) continue to pursue adequate reimbursement for vaccines and their administration from all public and private payers; (3) encourage health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular vaccine; (4) seek legislation mandating that health insurance companies in applicable states either adequately pay for vaccines recommended by the Advisory Committee on Immunization Practices, or clearly state in large bold font in their notices to patients and businesses that they do not follow the federal advisory body on vaccine recommendations, the Advisory Committee on Immunization Practices; and (5) advocate that a physician’s office can bill Medicare for all vaccines administered to Medicare beneficiaries and that the patient shall only pay the applicable copay to prevent fragmentation of care.

Citation: BOT Rep. 20, A-03; Reaffirmation A-07; Res. 128, A-09; Reaffirmation I-10;  
Reaffirmed: Res. 807, I-11; Appended: Res. 217, A-19; Reaffirmed: CMS Rep. 3, I-20; Res.  
408, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 806  
(1-22)

Introduced by: Georgia

Subject: Healthcare Marketplace Plan Selection

Referred to: Reference Committee J

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1 Whereas, Insurance plans purchased on the Healthcare Marketplace often have very narrow  
2 networks; and

3  
4 Whereas, These narrow networks often require patients to only see physicians within the county  
5 in which the plan was purchased; and

6  
7 Whereas, Patients are required to purchase a plan based on the county in which they reside;  
8 and

9  
10 Whereas, Some patients must pay for care in cash outside their plan to keep their doctor of  
11 choice making their comprehensive plan more of an expensive catastrophic plan; and

12  
13 Whereas, This limits patient choice by preventing patients from choosing their plan based on  
14 access to their physician of choice; therefore be it

15  
16 RESOLVED, That our American Medical Association advocate for patients to have expanded  
17 plan options on the Healthcare Marketplace beyond the current options based solely on the zip  
18 code of their primary residence or where their physician practices, including the interstate  
19 portability of plans. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 09/26/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 807  
(I-22)

Introduced by: Georgia

Subject: Medicare Advantage Record Requests

Referred to: Reference Committee J

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- 1 Whereas, Medicare Advantage rules for plans do not stipulate how record requests are handled,  
2 nor any limits to number or repetitiveness of these requests; and  
3  
4 Whereas, Complying with these record requests can require extensive staff time and other  
5 associated costs; and  
6  
7 Whereas, Practices are not reimbursed by Medicare Advantage companies for the staff time  
8 involved in complying with these requests; and  
9  
10 Whereas, Each Medicare Advantage plan has different rules for record requests governed by  
11 the contract between the plan and provider; therefore be it  
12  
13 RESOLVED, That our American Medical Association advocate for the relevant agencies and  
14 stakeholders to prevent Medicare Advantage plans from requesting records from practices  
15 solely to data mine for more funds and limit requests to 2% of plan participants, and otherwise  
16 advocate that the plan will reimburse the practices for their efforts in obtaining additional  
17 requested information. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 09/26/22

**RELEVANT AMA POLICY**

**Limiting Access to Medical Records H-315.987**

Our AMA: (1) will pursue the adoption of federal legislation and regulations that will: limit third party payers' random access to patient records unrelated to required quality assurance activities; limit third party payers' access to medical records to only that portion of the record (or only an abstract of the patient's records) necessary to evaluate for reimbursement purposes; require that requests for information and completion of forms be delineated and case specific; allow a summary of pertinent information relative to any inquiry into a patient's medical record be provided in lieu of a full copy of the records (except in instances of litigation where the records would be discoverable); and provide proper compensation for the time and skill spent by physicians and others in preparing and completing forms or summaries pertaining to patient records; and (2) supports the policy that copies of medical records of service no longer be required to be sent to insurance companies, Medicaid or Medicare with medical bills. Citation: Sub. Res. 222, I-94; Appended: Res. 218, A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmed: BOT Rep. 06, A-16; Reaffirmed: BOT Rep. 16, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 808  
(I-22)

Introduced by: Georgia  
Subject: Reinstatement of Consultation Codes  
Referred to: Reference Committee J

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1 Whereas, In 2010, due to a perception of abuse or misuse of consult codes, Medicare  
2 eliminated consult codes in what they calculated to be a revenue neutral manner, whereby they  
3 increased the value of other evaluation and management (E+M) codes; and  
4  
5 Whereas, Medicare has proposed re-valuation of E+M codes, effective 2021 if finalized; and  
6  
7 Whereas, United Health Care (UHC) and Cigna are moving to eliminate consult codes; and  
8  
9 Whereas, The American Medical Association House of Delegates passed Resolution 819 in  
10 2017, which passed without changes but has progressed negatively; and  
11  
12 Whereas, It appears cognitive care is undervalued; therefore be it  
13  
14 RESOLVED, That our American Medical Association proactively engage and advocate with any  
15 commercial insurance company that discontinues payment for consultation codes or that is  
16 proposing to or considering eliminating payment for such codes, requesting that the company  
17 reconsider the policy change. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 09/26/22

**RELEVANT AMA POLICY**

**Medicare's Proposal to Eliminate Payments for Consultation Service Codes D-70.953**

1. Our American Medical Association opposes all public and private payer efforts to eliminate payments for inpatient and outpatient consultation service codes, and supports legislation to overturn recent Center for Medicare & Medicaid Services' (CMS) action to eliminate consultation codes. 2. Our AMA will work with CMS and interested physician groups through the CPT Editorial Panel to address all concerns with billing consultation services either through revision or replacement of the current code sets or by some other means. 3. Our AMA will, at the conclusion of the CPT Editorial Panel's work to address concerns with billing consultation services, work with CMS and interested physician groups to engage in an extensive education campaign regarding appropriate billing for consultation services. 4. Our AMA will: (a) work with the Centers for Medicare & Medicaid Services to consider a two-year moratorium on RAC audit claims based on three-year rule violations for E/M services previously paid for as consultations; and (b) pursue Congressional action through legislation to reinstate payment for consultation codes within the Medicare Program and all other governmental programs. 5. Our AMA will petition the CMS to limit RAC reviews to less than one year from payment of claims.

Citation: Res. 807, I-09; Appended: Sub. Res. 212, I-10; Reaffirmation A-12; Appended: Res. 216, A-12; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-17

**Consultation Codes and Private Payers D-385.955**

1. Our AMA will proactively engage and advocate with any commercial insurance company that discontinues payment for consultation codes or that is proposing to or considering eliminating payment for such codes, requesting that the company reconsider the policy change.

2. Where a reason given by an insurance company for policy change to discontinue payment of consultation codes includes purported coding errors or abuses, our AMA will request the company carry out coding education and outreach to physicians on consultation codes rather than discontinue payment for the codes, and call for release of de-identified data from the company related to purported coding issues in order to help facilitate potential education by physician societies.

Citation: Res. 819, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 809  
(I-22)

Introduced by: Senior Physicians Section

Subject: Uniformity and Enforcement of Medicare Advantage Plans and Regulations

Referred to: Reference Committee J

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1 Whereas, Medicare Advantage plans must provide enrollees with coverage of all services  
2 covered by Medicare Parts A and B, plus additional benefits beyond those covered by  
3 Medicare; and  
4

5 Whereas, Seniors are determining specifics of plans across the US, looking for uniformity to  
6 compare policies in advance of enrollment; and  
7

8 Whereas, Many seniors select Medicare Advantage plans because they have lower premiums  
9 than Medicare; and  
10

11 Whereas, When Medicare supplement plans cannot be used in Medicare Advantage, patients  
12 are required to pay the copayments themselves; and  
13

14 Whereas, Medicare Advantage plans often employ prior authorization and deny claims that  
15 would have been paid if the patient had been in regular Medicare; and  
16

17 Whereas, Many seniors have little interest in the choice of health plans and more of an interest  
18 in the choice of physicians in their geographical areas; therefore be it  
19

20 RESOLVED, That our American Medical Association advocate for better enforcement of  
21 Medicare Advantage regulations to hold the Centers for Medicare & Medicaid Services (CMS)  
22 accountable for presenting transparency of minimum standards and to determine if those  
23 standards are being met for senior physicians and their patients (Reaffirm HOD Policy); and be  
24 it further  
25

26 RESOLVED, That our AMA advocate that Medicare Advantage plans be required to post all  
27 components of Medicare covered in all plans across the US on their website along with  
28 additional benefits provided (Directive to Take Action); and be it further  
29

30 RESOLVED, That our AMA advocate that CMS provide an accurate, up-to-date list of  
31 physicians and the plans with which they may or may not be accepting as well as if the practice  
32 is no longer participating, continuing on with current patients, or taking new patients for plans  
33 that they are contracted for under Medicare Advantage. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 09/29/22

## **RELEVANT AMA POLICY**

### **Medicare Advantage Policies H-285.913**

Our AMA will:

1. pursue legislation requiring that any Medicare Advantage policy sold to a Medicare patient must include a seven-day waiting period that allows for cancellation without penalty;
2. pursue legislation to require that Medicare Advantage policies carry a separate distinct page, which the patient must sign, including the statement, "THIS COVERAGE IS NOT TRADITIONAL MEDICARE. YOU HAVE CHOSEN TO CANCEL YOUR TRADITIONAL MEDICARE COVERAGE; NOT ALL PHYSICIANS, HOSPITALS AND LABORATORIES ACCEPT THIS NEW MEDICARE ADVANTAGE POLICY AND YOU MAY PERMANENTLY LOSE THE ABILITY TO PURCHASE MEDIGAP SECONDARY INSURANCE" (or equivalent statement) and specifying the time period before they can resume their traditional Medicare coverage; and
3. petition the Centers for Medicare and Medicaid Services to implement the patient's signature page in a Medicare Advantage policy.

Citation: Res. 907, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 01, A-18; Reaffirmation: I-18

### **Prevent Medicare Advantage Plans from Limiting Care D-285.959**

Our AMA will: (1) ask the Centers for Medicare and Medicaid Services to further regulate Medicare Advantage Plans so that the same treatment and authorization guidelines are followed for both fee-for-service Medicare and Medicare Advantage patients, including admission to inpatient rehabilitation facilities; and (2) advocate that proprietary criteria shall not supersede the professional judgment of the patient's physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions. Citation: Res. 706, A-21;

### **Transparency of Costs to Patients for Their Prescription Medications Under Medicare Part D and Medicare Advantage Plans H-330.870**

Our AMA will: (1) advocate for provision of transparent print and audio/video patient educational resources to patients and families in multiple languages from health care systems and from Medicare - directly accessible - by consumers and families, explaining clearly the different benefits, as well as the varied, programmatic and other out-of-pocket costs for their medications under Medicare, Medicare Supplemental and Medicare Advantage plans; (2) advocate for printed and audio/video patient educational resources regarding personal costs, changes in benefits and provider panels that may be incurred when switching (voluntarily or otherwise) between Medicare, Medical Supplemental and Medicare Advantage or other plans, including additional information regarding federal and state health insurance assistance programs that patients and consumers could access directly; and (3) advocate for increased funding for federal and state health insurance assistance programs and educate physicians, hospitals, and patients about the availability of and access to such programs.

Citation: Res. 817, I-19; Modified: Res. 125, A-22

### **Medicare Advantage Opt Out Rules H-330.913**

Our AMA: (1) opposes managed care "bait and switch" practices, whereby a plan entices patients to enroll by advertising large physician panels and/or generous patient benefits, then reduces physician reimbursement and/or patient benefits, so that physicians leave the plan, but patients who can't must choose new doctors; (2) supports current proposals to extend the 30 day waiting period that limits when Medicare recipients may opt out of managed care plans, if such proposals can be amended to create an exemption to protect patients whenever a plan alters benefits or whenever a patient's physician leaves the plan; and (3) supports changes in CMS regulations which would require Medicare Advantage plans to immediately notify patients, whenever such a plan alters benefits or whenever a patient's physician leaves the plan, and to give affected patients a reasonable opportunity to switch plans.

Citation: Res. 707, A-99; Reaffirmed: CMS Rep. 5, A-09; Modified: CMS Rep. 01, A-19

**Legislation for Assuring Equitable Participation of Physicians in Medicare Advantage H-330.916**

Our AMA seeks to have the CMS, while contracting with Medicare Advantage organizations for Medicare services, require the following guarantees to assure quality patient care to medical beneficiaries: (1) a Medicare Advantage patient shall have the right to see a duly licensed physician of the appropriate training and specialty; (2) if CMS decertifies a Medicare Advantage plan, enrollees in that plan who are undergoing a course of treatment by a physician at the time of such termination shall continue to receive care from their treating physician until an appropriate transfer is accomplished; and (3) any Medicare Advantage plan deselection of participating physicians may occur only after the physician has been given the opportunity to appeal the deselection decision to an Independent Review Body.

Citation: Res. 707, I-98; Reaffirmed: BOT Rep. 23, A-09; Modified: CMS Rep. 01, A-19

**Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans D-330.930**

Our AMA will continue its efforts to educate physicians and the general public on the implications of participating in programs offered under Medicare Advantage and educate physicians and the public about the lack of secondary coverage (Medigap policies) with Medicare Advantage plans and how this may affect enrollees.

Citation: BOT Action in response to referred for decision Res. 711, I-06; Reaffirmation A-08; Modified: CMS Rep. 01, A-19;

**Medicare Cost-Sharing D-330.951**

Our AMA will urge the Centers for Medicare and Medicaid Services to require companies that participate in the Medicare Advantage program to provide enrollees and potential enrollees timely information in a comparable, standardized, and clearly-written format that details enrollment restrictions, as well as all coverage restrictions and beneficiary cost-sharing requirements for all services.

Citation: CMS Rep. 2, I-04; Reaffirmation A-08; Reaffirmed: CMS Rep. 01, A-18; Reaffirmation: I-18

**Support for Seamless Physician Continuity of Care H-390.836**

Our AMA encourages physicians who encounter contractual difficulties with Medicare Advantage (MA) plans to contact their Centers for Medicare & Medicaid Services (CMS) Regional office.

Citation: BOT Action in response to referred for decision Res. 816, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 810  
(I-22)

Introduced by: Senior Physicians Section  
Subject: Medicare Drug Pricing and Pharmacy Costs  
Referred to: Reference Committee J

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1 Whereas, Many seniors look to the federal government to negotiate prices for prescription drugs  
2 covered under Medicare; and  
3  
4 Whereas, For seniors 65 years of age and older, 40% have at least five prescription drugs,  
5 compared with 23% of 50- to 64-year-olds and fewer than 10% of those under 50;<sup>1</sup> and  
6  
7 Whereas, With increased attention among policymakers towards prescription drug costs, a  
8 February 2019 poll found that a majority of adults, including seniors, are in favor of policy  
9 options to curb prescription drug costs;<sup>2</sup> and  
10  
11 Whereas, With the Inflation Reduction Act of 2022, the Centers for Medicare & Medicaid  
12 Services (CMS) will be required to negotiate prices of certain prescription drugs beginning in  
13 2026;<sup>3</sup> and  
14  
15 Whereas, There are 510 different drugs recognized in the US, but the Inflation Reduction Act of  
16 2022 requires CMS to negotiate the prices of only 10 drugs in 2026, 15 drugs in 2027 and 2028,  
17 and 20 drugs in 2029 and each year after;<sup>4</sup> and  
18  
19 Whereas, The pace of negotiating a miniscule number of prescription prices each year is not  
20 beneficial to seniors or the general public; and  
21  
22 Whereas, The business model of making profits for pharmaceutical company's shareholders  
23 should not be at the expense of generating profits; and  
24  
25 Whereas, Seniors should not be stretched to find funding for needed medications; therefore be  
26 it  
27  
28 RESOLVED, That our American Medical Association advocate for immediate, timely and  
29 transparent negotiations for how Medicare drug prices are set to be incorporated into law  
30 (Directive to Take Action); and be it further  
31  
32 RESOLVED, That our AMA advocate to eliminate loopholes such as new usage for current  
33 medications (commonly known as patent evergreening) (Directive to Take Action); and be it  
34 further  
35  
36 RESOLVED, That our AMA advocate for a ban on direct-to-consumer advertising for  
37 prescription drugs by no later than five years, in 2027. (Reaffirm HOD policy)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 09/29/22

**REFERENCES:**

1. Kirzinger A, et al. KFF Health Tracking Poll - February 2019: Prescription Drugs. Internet Document : 1 Mar 2019. Available from: URL: <https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-february-2019-prescription-drugs/>
2. Kirzinger A, et al. KFF Health Tracking Poll - February 2019: Prescription Drugs. Internet Document : 1 Mar 2019. Available from: URL: <https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-february-2019-prescription-drugs/>
3. Congress.gov. "Text – H.R. 5376 – 117th Congress (2021-2022): Inflation Reduction Act of 2022." August 16, 2022. <http://www.congress.gov/>.
4. Congress.gov. "Text – H.R. 5376 – 117th Congress (2021-2022): Inflation Reduction Act of 2022." August 16, 2022. <http://www.congress.gov/>.

**RELEVANT AMA POLICY**

**Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices H-105.988**

1. To support a ban on direct-to-consumer advertising for prescription drugs and implantable medical devices.
2. That until such a ban is in place, our AMA opposes product-claim DTCA that does not satisfy the following guidelines:
  - (a) The advertisement should be indication-specific and enhance consumer education about the drug or implantable medical device, and the disease, disorder, or condition for which the drug or device is used.
  - (b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing.
  - (c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical device to distinguish such advertising from other advertising for non-prescription products.
  - (d) The advertisement should not encourage self-diagnosis and self-treatment, but should refer patients to their physicians for more information. A statement, such as "Your physician may recommend other appropriate treatments," is recommended.
  - (e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable.
  - (f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without distraction of content, and will help facilitate communication between physician and patient.
  - (g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition.
  - (h) In general, product-claim DTCA should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in DTCA, a disclaimer should be prominently displayed.
  - (i) The use of actual health care professionals, either practicing or retired, in DTCA to endorse a specific drug or implantable medical device product is discouraged but if utilized, the advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement.
  - (j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved.
  - (k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines.

3. That the FDA review and pre-approve all DTCA for prescription drugs or implantable medical device products before pharmaceutical and medical device manufacturers (sponsors) run the ads, both to ensure compliance with federal regulations and consistency with FDA-approved labeling for the drug or implantable medical device product.
  4. That the Congress provide sufficient funding to the FDA, either through direct appropriations or through prescription drug or implantable medical device user fees, to ensure effective regulation of DTCA.
  5. That DTCA for newly approved prescription drug or implantable medical device products not be run until sufficient post-marketing experience has been obtained to determine product risks in the general population and until physicians have been appropriately educated about the drug or implantable medical device. The time interval for this moratorium on DTCA for newly approved drugs or implantable medical devices should be determined by the FDA, in negotiations with the drug or medical device product's sponsor, at the time of drug or implantable medical device approval. The length of the moratorium may vary from drug to drug and device to device depending on various factors, such as: the innovative nature of the drug or implantable medical device; the severity of the disease that the drug or implantable medical device is intended to treat; the availability of alternative therapies; and the intensity and timeliness of the education about the drug or implantable medical device for physicians who are most likely to prescribe it.
  6. That our AMA opposes any manufacturer (drug or device sponsor) incentive programs for physician prescribing and pharmacist dispensing that are run concurrently with DTCA.
  7. That our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries to conduct or fund research on the effect of DTCA, focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public.
  8. That our AMA supports the concept that when companies engage in DTCA, they assume an increased responsibility for the informational content and an increased duty to warn consumers, and they may lose an element of protection normally accorded under the learned intermediary doctrine.
  9. That our AMA encourages physicians to be familiar with the above AMA guidelines for product-claim DTCA and with the Council on Ethical and Judicial Affairs Ethical Opinion E-9.6.7 and to adhere to the ethical guidance provided in that Opinion.
  10. That the Congress should request the Agency for Healthcare Research and Quality or other appropriate entity to perform periodic evidence-based reviews of DTCA in the United States to determine the impact of DTCA on health outcomes and the public health. If DTCA is found to have a negative impact on health outcomes and is detrimental to the public health, the Congress should consider enacting legislation to increase DTCA regulation or, if necessary, to prohibit DTCA in some or all media. In such legislation, every effort should be made to not violate protections on commercial speech, as provided by the First Amendment to the U.S. Constitution.
  11. That our AMA supports eliminating the costs for DTCA of prescription drugs as a deductible business expense for tax purposes.
  12. That our AMA continues to monitor DTCA, including new research findings, and work with the FDA and the pharmaceutical and medical device industries to make policy changes regarding DTCA, as necessary.
  13. That our AMA supports "help-seeking" or "disease awareness" advertisements (i.e., advertisements that discuss a disease, disorder, or condition and advise consumers to see their physicians, but do not mention a drug or implantable medical device or other medical product and are not regulated by the FDA).
  14. Our AMA will advocate to the applicable Federal agencies (including the Food and Drug Administration, the Federal Trade Commission, and the Federal Communications Commission) which regulate or influence direct-to-consumer advertising of prescription drugs that such advertising should be required to state the manufacturer's suggested retail price of those drugs.
- Citation: BOT Rep. 38 and Sub. Res. 513, A-99; Reaffirmed: CMS Rep. 9, Amended: Res. 509, and Reaffirmation I-99; Appended & Reaffirmed: Sub. Res. 503, A-01; Reaffirmed: Res. 522, A-02; Reaffirmed: Res. 914, I-02; Reaffirmed: Sub. Res. 504, A-03; Reaffirmation A-04; Reaffirmation A-05; Modified: BOT Rep. 9, A-06; Reaffirmed in lieu of Res. 514, A-07; BOT Action in response to referred for decision: Res. 927, I-15; Modified: BOT Rep. 09, I-16; Appended: Res. 236, A-17; Reaffirmed in lieu of: Res. 223, A-17; Reaffirmed in lieu of: Res. 112, A-19

#### **Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980**

1. Our AMA will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:

- a. The arbitration process should be overseen by objective, independent entities;
  - b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
  - c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
  - d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
  - e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision;
  - f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer;
  - g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases;
  - h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision; and
  - i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
- a. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;
  - b. The use of any international drug price index or average should preserve patient access to necessary medications;
  - c. The use of any international drug price index or average should limit burdens on physician practices; and
  - d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly.
3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction.

Citation: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Modified: CMS Rep. 4, A-22

#### **The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987**

1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
5. Our AMA supports improved transparency of PBM operations, including disclosing:
  - Utilization information;
  - Rebate and discount information;
  - Financial incentive information;
  - Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;
  - Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
  - Methodology and sources utilized to determine drug classification and multiple source generic pricing;and
  - Percentage of sole source contracts awarded annually.
6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.

Citation: CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 6, I-20

**Reducing Prescription Drug Prices D-110.993**

Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation.

Citation: (CMS Rep. 3, I-04; Modified: CMS Rep. 1, A-14; Reaffirmation A-14; Reaffirmed in lieu of Res. 229, I-14)

**Cost of New Prescription Drugs H-110.998**

Our AMA urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs.

Citation: (Res. 112, I-89; Reaffirmed: Res. 520, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed in lieu of Res. 229, I-14)

**Prescription Drug Prices and Medicare D-330.954**

1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS.

Citation: Res. 211, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 201, I-11; Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended: Res. 203, A-17; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Reaffirmed: Res. 113, I-21; Reaffirmed: CMS Rep. 4, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 811  
(I-22)

Introduced by: Senior Physicians Section

Subject: Covering Vaccinations for Seniors through Medicare Part B

Referred to: Reference Committee J

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1 Whereas, The recently passed Inflation Reduction Act of 2022 eliminates cost-sharing in  
2 Medicare for vaccines; and

3

4 Whereas, Medicare coverage rules vary across vaccines as well as Parts B and D; and

5

6 Whereas, These differences can act as significant barriers to vaccination especially in different  
7 socioeconomic groups of seniors; and

8

9 Whereas, It is difficult for physician practices to contract with multiple individual Medicare  
10 Part D plans; therefore be it

11

12 RESOLVED, That our American Medical Association advocate that Medicare Part B cover the  
13 full cost of all vaccinations administered to Medicare patients that are recommended by the  
14 Advisory Committee on Immunization Practices (ACIP), the US Preventive Services Task Force  
15 (USPSTF), or based on prevailing preventive clinical health guidelines. (Directive to Take  
16 Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 09/29/22

**RELEVANT AMA POLICY**

**Medicare Prescription Drug and Vaccine Coverage and Payment D-330.898**

Our AMA will: (1) continue to solicit input from national medical specialty societies and state medical associations for their recommendations to ensure adequate Medicare Part B drug reimbursement; (2) work with interested national medical specialty societies on alternative methods to reimburse physicians and hospitals for the cost of Part B drugs; and (3) continue working with interested stakeholders to improve the utilization rates of adult vaccines by individuals enrolled in Medicare.

Citation: CMS Rep. 3, I-20;

**Reimbursement for Influenza Vaccine H-440.848**

Our AMA: (1) will work with third party payers, including the Centers for Medicare and Medicaid Services, to establish a fair reimbursement price for the flu vaccine; (2) encourage the manufacturers of influenza vaccine to publish the purchase price by June 1st each year; (3) shall seek federal legislation or regulatory relief, or otherwise work with the federal government to increase Medicare reimbursement levels for flu vaccination and other vaccinations.

Citation: CSAPH Rep. 5, I-12; Reaffirmed: CSAPH Rep. 1, A-22

**Financing of Adult Vaccines: Recommendations for Action H-440.860**

1. Our AMA supports the concepts to improve adult immunization as advanced in the Infectious Diseases Society of America's 2007 document "Actions to Strengthen Adult and Adolescent Immunization Coverage in the United States," and support the recommendations as advanced by the National Vaccine Advisory Committee's 2008 white paper on pediatric vaccine financing.
2. Our AMA will advocate for the following actions to address the inadequate financing of adult vaccination in the United States:

Provider-related

- a. Develop a data-driven rationale for improved vaccine administration fees.
- b. Identify and explore new methods of providing financial relief for adult immunization providers through, for example, vaccine company replacement systems/deferred payment/funding for physician inventories, buyback for unused inventory, and patient assistance programs.
- c. Encourage and facilitate adult immunization at all appropriate points of patient contact; e.g., hospitals, visitors to long-term care facilities, etc.
- d. Encourage counseling of adults on the importance of immunization by creating a mechanism through which immunization counseling alone can be reimbursed, even when a vaccine is not given.

Federal-related

- a. Increase federal resources for adult immunization to: (i) Improve Section 317 funding so that the program can meet its purpose of improving adult immunizations; (ii) Provide universal coverage for adult vaccines and minimally, uninsured adults should be covered; (iii) Fund an adequate universal reimbursement rate for all federal and state immunization programs.
- b. Optimize use of existing federal resources by, for example: (i) Vaccinating eligible adolescents before they turn 19 years of age to capitalize on VFC funding; (ii) Capitalizing on public health preparedness funding.
- c. Ease federally imposed immunization burdens by, for example: (i) Providing coverage for Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B; (ii) Creating web-based billing mechanisms for physicians to assess coverage of the patient in real time and handle the claim, eliminating out-of-pocket expenses for the patient; (iii) Simplifying the reimbursement process to eliminate payment-related barriers to immunization.
- d. The Centers for Medicare & Medicaid Services should raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations.

State-related

- a. State Medicaid programs should increase state resources for funding vaccines by, for example: (i) Raising and funding the maximum Medicaid reimbursement rate for vaccine administration fees; (ii) Establishing and requiring payment of a minimum reimbursement rate for administration fees; (iii) Increasing state contributions to vaccination costs; and (iv) Exploring the possibility of mandating immunization coverage by third party payers.
- b. Strengthen support for adult vaccination and appropriate budgets accordingly.

Insurance-related

1. Provide assistance to providers in creating efficiencies in vaccine management by: (i) Providing model vaccine coverage contracts for purchasers of health insurance; (ii) Creating simplified rules for eligibility verification, billing, and reimbursement; (iii) Providing vouchers to patients to clarify eligibility and coverage for patients and providers; and (iv) Eliminating provider/public confusion over insurance payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines.
- b. Increase resources for funding vaccines by providing first-dollar coverage for immunizations.
- c. Improve accountability by adopting performance measurements.
- d. Work with businesses that purchase private insurance to include all ACIP-recommended immunizations as part of the health plan.
- e. Provide incentives to encourage providers to begin immunizing by, for example: (i) Including start up costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for reimbursing the provision of immunizations; (ii) Simplifying payment to and encouraging immunization by nontraditional providers; (iii) Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility).

**Manufacturer-related**

Market stability for adult vaccines is essential. Thus: (i) Solutions to the adult vaccine financing problem should not deter research and development of new vaccines; (ii) Solutions should consider the maintenance of vibrant public and private sector adult vaccine markets; (iii) Liability protection for manufacturers should be assured by including Vaccine Injury Compensation Program coverage for all ACIP-recommended adult vaccines; (iv) Educational outreach to both providers and the public is needed to improve acceptance of adult immunization.

3. Our AMA will conduct a survey of small- and middle-sized medical practices, hospitals, and other medical facilities to identify the impact on the adult vaccine supply (including influenza vaccine) that results from the large contracts between vaccine manufacturers/distributors and large non-government purchasers, such as national retail health clinics, other medical practices, and group purchasing programs, with particular attention to patient outcomes for clinical preventive services and chronic disease management.

Citation: CSAPH Rep. 4, I-08; Reaffirmation I-10; Reaffirmation: I-12; Reaffirmation I-14; Reaffirmed: CMS Rep. 3, I-20; Reaffirmation: A-22

**Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines H-440.875**

1. It is AMA policy that all persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as soon as possible following publication of these recommendations in the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality Weekly Report (MMWR).

2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine.

3. Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines.

4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of ACIP-recommended vaccines, and the timely distribution of ACIP-recommended vaccines to providers).

5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer ACIP-recommended vaccines.

6. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to address barriers associated with Medicare recipients receiving live zoster vaccine and the routine boosters Td and Tdap in physicians' offices.

7. Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly include newly ACIP-recommended vaccines in their list of covered benefits, and to pay health care professionals fairly for the purchase and administration of ACIP-recommended vaccines.

8. Our AMA will urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis.

9. Until compliance of AMA Policy H-440.875(6) is actualized to the AMA's satisfaction regarding the tetanus vaccine, our AMA will aggressively petition CMS to include tetanus and Tdap at both the "Welcome to Medicare" and Annual Medicare Wellness visits, and other clinically appropriate encounters, as additional "triggering event codes" (using the AT or another modifier) that allow for coverage and payment of vaccines to Medicare recipients.

10. Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines.

Citation: BOT Action in response to referred for decision Res. 524, A-06; Reaffirmation A-07; Appended: Res. 531, A-07; Reaffirmation A-09; Reaffirmed: Res. 501, A-09; Reaffirmation I-10; Reaffirmation A-11; Reaffirmed in lieu of Res. 422, A-11; BOT action in response to referred for decision Res. 422, A-11;

Reaffirmation: I-12; Appended: Res. 227, I-12; Appended: Res. 824, I-14; Reaffirmed: Res. 411, A-17; Reaffirmed: CMS Rep. 3, I-20; Reaffirmed: Res. 228, A-21; Reaffirmation: A-22

**Appropriate Reimbursements and Carve-outs for Vaccines D-440.981**

Our AMA will: (1) continue to work with the Centers for Medicare and Medicaid Services (CMS) and provide comment on the Medicare Program payment policy for vaccine services; (2) continue to pursue adequate reimbursement for vaccines and their administration from all public and private payers; (3) encourage health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular vaccine; (4) seek legislation mandating that health insurance companies in applicable states either adequately pay for vaccines recommended by the Advisory Committee on Immunization Practices, or clearly state in large bold font in their notices to patients and businesses that they do not follow the federal advisory body on vaccine recommendations, the Advisory Committee on Immunization Practices; and (5) advocate that a physician's office can bill Medicare for all vaccines administered to Medicare beneficiaries and that the patient shall only pay the applicable copay to prevent fragmentation of care. Citation: BOT Rep. 20, A-03; Reaffirmation A-07; Res. 128, A-09; Reaffirmation I-10; Reaffirmed: Res. 807, I-11; Appended: Res. 217, A-19; Reaffirmed: CMS Rep. 3, I-20; Res. 408, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 812  
(I-22)

Introduced by: Resident and Fellow Section

Subject: Implant-Associated Anaplastic Large Cell Lymphoma

Referred to: Reference Committee J

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- 1 Whereas, In 2016, the World Health Organization provisionally classified breast implant-  
2 associated anaplastic large cell lymphoma (BIA-ALCL) as a T-cell lymphoma<sup>1</sup>; and  
3  
4 Whereas, Policies concerning breast cancer treatment do not encompass BIA-ALCL given that  
5 this cancer is a lymphoma; and  
6  
7 Whereas, The 2019 National Comprehensive Cancer Care Network consensus guidelines state  
8 clearly that, “Essential to the treatment of BIA-ALCL is timely diagnosis and complete surgical  
9 excision.”<sup>2</sup>; and  
10  
11 Whereas, Patients with BIA-ALCL suffer delays in care as they fight with their insurance  
12 companies to cover surgery to remove the cancer and their breast implants, as the insurance  
13 company may initially classify the surgery as cosmetic and not cover it,<sup>3</sup> therefore be it  
14  
15 RESOLVED, That our American Medical Association support appropriate coverage of cancer  
16 diagnosis, treating surgery and other systemic treatment options for implant-associated  
17 anaplastic large cell lymphoma. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 09/30/22

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**RELEVANT AMA POLICY**

Breast Implants H-525.984

Our AMA: (1) supports that individuals be fully informed about the risks and benefits associated with breast implants and that once fully informed the patient should have the right to choose; and (2) based on current scientific knowledge, supports the continued practice of breast augmentation or reconstruction with implants when indicated.

Citation: CSA Rep. M, I-91; Modified: Sunset Report, I-01; Reaffirmed: Res. 727, I-02; Modified: CSAPH Rep. 1, A-12; Modified: CSAPH Rep. 1, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 813  
(I-22)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island,  
Vermont, Washington

Subject: Amending Policy on a Public Option to Maximize AMA Advocacy

Referred to: Reference Committee J

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- 1 Whereas, The Patient Protection and Affordable Care Act of 2010 (ACA) reduced the  
2 uninsurance rate in the United States but has not achieved universal coverage<sup>1,2</sup>; and  
3
- 4 Whereas, Tens of millions of Americans are either uninsured or underinsured with insurance  
5 that is too expensive to actually be used, significantly limiting their access to affordable  
6 healthcare<sup>3-5</sup>; and  
7
- 8 Whereas, Many individual insurance plans offered on the ACA's Health Insurance Marketplaces  
9 (hereafter referred to as "ACA Exchanges") have high premiums, deductibles, and other out-of-  
10 pocket costs that leave beneficiaries exposed to financial risk and limit their access to  
11 healthcare services<sup>2,6-8</sup>; and  
12
- 13 Whereas, Some ACA Exchanges, particularly those covering rural areas, offer only a small  
14 number of plans that are limited by very few insurers participating, which has been shown to  
15 lead to higher costs and faster premium growth due to limited competition<sup>9-13</sup>; and  
16
- 17 Whereas, Plans offered on the ACA Exchanges frequently have narrow provider networks,  
18 which reduces access to care and can lead to high out-of-pocket costs if patients go out-of-  
19 network<sup>14-16</sup>; and  
20
- 21 Whereas, A federally-managed public insurance plan ("public option") has been proffered as a  
22 mechanism to improve competition, increase access to affordable healthcare, and lower costs,  
23 particularly in areas where there are few participating insurers and a commensurate lack of  
24 competition between plans<sup>8,17-19</sup>; and  
25
- 26 Whereas, A recent analysis from the Urban Institute found that various public option proposals  
27 with different eligibility criteria and payment rates would all decrease the uninsured rate,  
28 significantly reduce premiums, and reduce the federal deficit<sup>20</sup>; and  
29
- 30 Whereas, RAND modeled four different scenarios under which a public option could be  
31 implemented and found that under all scenarios, premium costs in the public option were lower  
32 than in private plans, leading to more people being covered<sup>21</sup>; and  
33
- 34 Whereas, A Commonwealth Fund analysis of various healthcare reform proposals found that a  
35 public option would reduce the uninsured rate and significantly reduce costs to the federal  
36 government, permitting the implementation of more generous premium tax credits that could  
37 further reduce the uninsurance rate<sup>22</sup>; and

1 Whereas, A public option would have significant leverage during price negotiations with  
2 hospitals, pharmaceutical companies, pharmacy benefit managers, and other healthcare  
3 providers due to its large size and would likely have lower administrative costs per beneficiary  
4 than smaller private plans, leading to lower premiums and cost-sharing for beneficiaries and  
5 lower costs to the federal government<sup>9,21,23,24</sup>; and  
6

7 Whereas, A 2021 CBO report on key design considerations for a public option showed that the  
8 benchmark premium for insurance plans offered on the ACA Exchanges is closely correlated  
9 with the number of insurers participating in the market with more insurers leading to lower  
10 premiums, suggesting that the public option, as an additional insurer, would reduce premiums  
11 for public and private insurers alike<sup>25</sup>; and  
12

13 Whereas, Though there are concerns that a public option may reduce overall physician  
14 reimbursement through lower provider payment rates, CBO estimates of the impacts of  
15 Medicare-for-All proposals on physician reimbursement show that lower provider payment rates  
16 may be balanced by increased healthcare utilization after the expansion of public insurance  
17 programs, leading to small overall changes in physician reimbursement and a net increase in  
18 some scenarios<sup>28,29</sup>; and  
19

20 Whereas, Recent studies published by the CBO, JAMA, and AAFP have discussed the inherent  
21 tradeoffs between lowering costs through reduced provider reimbursement and developing  
22 provider networks attractive enough to convince prospective beneficiaries to enroll in the public  
23 option, highlighting how careful design of a public option can maximize benefit to patients and  
24 physicians alike<sup>30-32</sup>; and  
25

26 Whereas, The state of Washington created a public option-like program called Cascade Care in  
27 2019 that designed overall reimbursement to exceed no more than 160% of Medicare rates with  
28 a minimum reimbursement of 135% of Medicare rates for primary care practices, showing how a  
29 public option can be designed to reduce costs and expand coverage in ways that do not unduly  
30 burden physicians<sup>33,34</sup>; and  
31

32 Whereas, The AMA passed Policy H-165.823 in November 2020, which lays out a variety of  
33 criteria that a public option should meet, but does not go so far as to explicitly support a public  
34 option; and  
35

36 Whereas, H-165.823 already contains provisions to protect physicians and their practices,  
37 including a requirement that the public option not tie participation to participation in other public  
38 insurance programs, a requirement that contracts with physicians must be subject to meaningful  
39 negotiation, and a requirement that reimbursement exceed prevailing Medicare rates and be at  
40 levels sufficient to sustain the costs of medical practice; and  
41

42 Whereas, Based in large part upon on this policy, the AMA recently sent a letter to Congress  
43 regarding a public option, which highlighted the standards codified in H-165.823 while failing to  
44 mention the potential benefits or explicitly endorse a public option<sup>35</sup>; and  
45

46 Whereas, multiple physician groups, including the American College of Physicians, American  
47 Academy of Family Physicians, American Academy of Pediatrics, American College of  
48 Obstetricians and Gynecologists, American Osteopathic Association, American Psychiatric  
49 Association, and the Society of General Internal Medicine, have endorsed a public option<sup>36-38</sup>;  
50 therefore be it

1 RESOLVED, That our American Medical Association amend Policy H-165.823, “Options to  
2 Maximize Coverage under the AMA Proposal for Reform”, by addition and deletion to read as  
3 follows:  
4

- 5 1. Our AMA will advocate ~~that any~~ for a public option to expand health insurance  
6 coverage ~~must that~~ meets the following standards:  
7 a. The primary goals of establishing a public option are to maximize patient choice of  
8 health plan and maximize health plan marketplace competition.  
9 b. Eligibility for premium tax credit and cost-sharing assistance to purchase the  
10 public option is restricted to individuals without access to affordable employer-  
11 sponsored coverage that meets standards for minimum value of benefits.  
12 c. Physician payments under the public option are established through meaningful  
13 negotiations and contracts. Physician payments under the public option must be  
14 higher than prevailing Medicare rates and at rates sufficient to sustain the costs of  
15 medical practice.  
16 d. Physicians have the freedom to choose whether to participate in the public option.  
17 Public option proposals should not require provider participation and/or tie physician  
18 participation in Medicare, Medicaid and/or any commercial product to participation in  
19 the public option.  
20 e. The public option is financially self-sustaining and has uniform solvency  
21 requirements.  
22 f. The public option does not receive advantageous government subsidies in  
23 comparison to those provided to other health plans.  
24 g. The public option shall be made available to uninsured individuals who fall into the  
25 “coverage gap” in states that do not expand Medicaid – having incomes above  
26 Medicaid eligibility limits but below the federal poverty level, which is the lower limit  
27 for premium tax credits – at no or nominal cost. (Modify Current HOD Policy)

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## RELEVANT AMA POLICY

### Options to Maximize Coverage under the AMA Proposal for Reform H-165.823

1. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
  - a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
  - b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
  - c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
  - d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
  - e. The public option is financially self-sustaining and has uniform solvency requirements.
  - f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
  - g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.
2. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
  - a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
  - b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children’s Health Insurance Program (CHIP) or zero-premium marketplace coverage.
  - c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
  - d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
  - e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
  - f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
  - g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
  - h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.
3. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status.

Citation: CMS Rep. 1, I-20; Appended: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: Res. 122, A-22

#### **Universal Health Coverage H-165.904**

Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans

Citation: Sub. Res. 138, A-94; Appended: Sub. Res. 109, I-98; Reaffirmation A-02; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 1, A-22

#### **Evaluating Health System Reform Proposals H-165.888**

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:

- A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
- B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
- C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
- D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
- E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
- F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
- G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
- H. True health reform is impossible without true tort reform.

2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.

3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.

Citation: Res. 118, I-91; Res. 102, I-92; BOT Rep. NN, I-92; BOT Rep. S, A-93; Reaffirmed: Res. 135, A-93; Reaffirmed: BOT Reps. 25 and 40, I-93; Reaffirmed in lieu of Res. 714, I-93; Res. 130, I-93; Res. 316, I-93; Sub. Res. 718, I-93; Reaffirmed: CMS Rep. 5, I-93; Res. 124, A-94; Reaffirmed by BOT Rep.1- I-94; CEJA Rep. 3, A-95; Reaffirmed: BOT Rep. 34, I-95; Reaffirmation A-00; Reaffirmation A-01; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep. 2, A-03; Reaffirmed and Modified: CMS Rep. 5, A-04; Reaffirmed with change in title: CEJA Rep. 2, A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation I-07; Reaffirmed in lieu of Res. 113, A-08; Reaffirmation A-09; Res. 101, A-09; Sub. Res. 110, A-09; Res. 123, A-09; Reaffirmed in lieu of Res. 120, A-12; Reaffirmation: A-17

**Health System Reform Legislation H-165.838**

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
  - a. Health insurance coverage for all Americans
  - b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
  - c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
  - d. Investments and incentives for quality improvement and prevention and wellness initiatives
  - e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
  - f. Implementation of medical liability reforms to reduce the cost of defensive medicine
  - g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens
2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
  - a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
  - b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
  - c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
  - d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
  - e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
  - f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest
9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.
10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.

Citation: Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 814  
(I-22)

Introduced by: American College of Cardiology, American Society of Echocardiography, American Society of Nuclear Cardiology, Heart Rhythm Society, Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Computed Tomography, Texas

Subject: Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?

Referred to: Reference Committee J

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- 1 Whereas, A coronary artery calcium score (CACS) measured by computed tomography is a  
2 noninvasive, low-radiation diagnostic test that correlates with cardiovascular outcomes<sup>1</sup>; and  
3  
4 Whereas, Screening with CACS can help guide the course of clinical management in the  
5 borderline-and intermediate-risk patients with 10-year cardiovascular risk of 5% to  
6 20%, particularly those with risk-enhancing factors, e.g., chronic kidney disease, metabolic  
7 syndrome, an elevated high sensitivity C-reactive protein, a positive ankle-brachial index, or a  
8 positive family history<sup>2,3</sup> by the American College of Cardiology and American Heart Association  
9 2019 Primary Prevention Guidelines; and  
10  
11 Whereas, CACS is not covered by insurance except in the state of Texas<sup>4</sup>, and the out-of-  
12 pocket costs range from \$49-\$1209, which may represent a barrier for patients who may not be  
13 able to afford the test, but are likely to derive benefit from the results of the test; and  
14  
15 Whereas, A low-cost and no-charge CACS strategy has been tested in Cleveland, Ohio<sup>5</sup>,  
16 demonstrating a striking increase in CACS utilization in lower income patients, the black  
17 population, and women; therefore be it  
18  
19 RESOLVED, That our American Medical Association seek national and/or state legislation  
20 and/or a national coverage determination (NCD) to include coronary artery calcium scoring  
21 (CACS) for patients who meet the screening criteria set forth by the American College of  
22 Cardiology/American Heart Association 2019 Primary Prevention Guidelines, as a first-dollar  
23 covered preventive service, consistent with the current policy in the state of Texas (Directive to  
24 Take Action); and be it further  
25  
26 RESOLVED, That our AMA collaborate with the appropriate stakeholders to propose that  
27 hospitals strongly consider a no cost/nominal cost option for CACS in appropriate patients who  
28 are unable to afford this test, as a means to enhance disease detection, disease modification  
29 and management. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 10/04/22

**REFERENCES**

1. Detrano R, Guerci AD, Carr JJ, et al. Coronary calcium as a predictor of coronary events in four racial or ethnic groups. *N Engl J Med* 2008;358:1336-1345.
2. Roberts ET, Horne A, Martin SS, et al. Cost-effectiveness of coronary artery calcium testing for coronary heart and cardiovascular disease risk prediction to guide statin allocation: the Multi-Ethnic Study of Atherosclerosis (MESA). *PLoS One* 2015;10(3):e0116377.
3. Arnett DK, Blumenthal RS, Albert MA et al. 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *Circulation* 2019;140(11) e596–e646.
4. Naghavi M, Maron DJ, Kloner RA, et al. Coronary artery calcium testing: A call for universal coverage *Prev Med Rep.* 2019;15:100879. Published 2019 May 2. doi:10.1016/j.pmedr.2019.100879.
5. Al-Kindi SG, Costa M, Tashtish N et al., No Charge Coronary Calcium Risk Assessment. *J Am Coll Cardiol* 2020;76(10):1259-1262.

## Reference Committee K

### CSAPH Report(s)

- 01 Drug Shortages: 2022 Update
- 02 Climate Change and Human Health

### Resolution(s)

- 902 Reducing the Burden of Incarceration on Public Health
- 904 Immigration Status is a Public Health Issue
- 905 Minimal Age of Juvenile Justice Jurisdiction in the United States
- 906 Requirement for COVID-19 Vaccination in Public Schools Once Fully FDA-Authorized
- 907 A National Strategy for Collaborative Engagement, Study, and Solutions to Reduce the Role of Illegal Firearms in Firearm Related Injury
- 908 Older Adults and the 988 Suicide and Crisis Timeline
- 909 Decreasing Gun Violence and Suicide in Seniors
- 910 Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use
- 911 Critical Need for National ECC System to Ensure Individualized, State-Wide, care for STEMI, CS and OHCA, and to Reduce Disparities in Health Care for Patients with Cardiac Emergencies

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-I-22

Subject: Drug Shortages: 2022 Update

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee K

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1 INTRODUCTION

2

3 American Medical Association (AMA) Policy H-100.956, “National Drug Shortages,” directs the  
4 Council on Science and Public Health (CSAPH) to evaluate the drug shortage issue, including the  
5 impact of group purchasing organizations and pharmacy benefit managers on drug shortages, and  
6 report back at least annually to the House of Delegates (HOD) on progress made in addressing drug  
7 shortages in the United States. This report provides an update on continuing trends in national drug  
8 shortages and ongoing efforts to further evaluate and address this critical public health issue.

9

10 METHODS

11

12 English-language reports were selected from a PubMed and Google Scholar search from  
13 September 2019 to August 2022, using the text term “drug shortages.” Additional articles were  
14 identified by manual review of the references cited in these publications. Further information was  
15 obtained from the internet sites of the U.S. Food and Drug Administration (FDA), National  
16 Academies of Sciences, Engineering, and Medicine (NASEM), U.S. Department of Health and  
17 Human Services (HHS), American Society of Health-System Pharmacists (ASHP), and Duke  
18 Margolis Center for Health Policy.

19

20 BACKGROUND

21

22 CSAPH has issued twelve reports on drug shortages, with the most recent published at the  
23 November 2021 Special Meeting.<sup>1</sup> The findings and conclusions of the first five reports are  
24 summarized in CSAPH Report 2-I-15, “National Drug Shortages: Update.” The remainder of this  
25 report will provide an update on drug shortages since the 2021 report was developed, including  
26 specific comment on issues associated with the role of pharmacy benefit managers (PBMs).

27

28 CURRENT TRENDS IN DRUG SHORTAGES

29

30 Drug shortages remain an ongoing public health concern in the United States and the AMA  
31 continues to monitor the situation and take action when appropriate. Overall, new drug shortages  
32 are decreasing; however, a large number of shortages are still ongoing and pose continued  
33 problems for patient care. Additionally, new shortages may occur as manufacturing capacity in the  
34 pharmaceutical industry is prioritized during the continuing COVID-19 and monkeypox public  
35 health emergencies, specifically for the production of vaccines and treatments.

36

37 The two primary data sources for information on drug shortages in the United States continue to be  
38 the Drug Shortage Program at the FDA and the Drug Shortage Resource Center maintained by

1 ASHP in cooperation with the University of Utah Drug Information Service (see Box 1 for links to  
2 these resources).<sup>2,3</sup> It should be noted that FDA resources also include guidance on drugs which  
3 have had their use dates extended while a known shortage is ongoing.

4  
5 According to current ASHP statistics (see Appendix 1), the downward trend in new drug shortages  
6 over the last few years has continued. At its peak in 2011, there were 267 new drug shortages  
7 reported; in 2021, there were 114. For the first 6 months of 2022, there have been 81 newly  
8 reported shortages. However, while the number of new shortages may be decreasing each year, the  
9 number of active drug shortages has stayed relatively steady (282 active shortages in Q2 2019, 264  
10 shortages in Q2 2022), indicating that individual shortages are taking longer to resolve. For the first  
11 two quarters of 2022, the five classes of drugs with the most ongoing shortages include: central  
12 nervous system drugs (40 total), fluids and electrolytes (36), antimicrobials (30), cardiovascular  
13 (27), and hormones (19). Fluids and electrolytes were not present in last year's top five classes of  
14 drug shortages, indicating a surge in products currently facing shortage.

15  
16 In addition, the number of manufacturers reporting the underlying cause of the drug shortage as  
17 "unknown" has continued to decrease, from 82 percent in 2019 to 42 percent in 2021. Compared to  
18 2020, "business decision" has decreased as well from 14 percent to 4 percent in 2021. Behind  
19 "unknown," "supply/demand" was listed as the second most common reason (27 percent) for drug  
20 shortages by manufacturers in 2021. Beyond issues with manufacturing, ASHP has also reported  
21 that hospitals are having difficulty staffing their pharmacies with experienced staff to proactively  
22 identify, prevent and alleviate gaps in supply.<sup>4</sup>

#### 23 24 *The Food and Drug Administration*

25  
26 The FDA continues to utilize a mobile app to provide up-to-date access to information about drugs  
27 in shortage as well as notifications about new and resolved drug shortages. This mobile app also  
28 gives physicians the ability to report a drug shortage. The FDA Drug Shortages webpage includes a  
29 current shortages list, a link to the mobile app, and additional information (Box 1).

30  
31 The ninth annual report on drug shortages from the FDA to Congress published in early 2022  
32 summarizes the major actions the FDA took in calendar year 2021 related to drug shortages.<sup>5</sup>  
33 During the COVID-19 public health emergency, the FDA continued to closely monitor the medical  
34 product supply chain and as expected, the supply chain was impacted by the pandemic, leading to  
35 supply disruptions or shortages of drug products in the United States. Appendix 2 includes a  
36 breakdown of the FDA's calendar year 2021 metrics, including the number of expedited reviews  
37 (274) and expedited inspections (29).

#### 38 39 *The Essential Medicines Report*

40  
41 In May 2022, HHS and the Assistant Secretary for Preparedness and Response (ASPR) released the  
42 first Essential Medicines Supply Chain and Manufacturing Resilience Assessment.<sup>6</sup> A critical  
43 function of this report was to prioritize drugs for increased scrutiny from a previously developed  
44 list of essential medicines.<sup>7</sup> In their report, a group of stakeholders identified 86 medications as  
45 critical or important for minimum acute patient care with no other alternative available. Of the  
46 drugs identified, 56 drugs (65 percent) at the time of publication were in shortage as described by  
47 the ASHP database. Within their report, the group outlines six challenges for addressing drug  
48 shortages: market structure, global competition, labor/workforce, manufacturing processes, supply  
49 chain/distribution, and regulatory barriers.

1 *The Drug Enforcement Administration*

2  
3 Outside of the FDA, HHS and ASPR, the Drug Enforcement Administration (DEA) is another  
4 critical federal agency that impacts drug shortages. As part of its regulatory authority under the  
5 Controlled Substances Act, the DEA maintains a closed system around the manufacturing of  
6 Schedule I and II drugs, as well as List I chemicals (ephedrine, pseudoephedrine and  
7 phenylpropanolamine). This closed system means that the DEA requires the registration and  
8 continuous oversight of any entity involved in the manufacturing and distribution supply chain of  
9 these drugs, including a strict quota on the volume and quantity of a controlled substance that can  
10 be manufactured at a given time. Per the DEA, this quota is intended “prevent, detect, and  
11 investigate the diversion of controlled pharmaceuticals and listed chemicals from legitimate  
12 sources while ensuring an adequate and uninterrupted supply for legitimate medical, commercial,  
13 and scientific needs.”<sup>8</sup> The FDA and DEA have an ongoing memorandum of understanding to  
14 share information regarding information that may impact drug shortages.<sup>9</sup>

15  
16 However, there have been several instances where DEA quotas have either directly or indirectly  
17 caused a drug shortage of a critically necessary medication. For example, in 2019 the DEA  
18 proposed a 53 percent decrease to the overall quota of Schedule II opioids that could be  
19 manufactured in 2020.<sup>10</sup> However, by the spring of 2020, there was a surge in demand for  
20 injectable opioids to help patients on ventilators fighting COVID-19.

21  
22 In response to a 2020 joint letter from AMA, ASHP and other stakeholders,<sup>11</sup> the DEA increased  
23 the manufacturing quota by 15 percent, yet injectable fentanyl, hydromorphone, and morphine are  
24 all still classified as active shortages by ASHP in 2022.<sup>12</sup> Other drugs, such as mixed amphetamine  
25 salts for the treatment of attention deficit hyperactivity disorder, are similarly facing decreases in  
26 DEA manufacturing quotas while under an active drug shortage.

27  
28 In light of the opioid crisis, in which medications that help prevent overdose are underprescribed  
29 nationwide, supply restrictions may have significant unintended consequences. The potential  
30 benefit of supply reduction is that it may discourage the diversion of controlled substances. The  
31 potential harm of supply reduction is that patients may suffer serious harm when needed  
32 medications are unavailable for any reason. Your Council on Science and Public Health is currently  
33 unaware of any evidence that the overall benefits of supply reductions outweigh the overall harms.

34  
35 *Pharmacy Benefit Managers*

36  
37 At the AMA 2022 Annual Meeting, the topic of PBMs and their role in driving drug shortages was  
38 specifically raised. PBMs, which serve as an intermediary between health insurers and  
39 pharmaceutical companies, have long been a source of scrutiny by our AMA, with a multitude of  
40 policies directly calling for oversight or reform of PBM activities.

41  
42 Concern around PBMs and drug shortages is the potential for manipulating price and access to  
43 medications. However, these claims cannot be tested as PBM pricing information has historically  
44 been opaque, but that may be changing. On June 7, 2022, the Federal Trade Commission (FTC)  
45 announced that it has launched an investigation into vertically integrated PBMs and has specifically  
46 cited issues around PBM-owned pharmacies and prior authorizations.<sup>13</sup> In April 2022, prior to the  
47 FTC’s decision, the AMA sent a letter urging the FTC to take action and increase PBM  
48 transparency.<sup>14</sup> Additional bipartisan legislation, the Pharmacy Benefit Manager Transparency Act  
49 of 2022, was introduced on May 24, 2022, and at the time of writing is pending review by the  
50 Senate Commerce, Science and Transportation committee. In its current form, the PBM

1 Transparency Act would require, among other things, for PBMs to file annual reports with the FTC  
2 on many of their practices.<sup>15</sup>

3  
4 Beyond possible manipulations of cost and access, other PBM practices may exacerbate drug  
5 shortages or otherwise impact the ability of a practice to mitigate shortages. For example, PBMs  
6 may utilize techniques known as “brown bagging,” in which a health plan requires a patient to  
7 obtain a medication from a PBM-owned specialty pharmacy and then bring it to the clinic for the  
8 practitioner to administer. Previously, the Council on Medical Service has investigated the issue of  
9 brown bagging medications in the context of patient care.<sup>16</sup> In the context of drug shortages, brown  
10 bagging decreases visibility of the supply chain for hospitals and practices; they are unable to  
11 predict which medications are to be needed when, and as such may be unable to procure or  
12 adequately plan for future demand.

### 13 14 *Monkeypox Vaccines*

15  
16 Amidst the monkeypox public health emergency, there is currently a shortage of vaccinations  
17 available in the United States. Two vaccines may be used for the prevention of monkeypox  
18 disease.<sup>17</sup> The JYNNEOS vaccine, a third-generation vaccine produced by a small European  
19 biotech company, Bavarian Nordic, is approved for the prevention of monkeypox and smallpox  
20 disease and the ACAM2000 vaccine, produced by Baxter, is approved for immunization against  
21 smallpox disease and made available for use against monkeypox under an Expanded Access  
22 Investigational New Drug (EA-IND) protocol. In the United States, there is a large supply of  
23 ACAM2000, but this vaccine has more known side effects and contraindications.<sup>18</sup> JYNNEOS is  
24 the primary vaccine being used in the U.S monkeypox outbreak.

25  
26 After its FDA approval in 2019, the Strategic National Stockpile (SNS) was reportedly supposed to  
27 procure 120 million doses of JYNNEOS, enough to immunize sixty million people as one element  
28 of the U.S. government’s smallpox preparedness efforts.<sup>19</sup> However, as with other supplies in the  
29 national stockpile, JYNNEOS inventory was not maintained to an appropriate level due to chronic  
30 underfunding as well as the redirection of funds to other purposes, such as shelter for 20 thousand  
31 unhoused migrant children at the southern border.<sup>20,21</sup> With a shelf-life of 3 years, millions of doses  
32 of JYNNEOS in the SNS had expired.<sup>22</sup> Only 2,400 doses of the JYNNEOS vaccine were available  
33 in the immediate holdings of the SNS at the onset of the current monkeypox outbreak.<sup>23</sup> More than  
34 1.1 million doses of the vaccine purchased by the U.S. government were at Bavarian Nordic’s  
35 facility in Denmark and required authorization from an on-site FDA inspection before they could  
36 be shipped to the U.S.<sup>24</sup>

37  
38 To help alleviate the shortage, the FDA granted emergency use authorization for intradermal  
39 administration of JYNNEOS, which utilizes approximately one-fifth of the total volume of vaccine  
40 compared to currently approved subcutaneous administration.<sup>25</sup> In addition, the administration has  
41 increased efforts to boost domestic manufacturing, including partnerships with Michigan-based  
42 facilities to perform filling and finishing to expedite the distribution of previously ordered  
43 vaccines.<sup>26</sup>

### 44 45 CURRENT AMA DRUG SHORTAGE ACTIVITIES

46  
47 AMA staff continue to remain engaged in drug shortage activities. Staff are involved in a multi-  
48 stakeholder effort to remain current on policies, drug shortage and supply chain issues, and to  
49 develop group recommendations on the topics. The effort includes our AMA, the ASHP, the  
50 American Hospital Association (AHA), the United States Pharmacopeia (USP), the American  
51 Society of Anesthesiologists (ASA), and the American Society of Clinical Oncology (ASCO).

1 Earlier this year, our AMA additionally sent a letter to leadership of the Senate Committee on  
2 Health, Education, Labor and Pensions to advocate for legislation modernizing the medical supply  
3 chain.<sup>27</sup> In the letter, the AMA called upon Congress to, among other things:

- 4
- 5 • Incentivize advanced manufacturing technology and develop new continuous
- 6 manufacturing technology for critical drugs and active pharmaceutical ingredients;
- 7 • Improve the function and composition of the Strategic National Stockpile;
- 8 • Improve multinational cooperation on supply chain resilience;
- 9 • Incentivize quality and resilience; and
- 10 • Replicate asks for critical drug manufacturing transparency and oversight for medical
- 11 devices and ancillary supplies (e.g., PPE).

## 12

### 13 CONCLUSION

14

15 The rate of new medical product shortages is decreasing, but individual shortages are lasting  
16 longer. Due to the ongoing COVID-19 and monkeypox public health emergencies, the medical  
17 supply chain has been under intense, increased scrutiny. The AMA's drug shortage policy is timely  
18 and already addresses a variety of issues that are under consideration by the White House, FDA,  
19 and other stakeholders. Additional policy modifications have been recommended to reflect ongoing  
20 efforts by other organizations interacting with the drug manufacturing space, such as the DEA and  
21 FTC.

### 22

### 23 RECOMMENDATIONS

24

25 The Council on Science and Public Health recommends that the following be adopted and the  
26 remainder of the report be filed.

27

28 1. Policy H-100.956, "National Drug Shortages" be amended by addition to read as follows:

- 29
- 30 1. Our AMA considers drug shortages to be an urgent public health crisis, and recent
- 31 shortages have had a dramatic and negative impact on the delivery and safety of
- 32 appropriate health care to patients.
- 33
- 34 2. Our AMA supports recommendations that have been developed by multiple stakeholders to
- 35 improve manufacturing quality systems, identify efficiencies in regulatory review that can
- 36 mitigate drug shortages, and explore measures designed to drive greater investment in
- 37 production capacity for products that are in short supply, and will work in a collaborative
- 38 fashion with these and other stakeholders to implement these recommendations in an
- 39 urgent fashion.
- 40
- 41 3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human
- 42 Services (DHHS) to expedite facility inspections and the review of manufacturing changes,
- 43 drug applications and supplements that would help mitigate or prevent a drug shortage.
- 44
- 45 4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or
- 46 Congress require drug manufacturers to establish a plan for continuity of supply of vital
- 47 and life-sustaining medications and vaccines to avoid production shortages whenever
- 48 possible. This plan should include establishing the necessary resiliency and redundancy in
- 49 manufacturing capability to minimize disruptions of supplies in foreseeable circumstances
- 50 including the possibility of a disaster affecting a plant.

- 1 5. The Council on Science and Public Health shall continue to evaluate the drug shortage  
2 issue, including the impact of group purchasing organizations and pharmacy benefit  
3 managers on drug shortages, and report back at least annually to the House of Delegates on  
4 progress made in addressing drug shortages.  
5
- 6 6. Our AMA urges continued analysis of the root causes of drug shortages that includes  
7 consideration of federal actions, evaluation of manufacturer, Group Purchasing  
8 Organization (GPO), pharmacy benefit managers, and distributor practices, contracting  
9 practices by market participants on competition, access to drugs, pricing, and analysis of  
10 economic drivers, and supports efforts by the Federal Trade Commission to oversee and  
11 regulate such forces.  
12
- 13 7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs  
14 by ensuring that such products are not removed from the market or caused to stop  
15 production due to compliance issues unless such removal is clearly required for significant  
16 and obvious safety reasons.  
17
- 18 8. Our AMA supports the view that wholesalers should routinely institute an allocation  
19 system that attempts to fairly distribute drugs in short supply based on remaining inventory  
20 and considering the customer's purchase history.  
21
- 22 9. Our AMA will collaborate with medical specialty society partners and other stakeholders  
23 in identifying and supporting legislative remedies to allow for more reasonable and  
24 sustainable payment rates for prescription drugs.  
25
- 26 10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving  
27 pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to  
28 determine whether such an activity has the potential to worsen drug shortages.  
29
- 30 11. Our AMA urges the FDA to require manufacturers to provide greater transparency  
31 regarding the pharmaceutical product supply chain, including production locations of  
32 drugs, and provide more detailed information regarding the causes and anticipated duration  
33 of drug shortages.  
34
- 35 12. Our AMA supports the collection and standardization of pharmaceutical supply chain data  
36 in order to determine the data indicators to identify potential supply chain issues, such as  
37 drug shortages.  
38
- 39 13. Our AMA encourages global implementation of guidelines related to pharmaceutical  
40 product supply chains, quality systems, and management of product lifecycles, as well as  
41 expansion of global reporting requirements for indicators of drug shortages.  
42
- 43 14. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing  
44 technologies such as continuous pharmaceutical manufacturing.  
45
- 46 15. Our AMA supports the concept of creating a rating system to provide information about  
47 the quality management maturity, resiliency and redundancy, and shortage mitigation  
48 plans, of pharmaceutical manufacturing facilities to increase visibility and transparency  
49 and provide incentive to manufacturers. Additionally, our AMA encourages GPOs and

- 1 purchasers to contractually require manufacturers to disclose their quality rating, when  
2 available, on product labeling.  
3
- 4 16. Our AMA encourages electronic health records (EHR) vendors to make changes to their  
5 systems to ease the burden of making drug product changes.  
6
- 7 17. Our AMA urges the FDA to evaluate and provide current information regarding the quality  
8 of outsourcer compounding facilities.  
9
- 10 18. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine  
11 and consider drug shortages as a national security initiative and include vital drug  
12 production sites in the critical infrastructure plan.  
13
- 14 19. Our AMA urges the Drug Enforcement Administration and other federal agencies to  
15 regularly communicate and consult with the FDA regarding regulatory actions which may  
16 impact the manufacturing, sourcing, and distribution of drugs and their ingredients.  
17 (Modify Current HOD Policy)  
18
- 19 2. That Policy H-440.847, "Pandemic Preparedness," which addresses the adequacy of the  
20 Strategic National Stockpile, be reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: Less than \$1,000

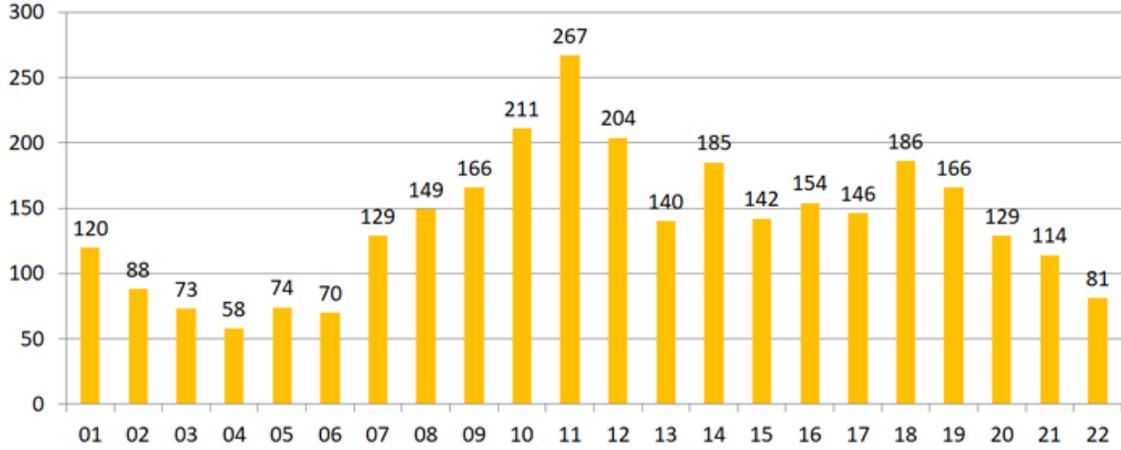
**Box 1. Resources available to assist in mitigation of drug shortages.**

1. [ASHP Resource Center](#)
2. ASHP [list](#) of current shortages
3. [FDA Drug Shortages Page](#) (includes current shortages list, extended use dates, mobile app, and additional information)

APPENDIX 1

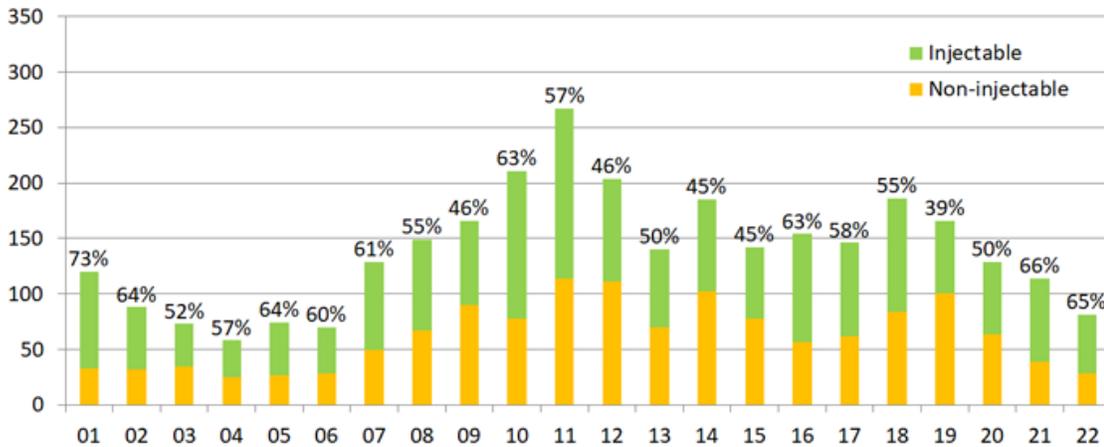
ASHP/University of Utah Drug Information Service Drug Shortage Data

**Figure 1. National Drug Shortages: New Shortages by Year: January 2001 to June 30, 2022**



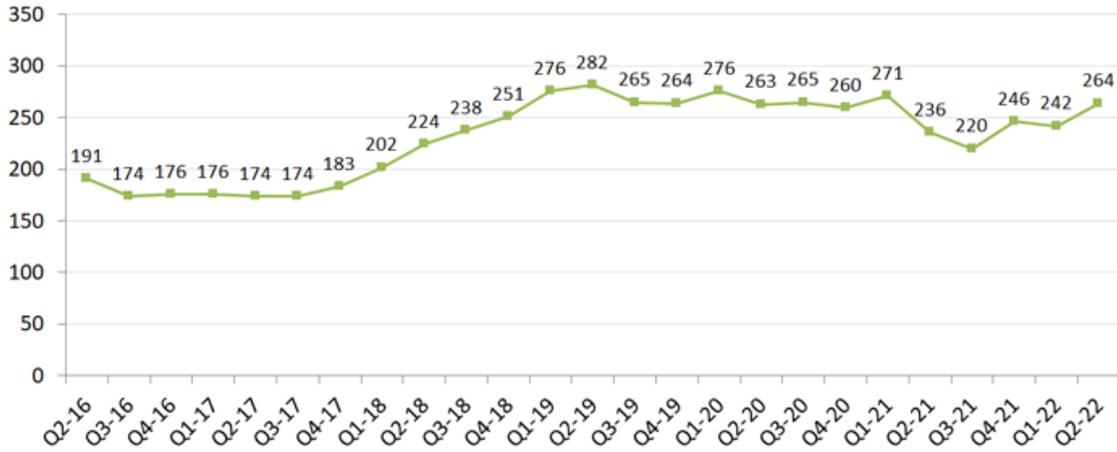
Note: Each column represents the number of new shortages identified during that year.  
 University of Utah Drug Information Service  
 Contact: Erin.Fox@hsc.utah.edu, @foxerinr for more information.

**Figure 2. National Drug Shortages: New Shortages by Year - Percent Injectable: January 2001 to June 30, 2022, % Injectable**



Note: Each column represents the number of new shortages identified during that year.  
 University of Utah Drug Information Service  
 Contact: Erin.Fox@hsc.utah.edu, @foxerinr for more information.

**Figure 3. National Drug Shortages: Active Shortages by Quarter: 5 Year Trend**

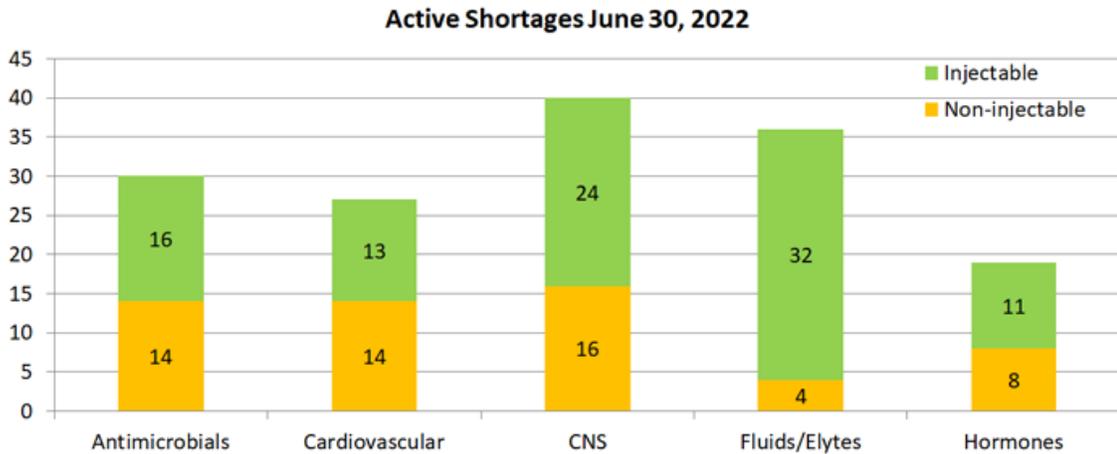


Note: Each point represents the number of active shortages at the end of each quarter.

University of Utah Drug Information Service

Contact: Erin.Fox@hsc.utah.edu, @foxerinr for more information.

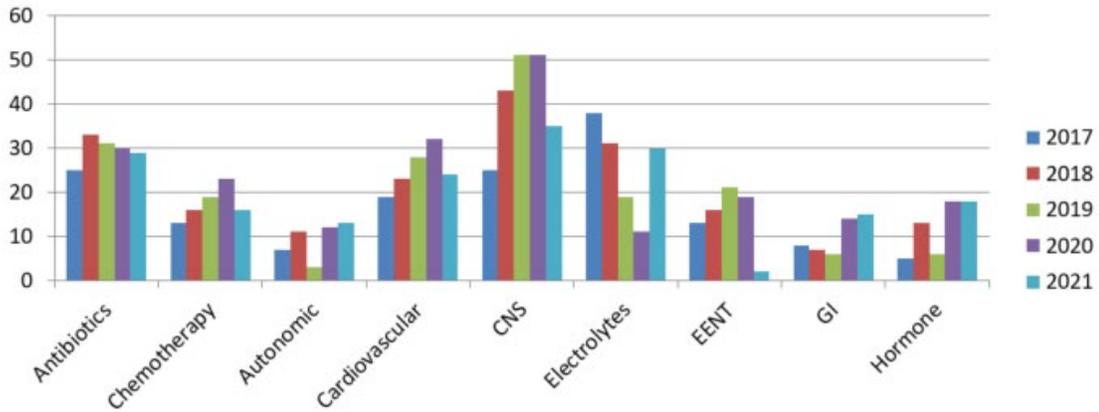
**Figure 4. National Drug Shortages: Active Shortages Top 5 Drug Classes**



University of Utah Drug Information Service

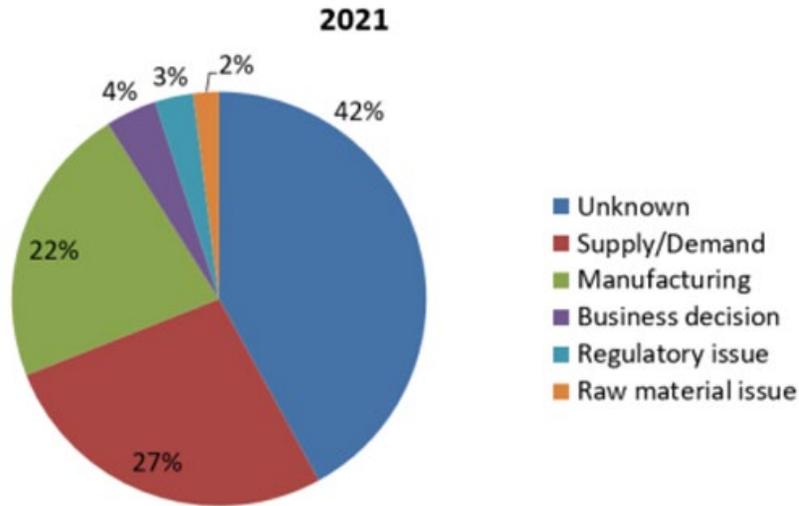
Contact: Erin.Fox@hsc.utah.edu, @foxerinr for more information.

**Figure 5. National Drug Shortages: Common Drug Classes in Short Supply: 5 Year Trend**



University of Utah Drug Information Service  
 Contact: Erin.Fox@hsc.utah.edu, @foxeinr for more information.

**Figure 6. National Drug Shortages: Reasons for Shortages as Reported by Manufacturers During UUDIS Investigation — 2021**



University of Utah Drug Information Service  
 Contact: Erin.Fox@hsc.utah.edu, @foxeinr for more information.

## APPENDIX 2

**Breakdown of CDER's and CBER's Shortage Numbers, CY 2021**

	<b>CDER</b>	<b>CBER</b>
New Shortages	38	3
Prevented Shortages	303	14
Ongoing Shortages	79	4
Notifications	744	33
No. of Manufacturers Notifying	98	23
<b>ACTIONS TAKEN TO MITIGATE SHORTAGES</b>		
Regulatory Flexibility and Discretion	97	0
Expedited Reviews	260	14*
Expedited Inspections	29	0

\* This number includes expedited reviews for eight biologics license application (BLA)/BLA supplements and six lot-release submissions for CBER-regulated products.

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REPORT 02 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-22)  
Climate Change and Human Health  
(Reference Committee K)

EXECUTIVE SUMMARY

**Objective.** The Council on Science and Public Health initiated this report due to the significant public health threat that climate change represents and the impact on the health of patients, with marginalized populations expected to be disproportionately impacted. The Council’s last update on climate change was CSAPH Report 3-I-08, “Global Climate Change and Human Health.”

**Methods.** Sentinel reports on climate, global climate change, and human health were reviewed including the Intergovernmental Panel on Climate Change (IPCC) assessment reports, *Lancet* Countdown on Health and Climate Change reports, reports from the World Health Organization (WHO), the Environmental Protection Agency (EPA), and the National Oceanic and Atmospheric Administration (NOAA). English language articles were selected from searches of the PubMed, Google Scholar, and Cochrane Library databases from January 2012 to June 2022 using the search terms: “climate change and health,” “climate crisis and health,” “decarbonization and health,” and “climate change and equity.” Additional articles were also identified by manual review of the reference lists of pertinent publications. Websites managed by federal agencies, applicable professional organizations, and foundations were reviewed for relevant information

**Results.** It is unequivocal that human influence has warmed the atmosphere, ocean and land. The scale of recent changes across the climate system are unprecedented over many centuries. Human-induced climate change is affecting weather and climate extremes in every region across the globe. The extent and magnitude of climate change impacts are larger than previously estimated and they are causing severe and widespread disruption in nature and in society; reducing our ability to grow nutritious food or provide enough clean drinking water, thus affecting people's health and well-being and damaging livelihoods. Limiting global warming to 1.5 degrees Celsius would require “rapid and far-reaching” transitions in land, energy, industry, buildings, transport, and cities.

**Conclusion.** Impacts from climate change on extreme weather, air quality, and the transmission of disease increasingly threaten the health and well-being of people in the U.S., and it is widely recognized that many of the impacts of warming will disproportionately impact the most vulnerable. The health effects of climate change include increased allergies, asthma, respiratory and cardiovascular disease; injuries and premature deaths related to extreme weather events; heat-related deaths due to continued warming; changes in the prevalence and geographical distribution of food- and water-borne illnesses and other infectious diseases, and threats to mental health.

To meet the Paris Agreement goals and prevent catastrophic levels of global warming, global GHG emissions must decline by half within a decade. Emissions are declining too slowly or heading in the wrong direction in the highest emitting sectors. This delay in progress is contributing to millions of deaths each year. The U.S. health care sector is responsible for an estimated 8.5 percent of national carbon emissions. These emissions stem from the operations of health care facilities (scope 1), from both purchased sources of energy, heating, and cooling (scope 2) and from the supply chain of health care goods and services (scope 3). The U.S. health sector accounts for 25 percent of global health sector emissions—the highest proportion attributable to any individual country’s health sector. Physician’s pledge to do no harm, it’s time for the health sector to do the same by addressing the climate crisis and protecting public health

# REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-I-22

Subject: Climate Change and Human Health

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee K

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1 The Council on Science and Public Health initiated this report due to the significant public health  
2 threat that climate change represents and the impact on the health of patients, with marginalized  
3 populations expected to be disproportionately impacted. The Council’s last update on climate  
4 change was CSAPH Report 3-I-08, “Global Climate Change and Human Health.”  
5

6 The Council’s 2008 report recognized that ongoing adverse global climate change is widely  
7 accepted by the majority of scientists, climatologists, and meteorologists, and human activity is  
8 influencing the rate and extent of this process. The report noted that the extent of climate change  
9 will depend on many factors, most notably, changes in global greenhouse gas (GHG) emissions.  
10 Anthropogenic contributions to global climate change exist, and the International Panel on Climate  
11 Change (IPCC), as well as many other reports, make a compelling case for linkage between these  
12 events. The report concluded the potential exists for devastating events with serious health  
13 implications, including extreme heat and cold events, flooding and droughts, increases in vectors  
14 carrying infectious diseases, and greater air pollution. Furthermore, the report noted the health  
15 effects from these events should be of concern to the medical community and require action. The  
16 report called on the health care community to advocate for public health policies that recognize and  
17 mitigate climate risk and strengthen health services, as well as improve communication and  
18 coordination at regional and international levels.  
19

20 While the American Medical Association (AMA) House of Delegates (HOD) has adopted  
21 numerous policies on climate changes since 2008, the Council initiated this report with  
22 acknowledgement that an update on this topic is long overdue. There is growing recognition of the  
23 impacts of climate change on health, with record-breaking heat waves, wildfires, droughts, and  
24 devastating floods impacting our patients and our communities and a limited window to act. We  
25 acknowledge that additional reports on the topics of climate mitigation and adaptation will be  
26 necessary but have decided to focus this report on the health effects of climate change and  
27 decarbonization. We also want to recognize that the AMA Board of Trustees (BOT) is working on  
28 a strategic plan on climate change, which will be presented to the HOD at the 2023 Annual  
29 Meeting. The BOT will also consider Resolution 605-A-22, which called for the AMA to establish  
30 a climate crisis campaign, determine high-yield advocacy and leadership opportunities, and  
31 centralize our AMA’s efforts towards environmental justice and an equitable transition to a net-  
32 zero carbon neutral society. We hope that this report informs the strategy being developed by the  
33 BOT.  
34

## 35 EXISTING AMA POLICY

36  
37 In June 2022, the AMA declared climate change a public health crisis that threatens the health and  
38 well-being of all individuals and called on the AMA to protect patients by advocating for policies

1 that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas  
2 emissions aimed at carbon neutrality by 2050, and (c) support rapid implementation and  
3 incentivization of clean energy solutions and significant investments in climate resilience through a  
4 climate justice lens. The policy also called on the AMA to develop a strategic plan for how we will  
5 enact our climate change policies including advocacy priorities and strategies to decarbonize  
6 physician practices and the health sector with report back to the House of Delegates at the 2023  
7 Annual Meeting. (D-135.966, “Declaring Climate Change a Public Health Crisis”)

8  
9 AMA policy supports scientific findings that the Earth is undergoing adverse climate change which  
10 will create conditions that affect public health and will have a disproportionate impact on  
11 vulnerable populations, including children, the elderly, and the poor (H-135.938, “Global Climate  
12 Change and Human Health”). Accordingly, our AMA supports increased climate change education  
13 so physicians may understand the health risks that climate change poses and counsel patients on  
14 how to protect themselves from those health risks (H-135.919, “Climate Change Education Across  
15 the Medical Education Continuum”). It is the policy of the AMA to encourage physicians to  
16 implement programs in their practices that promote environmental sustainability and communicate  
17 these practices to their patients and their community (H-135.923, “AMA Advocacy for  
18 Environmental Sustainability and Climate”). Additionally, the AMA will urge physicians to  
19 become spokespersons for environmental stewardship (H-135.969, “Environmental Health  
20 Programs”).

21  
22 With respect to air pollution and GHG reduction, the AMA urges the enactment of comprehensive  
23 legislation to address adverse health effects that are the product of air pollution (H-135.984,  
24 “Federal Clean Air Legislation”). The AMA encourages the US EPA to use its authority to regulate  
25 GHG emissions and limit carbon dioxide emissions. The AMA believes the coordinated efforts of  
26 the government along with industry and the public is the best way to minimize air pollution  
27 (H-135.999, “Federal Programs”).

## 28 29 METHODS

30  
31 Sentinel reports on climate, global climate change, and human health were reviewed including the  
32 Intergovernmental Panel on Climate Change (IPCC) assessment reports, *Lancet* Countdown on  
33 Health and Climate Change reports, reports from the World Health Organization (WHO), the  
34 Environmental Protection Agency (EPA), and the National Oceanic and Atmospheric  
35 Administration (NOAA).

36  
37 English language articles were selected from searches of the PubMed, Google Scholar, and  
38 Cochrane Library databases from January 2012 to June 2022 using the search terms: “climate  
39 change and health,” “climate crisis and health,” “decarbonization and health,” and “climate change  
40 and equity.” Additional articles were also identified by manual review of the reference lists of  
41 pertinent publications. Websites managed by federal agencies, applicable professional  
42 organizations, and foundations were reviewed for relevant information.

## 43 44 DEFINITIONS

45  
46 Adaptation is “taking action to prepare for and adjust to both the current and projected impacts of  
47 climate change.”<sup>1</sup>

48  
49 Climate change is “a long-term change in the average weather patterns that have come to define  
50 Earth’s local, regional and global climates.”<sup>2</sup>

1 Decarbonization means “switching from the use of fossil fuels such as coal, natural gas or oil to  
2 carbon-free and renewable energy sources.”

3  
4 Global warming is “the long-term heating of Earth’s surface observed since the pre-industrial  
5 period (between 1850 and 1900) due to human activities, primarily fossil fuel burning, which  
6 increases heat-trapping greenhouse gas levels in Earth’s atmosphere. This term is not  
7 interchangeable with the term “climate change.”<sup>3</sup>

8  
9 Greenhouse gases (GHGs) are gases that trap heat in the atmosphere.<sup>4</sup> GHGs emitted in the US  
10 include carbon dioxide (79 percent), methane (11 percent), nitrous oxide (7 percent), and  
11 fluorinated gases (3 percent).<sup>5</sup>

## 12 THE INTERGOVERNMENTAL PANEL ON CLIMATE CHANGE (IPCC)

13  
14  
15 The IPCC is the United Nations body for assessing the science related to climate change. Limiting  
16 global warming to no more than 2 degrees Celsius above pre-industrial levels was the *de facto*  
17 target for global policymakers at the UN’s 2010 climate conference in Cancun, Mexico. In 2015,  
18 scientists warned that the 2 degrees Celsius limit was not adequate for avoiding some of the more  
19 severe impacts of climate change and reducing the limit to 1.5 degrees Celsius would be  
20 preferable.<sup>6</sup>

### 21 *The Paris Agreement*

22  
23  
24 The Paris Agreement is a legally binding international treaty on climate change. It was adopted by  
25 196 Parties at the UN Climate Change Conference of the Parties (COP) 21, on December 12, 2015,  
26 and entered into force on November 4, 2016.<sup>7</sup> Its goal is to limit global warming to well below 2,  
27 preferably to 1.5 degrees Celsius, compared to pre-industrial levels. To achieve this goal, countries  
28 aim to reach global peaking of greenhouse gas emissions as soon as possible to achieve a climate  
29 neutral world by mid-century. The Paris Agreement is important because for the first time, a  
30 binding agreement brings all nations into a common cause to undertake ambitious efforts to combat  
31 climate change and adapt to its effects.

### 32 *Special Report on Global Warming of 1.5°C*

33  
34  
35 In 2018, the IPCC issued a special report on the impacts of global warming of 1.5 degrees Celsius  
36 above pre-industrial levels and related GHG emission pathways contained in the Paris Agreement.<sup>8</sup>  
37 The report concluded the global climate has changed relative to the pre-industrial period, and there  
38 is evidence that these changes have had impacts on organisms and ecosystems, as well as on human  
39 systems and well-being.<sup>9</sup> Human activities are estimated to have caused approximately 1.0 degree  
40 Celsius of global warming above pre-industrial levels, with a likely range of 0.8 to 1.2 degrees  
41 Celsius.<sup>10</sup> Risks to natural and human systems are expected to be lower at 1.5 degrees Celsius than  
42 at 2 degrees Celsius of global warming. This is true for heat-related morbidity and mortality and for  
43 ozone-related mortality if emissions needed for ozone formation remain high. Global warming is  
44 likely to reach 1.5 degree Celsius between 2030 and 2052 if it continues to increase at the current  
45 rate.<sup>11</sup> The report finds that limiting global warming to 1.5 degrees Celsius would require “rapid  
46 and far-reaching” transitions in land, energy, industry, buildings, transport, and cities.<sup>12</sup> Global net  
47 human-caused emissions of carbon dioxide would need to fall by about 45 percent from 2010  
48 levels by 2030, reaching ‘net zero’ around 2050. The report also recognized that many of the  
49 impacts of warming will fall disproportionately on the poor and vulnerable.

1 *The Sixth Assessment Cycle*

2  
3 To date the IPCC has released three reports during this cycle. The Synthesis Report for this cycle is  
4 scheduled to be released in late 2022 or early 2023. Below are the high-level findings from the  
5 Sixth Assessment reports.

6  
7 The Physical Science Basis<sup>13</sup> (2021). It is unequivocal that human influence has warmed the  
8 atmosphere, ocean and land. The scale of recent changes across the climate system as a whole are  
9 unprecedented over many centuries to many thousands of years. Human-induced climate change is  
10 already affecting many weather and climate extremes in every region across the globe. Evidence of  
11 observed changes in extremes such as heatwaves, heavy precipitation, droughts, and tropical  
12 cyclones, and their attribution to human influence, has strengthened. Global warming of 1.5 and 2  
13 degrees Celsius will be exceeded during the 21st century unless deep reductions in GHG emissions  
14 occur in the coming decades.

15  
16 Mitigation of Climate Change<sup>14</sup> (2022). Total net anthropogenic GHG emissions have continued to  
17 rise during the period 2010–2019, and average annual GHG emissions during 2010–2019 were  
18 higher than in any previous decade, but the rate of growth between 2010 and 2019 was lower than  
19 that between 2000 and 2009. Net anthropogenic GHG emissions have increased since 2010 across  
20 all major sectors globally. An increasing share of emissions can be attributed to urban areas. The  
21 unit costs of several low-emission technologies (solar energy, wind energy, and lithium-ion  
22 batteries) have decreased, but innovation has lagged in developing countries due to weaker  
23 enabling conditions.

24  
25 Global GHG emissions are projected to peak between 2020 and 2025 in global modelled pathways  
26 that limit warming to 1.5 degrees Celsius with no or limited overshoot and in those that limit  
27 warming to 2 degrees Celsius. Global net zero CO<sub>2</sub> emissions are reached in the early 2050s in  
28 modelled pathways that limit warming to 1.5°C (>50%) with no or limited overshoot, and around  
29 the early 2070s in modelled pathways that limit warming to 2°C (>67%). Reaching and sustaining  
30 global net zero GHG emissions results in a gradual decline in warming. Reducing GHG emissions  
31 across the full energy sector requires major transitions, including a substantial reduction in overall  
32 fossil fuel use, the deployment of low-emission energy sources, switching to alternative energy  
33 carriers, and energy efficiency and conservation. The deployment of carbon dioxide removal  
34 (CDR) to counterbalance hard-to-abate residual emissions is unavoidable if net zero CO<sub>2</sub> or GHG  
35 emissions are to be achieved.

36  
37 Impacts, Adaptation, and Vulnerability<sup>15</sup> (2022). Climate change is affecting nature, people's lives  
38 and infrastructure and its dangerous and pervasive impacts are increasingly evident in every region  
39 of the world. These impacts are hindering efforts to meet basic human needs and they threaten  
40 sustainable development. This report found that the extent and magnitude of climate change  
41 impacts are larger than estimated in previous assessments. They are causing severe and widespread  
42 disruption in nature and in society; reducing our ability to grow nutritious food or provide enough  
43 clean drinking water, thus affecting people's health and well-being and damaging livelihoods.

44  
45 Many species are reaching limits in their ability to adapt to climate change, and those that cannot  
46 adjust or move fast enough are at risk of extinction. We see a lengthening wildfire season and  
47 increases in the area burned. Roughly half of the world's population experiences severe water  
48 shortages at some point during the year, in part due to climate change and extreme events such as  
49 flooding and droughts. Drought conditions have become more frequent in many regions, negatively  
50 affecting agriculture and energy production from hydroelectric power plants. Globally, climate  
51 change is increasingly causing injuries, illness, malnutrition, threats to physical and mental health

1 and well-being, and even deaths. Climate change impacts are expected to intensify with additional  
2 warming.

3  
4 Climate change risks and impacts can be reduced, within limits, if humans and nature adapt to the  
5 changing conditions. The scale and scope of actions to reduce climate risks have increased  
6 worldwide. However, there are large gaps between ongoing efforts and adaptation needed to cope  
7 with current levels of warming. Poverty and inequality present significant adaptation limits,  
8 resulting in unavoidable impacts for vulnerable groups, including women, young people, the  
9 elderly, ethnic and religious minorities, indigenous people, and refugees.

## 10 11 HEALTH EFFECTS OF CLIMATE CHANGE

12  
13 Impacts from climate change on extreme weather, air quality, and the transmission of disease  
14 increasingly threaten the health and well-being of people in the U.S., particularly populations that  
15 at increased risk.<sup>16</sup> The health effects of climate change include increased allergies, asthma,  
16 respiratory and cardiovascular disease; injuries and premature deaths related to extreme weather  
17 events; heat-related deaths due to continued warming; changes in the prevalence and geographical  
18 distribution of food- and water-borne illnesses and other infectious diseases, and threats to mental  
19 health.<sup>1</sup> (See Figure 1.) While not discussed in detail in this report, it is important to recognize that  
20 climate change can cause or exacerbate resource scarcity, which may result in conflict or migration  
21 of populations.<sup>17</sup> Individuals most at risk are typically the least able to relocate.<sup>18</sup> The health effects  
22 of climate change are outlined in the Council's 2008 report, but as the IPCC reports indicate, the  
23 frequency and intensity of extreme weather events will likely increase.

24  
25 Allergies and Respiratory Health. The combustion of fossil fuels is a major source of air pollution  
26 and cause of climate change. Fossil fuels release airborne fine particulate matter and ground-level  
27 ozone. Poor air quality contributes to a range of non-communicable diseases, including  
28 cardiovascular and respiratory disease.<sup>19</sup> It is estimated that more than 8 million people died in  
29 2018 from fossil fuel pollution, significantly higher than previous estimates—meaning that air  
30 pollution from burning fossil fuels was responsible for about 1 in 5 deaths worldwide.<sup>20</sup>  
31 Furthermore, hotter temperatures and lack of rainfall increase the risk of drought and wildfires,  
32 both of which create particle pollution.<sup>21</sup> As temperatures rise, plants produce more pollen,  
33 increasing ragweed and other allergens. Warmer temperatures allow allergens to thrive in new  
34 regions and for allergy seasons to last longer.<sup>22,23</sup>

35  
36 Cardiovascular Disease. Air pollution can exacerbate cardiovascular disease and contribute to the  
37 development of the disease. The evidence is particularly strong for outdoor particle pollution  
38 exposure. Exposure to PM <2.5 µm in diameter (PM<sub>2.5</sub>) over a few hours to weeks can trigger  
39 cardiovascular disease–related mortality and nonfatal events; longer-term exposure (increases the  
40 risk for cardiovascular mortality to an even greater extent and reduces life expectancy within more  
41 highly exposed segments of the population by several months to a few years; reductions in PM  
42 levels are associated with decreases in cardiovascular mortality within a time frame as short as a  
43 few years.<sup>24</sup> Short -and long-term exposure to increased concentrations of PM<sub>2.5</sub> has been shown to  
44 increase hospitalizations for serious cardiovascular events such as coronary syndrome, arrhythmia,  
45 heart failure, stroke, and sudden cardiac death, particularly in people with established heart  
46 disease.<sup>25</sup> Numerous studies have shown that exposure to higher concentrations of PM<sub>2.5</sub> and some  
47 gaseous air pollutants (nitrogen oxides, sulfur dioxide, and ozone) can also result in arterial  
48 hypertension and increased blood pressure.<sup>26</sup> Extreme heat also impacts heart health. A recent  
49 study showed 600-700 additional deaths from cardiovascular disease annually over a decade-long  
50 period in the U.S.<sup>27</sup> The spike in deaths during heat waves was most pronounced in men and non-  
51 Hispanic Black adults.<sup>28</sup>

1 Agriculture and Food Security. The agriculture sector is responsible for 11 percent of U.S. GHG  
2 emissions, which come from livestock, agricultural soils, and rice production.<sup>29</sup> GHG emissions  
3 from agriculture have increased by 6 percent since 1990, largely driven by a 62 percent growth in  
4 combined CH<sub>4</sub> and N<sub>2</sub>O emissions from livestock manure management systems.<sup>30</sup> Research  
5 indicates that shifts towards sustainable diets could lead to co-benefits, such as minimizing GHG  
6 emissions and land use, reducing the environmental footprint, aiding in climate change mitigation,  
7 and improving population health.<sup>31</sup> This is possible by reducing reliance on red meat consumption  
8 and prioritizing plant-based foods and other healthier alternatives, which can reduce chronic  
9 disease risk. Climate change is also expected to threaten food production, food prices, and  
10 distribution systems. Crop yields are predicted to decline due to changes in rainfall, severe weather  
11 events, and increasing competition from weeds and pests.<sup>32</sup> Prices are expected to rise in response  
12 to declining food production leading to food insecurity and a reliance on foods of poor nutrient  
13 quality.

14  
15 Vector-borne diseases. Climatic hazards have enhanced specific aspects of pathogens, including  
16 improved climate suitability for reproduction, acceleration of the life cycle, increasing  
17 seasons/length of likely exposure, enhancing pathogen-vector interactions (for example, by  
18 shortening incubations) and increasing virulence. Between 2004 and 2018, the number of reported  
19 illnesses from mosquito, tick, and flea bites more than doubled, with more than 760,000 cases  
20 reported in the United States.<sup>33,36</sup> Nine new germs spread by mosquitoes and ticks were discovered  
21 or introduced into the United States during this period.<sup>34</sup> Warming had positive effects on mosquito  
22 population development, survival, biting rates and viral replication, increasing the transmission  
23 efficiency of West Nile virus.<sup>35</sup> Global mobility, urbanization and climate change is also major  
24 driver of the increase in the number of dengue virus infections, which have doubled every decade  
25 since 1990.<sup>36,37</sup> Further, the geographic ranges where ticks spread Lyme disease, anaplasmosis,  
26 ehrlichiosis, and spotted fever rickettsiosis have expanded, and experts predict that tickborne  
27 diseases will continue to increase and perhaps worsen.<sup>38</sup>

28  
29 Fungi. Rising temperatures have allowed certain disease-causing fungi to spread into new areas  
30 that previously were too cold for them to survive. For example, Valley fever, caused by a fungus  
31 that lives in the soil in hot and dry areas, has already spread into the Pacific Northwest.<sup>39</sup>

32  
33 Water-borne diseases. Ocean warming has accelerated the growth of harmful algal blooms and  
34 diseases caused by *Pseudo-nitzschia sp.*, blue green cyano-bacteria, and dinoflagellates.<sup>40</sup> Ocean  
35 warming and heavy precipitation, which reduces coastal water salinity, is predicted to also provide  
36 fertile conditions for *Vibrio vulnificus* and *Vibrio cholerae*, this being a leading explanation for  
37 Vibriosis outbreaks in areas where this disease is rare.<sup>41,42</sup> Further, floods and storms are associated  
38 with wastewater overflow, leading to the direct and foodborne transmission of noroviruses,  
39 hantavirus, hepatitis and *Cryptosporidium*.<sup>43,44,45</sup>

40  
41 Zoonotic diseases. Patterns of contact between human and wildlife reservoirs have increased as  
42 human populations move into previously unoccupied regions. Changing environmental conditions  
43 can also alter species range and density, leading to novel interactions between species, and increase  
44 the risk of zoonotic emergence.<sup>46</sup> Further, habitat disruptions caused by warming, drought,  
45 heatwaves, wildfires, storms, floods and land cover change were also associated with bringing  
46 pathogens closer to people. Spillovers from viruses (Nipah virus and Ebola), for instance, were  
47 associated with wildlife (bats, rodents, and primates) moving over larger areas foraging for limited  
48 food resources caused by drought or finding new habitats following wildfires.<sup>47</sup>

1 Mental Health. The connections between climate change and mental health have been mostly  
 2 discussed in relation to emergency preparedness and disaster response, particularly in the context  
 3 of extreme weather events. The mental health effects of disasters may include trauma and shock,  
 4 post-traumatic stress disorder (PTSD), feelings of abandonment, and anxiety and depression that  
 5 can lead to suicidal ideation and risky behavior.<sup>48</sup> Rising temperatures can lead to mood and  
 6 anxiety disorders, schizophrenia and vascular dementia, and can increase emergency department  
 7 usage and suicide rates.<sup>49</sup> Concern about climate change coupled with worry about the future can  
 8 lead to fear, anger, feelings of powerlessness, exhaustion, stress and sadness, which is being  
 9 referred to as “eco-anxiety” or “climate anxiety.” Climate anxiety and dissatisfaction with  
 10 government responses are widespread in children and young people and can impact their daily  
 11 functioning.<sup>50</sup> Distress about climate change in young people is associated with perceiving that they  
 12 have no future, that humanity is doomed, and that governments are failing to respond adequately,  
 13 and with feelings of betrayal and abandonment by governments and adults.<sup>51</sup>

## 14 15 DECARBONIZATION

16  
17 In 2021, President Biden announced the U.S. target was to achieve a 50-52 percent reduction from  
 18 2005 levels in economy-wide net GHG pollution by 2030.<sup>52</sup> Since 1990, gross U.S. GHG  
 19 emissions have decreased by 7 percent.<sup>53</sup> In 2020, U.S. GHG emissions decreased 11 percent  
 20 compared to 2019 levels primarily from CO<sub>2</sub> emissions from fossil fuel combustion largely due to  
 21 the COVID-19 pandemic and reductions in travel and economic activity.<sup>54</sup> However, it is estimated  
 22 that in 2021 U.S. GHG emissions increased by 6 percent above 2020 levels, returning to pre-  
 23 pandemic levels.<sup>55</sup>

24  
25 In efforts to reach the U.S. commitments under the Paris Agreement, the administration signed  
 26 Executive Order (EO) 14057, “Catalyzing Clean Energy Industries and Jobs Through Federal  
 27 Sustainability”, a multi-faceted approach to addressing climate change.<sup>56</sup> EO 14057’s stated goals  
 28 include:

- 29 • 100 percent carbon emission free electricity by 2030,
- 30 • 100 percent of government acquired vehicles to be zero emission vehicles by 2035,
- 31 • a net-zero emission federal building portfolio by 2032,
- 32 • a 65 percent reduction in overall greenhouse gas emissions by 2030

33  
34 Other goals without explicit time frames include net-zero emissions of federal procurements,  
 35 climate resilient infrastructure and a climate focused federal workforce.

### 36 37 *The Lancet Countdown on Health and Climate Change*

38  
39 Published annually, the *Lancet Countdown* is an international, multidisciplinary collaboration,  
 40 dedicated to monitoring the health profile of climate change, and independently assessing the  
 41 delivery of commitments made by governments under the Paris Agreement. In 2021, the report  
 42 indicated that the current global decarbonization commitments are “insufficient to meet Paris  
 43 Agreement ambitions and would lead to a roughly 2.4 degrees Celsius average global temperature  
 44 increase by the end of the century.”<sup>57</sup> To meet the Paris Agreement goals and prevent catastrophic  
 45 levels of global warming, global GHG emissions must reduce by half within a decade. Emissions  
 46 are declining too slowly or heading in the wrong direction in the highest emitting sectors. This  
 47 delay in progress is contributing to millions of deaths each year. At the current pace of reduction, it  
 48 would take more than 150 years for the energy system to fully decarbonize, and the unequal  
 49 response between countries is resulting in an uneven realization of the health benefits of a low-  
 50 carbon transition.<sup>58</sup> The use of public funds to subsidize fossil fuels is partly responsible for the

1 slow decarbonization rate, with 65 out of 84 countries reviewed still providing an overall subsidy  
2 to fossil fuels in 2018.<sup>59</sup> Despite years of scientific reporting on the impacts of climate change,  
3 efforts to build resilience have been slow and unequal, with countries with low levels of human  
4 development index being the least prepared to respond to the changing health profile of climate  
5 change and funding remaining a consistent challenge. Even with overwhelming evidence on the  
6 health impacts of climate change, countries are not delivering an adaptation response proportionate  
7 to the rising risks their populations face.<sup>60</sup>

### 8 9 *Role of the Health Sector*

10  
11 The U.S. health care sector is responsible for an estimated 8.5 percent of national carbon emissions.  
12 These emissions stem from the operations of health care facilities (scope 1), from both purchased  
13 sources of energy, heating, and cooling (scope 2) and from the supply chain of health care goods  
14 and services (scope 3). The U.S. health sector accounts for 25 percent of global health sector  
15 emissions—the highest proportion attributable to any individual country’s health sector.<sup>61</sup> In 2021,  
16 as part of the United Nations Climate Change Conference (COP26), 60 countries, including the  
17 United States, committed to creating climate-resilient, low-carbon, sustainable health systems, with  
18 20 countries committing to net-zero health care system emissions by 2050. However, while more  
19 than 90 percent of Standard & Poor’s 500 Companies annually publish sustainability reports, as do  
20 many private and nongovernmental entities, the same cannot be said of U.S. health care  
21 organizations, despite their commitment to improving health.<sup>62</sup>

### 22 23 *HHS Health Sector Climate Pledge*

24  
25 In 2022, the US Department of Health & Human Services announced a pledge initiative, calling  
26 upon the private health care sector to publicly commit to reducing and reversing their carbon  
27 footprint.<sup>63</sup> The voluntary pledge calls upon signees to reduce emissions by 50 percent by 2030,  
28 become net-zero emitters by 2050, complete an inventory of supply chain emissions and to develop  
29 climate resilience plans for their facilities and communities. The pledge has been signed by more  
30 than 60 major hospital groups, pharmaceutical companies, insurers, and medical associations.<sup>64</sup>

### 31 32 *National Academy of Medicine: Action Collaborative on Decarbonizing the U.S. Health Sector*

33  
34 NAM has launched an Action Collaborative on Decarbonizing the U.S. Health Sector. This public–  
35 private partnership includes leadership from the federal government, the biomedical and  
36 pharmaceutical industries, hospital systems, private payers, and health professions, including the  
37 AMA, with the aim to develop and implement a shared action plan for decarbonizing the health  
38 sector and strengthening its sustainability and resiliency.<sup>65</sup>

39  
40 The collaborative is focusing its decarbonization efforts in four areas: (1) working with industry to  
41 reduce scope 3 emissions, as well as facilitate coordination with the federal government to  
42 accelerate and better enable low-carbon innovations; (2) accelerating climate-sensitive health care  
43 delivery and practice, including reducing scope 1 and scope 2 emissions and identifying  
44 opportunities for linking performance on sustainability metrics to value-based payment and  
45 reimbursement; (3) expanding health professionals’ curricula and programming on climate change;  
46 and (4) developing sustainability metrics and indicators for industry and health systems, along with  
47 shared plans for public reporting.<sup>66</sup>

### 48 49 *Resources on Health System Decarbonization*

50

1 Health Care Without Harm has released a Road Map that provides a plan to get health care toward  
 2 zero emissions. By implementing this set of seven high-impact actions, health care can put itself  
 3 firmly on the road to zero emissions, while helping provide leadership for the rest of the world to  
 4 travel in the same direction.<sup>67</sup> The Road Map identifies seven high-impact actions as key to health  
 5 care decarbonization:

- 6
- 7 1. Power health care with 100 percent clean, renewable electricity.
- 8 2. Invest in zero emissions buildings and infrastructure.
- 9 3. Transition to zero emissions, sustainable travel, and transport.
- 10 4. Provide healthy, sustainably grown food and support climate resilient agriculture.
- 11 5. Incentivize and produce low-carbon pharmaceuticals.
- 12 6. Implement circular health care and sustainable health care waste management.
- 13 7. Establish greater health system effectiveness.
- 14

15 The UK's National Health Service (NHS) is the world's first health care system to commit to  
 16 achieve net-zero carbon emissions. Its Greener NHS plan contains critical lessons for the U.S.  
 17 health system.<sup>68</sup> The NHS has taken action in the following areas:

- 18
- 19 • Developing a framework to evaluate the carbon reduction associated with new models of
- 20 care under consideration.
- 21 • Working with suppliers to ensure they meet or exceed the NHS commitment on net-zero
- 22 emissions before the end of the decade, with new procurement from April 2022 onward
- 23 required to consider net zero as part of the purchasing process.
- 24 • Shifting to using zero-emission vehicles, including production of the world's first zero-
- 25 emission ambulance.
- 26 • Ensuring that digital transformation of health care aligns with the goal of becoming a net-
- 27 zero health service, investing in innovations to support that goal, and setting up a scanning
- 28 mechanism to identify future pipeline innovations.
- 29 • Supporting the construction of 40 new net-zero hospitals as part of the government's health
- 30 infrastructure plan, which includes a new net-zero carbon hospital standard.
- 31 • Completing a \$60 million LED lighting replacement program that will improve patient
- 32 comfort and save money.
- 33 • Making health care systems more resilient to enable them to withstand or adapt to the
- 34 demands of future climate events, such as floods and extreme temperatures.
- 35 • Appointing a new chief sustainability officer to lead the national program and report
- 36 regularly to the national board; ensuring that every NHS organization has a board-level
- 37 net-zero lead and a green plan; and supporting an update to the NHS constitution to include
- 38 the response to climate change as a core principle.
- 39

40 To support healthcare organizations in advancing toward their decarbonization commitments, the  
 41 Agency for Healthcare Research and Quality (AHRQ) contracted with the Institute for Healthcare  
 42 Improvement to develop a primer that offers guidance on high-priority measures and strategies for  
 43 health care organizations to reduce their carbon footprint.<sup>69</sup> The recommendations are intended to  
 44 inform organizations beginning their journey in measuring and reducing GHG emissions. The  
 45 primer describes six domains contributing to GHG emissions in health care: building energy,  
 46 transportation, anesthetic gas, pharmaceuticals and chemicals, medical devices and supplies, and  
 47 food. To meaningfully track and reduce GHG emissions, the primer recommends health care  
 48 organizations should use the Greenhouse Gas Protocol (GHGP) framework, a globally recognized  
 49 standard for quantifying and reporting on emissions.

1 *U.S. Securities and Exchange Commission (SEC) and Decarbonization*

2  
3 The SEC is expected to finalize a rule requiring publicly traded companies to disclose climate-  
4 related risks.<sup>70</sup> The proposed rules also would require a registrant to disclose information about its  
5 direct GHG emissions (Scope 1) and indirect emissions from purchased electricity or other forms  
6 of energy (Scope 2). In addition, a registrant would be required to disclose GHG emissions from  
7 upstream and downstream activities in its value chain (Scope 3), if material or if the registrant has  
8 set a GHG emissions target or goal that includes Scope 3 emissions. These proposals for GHG  
9 emissions disclosures would provide investors with decision-useful information to assess a  
10 registrant's exposure to, and management of, climate-related risks, and in particular transition risks.  
11

12 EPA AUTHORITY

13  
14 The Clean Air Act is the law that defines the EPA's authority and responsibility to regulate air  
15 pollutants. In 2015, the Obama Administration's Clean Power Plan (CPP) established guidelines  
16 for to cut power-plant emissions and instructed the states to submit their plans by 2018 and then  
17 gave them until 2030 to meet their goals. The CPP relied on section 7411 of the Clean Air Act to  
18 enforce guidelines on power plants. In 2019, the Trump Administration issued its Affordable Clean  
19 Energy (ACE) Rule which eliminated the guidelines set by the Clean Power Plan. However, the  
20 ACE rule was vacated by the U.S. Court of Appeals. As a result, petitioners challenged the EPA's  
21 authority to broadly regulate GHG emissions. In a recent Supreme Court decision, *West Virginia v.*  
22 *EPA*, the Court held Congress did not grant the EPA, under the Clean Air Act, the authority to  
23 devise emissions caps based on the generation shifting approach the agency took in the Clean  
24 Power Plan (CPP). This decision limited the EPA's ability to reduce pollution from power plants.  
25

26 FEDERAL LEGISLATION

27  
28 In August 2022, Congress passed H.R. 5376, also known as the Inflation Reduction Act of 2022  
29 (IRA). The IRA authorized spending of \$369 billion over the next ten years, with much targeted  
30 towards environmental policies. According to the Department of Energy, these policies are  
31 anticipated to cut domestic greenhouse gas emissions by up to 40 percent by 2030.<sup>71</sup> Several of the  
32 programs contained in the IRA are targeted at reducing or reimbursing the upfront investments  
33 required to convert to more environmentally friendly technology. For example, the IRA contains  
34 tax credits or reimbursements for electric vehicle purchases, households that install rooftop solar  
35 panels or heat pumps, and a new Advanced Industrial Facilities Deployment Program to provide  
36 financial assistance for facilities looking to modernize. Other key elements are investments in the  
37 domestic manufacturing workforce to promote green technology production within the United  
38 States.  
39

40 In addition to monetary investments, the IRA also contains important policy changes, particularly  
41 around the powers conferred to the EPA. While the IRA does not abrogate the holdings of *West*  
42 *Virginia v. EPA*, it does provide direct funding to the EPA for seven programs to reduce GHG, and  
43 it explicitly defines GHG as carbon dioxide, hydrofluorocarbons, methane, nitrous oxide,  
44 perfluorocarbons, and sulfur hexafluoride.<sup>72</sup> These changes are expected to strengthen the agency's  
45 ability to mount a legal defense against challenges similar to those levied in *West Virginia v. EPA*.  
46

47 The bill also includes tax credits for carbon capture and sequestration, which could extend the life  
48 of coal plants and make it harder to reach critical targets for clean power. The bill requires the  
49 federal government to offer parts of the Gulf of Mexico and Alaska's Cook Inlet for oil and gas  
50 development. It also requires additional oil and gas leasing for new wind and solar projects to be  
51 approved. As a part of the compromise, negotiators are expected to put forth a separate bill on oil

1 and gas “permitting reform” that could weaken environmental protections under the National  
2 Environmental Policy Act.

3  
4 STATE AND LOCAL ACTIONS

5  
6 At the state level, many of the most impactful state policies are enacted by coalitions of multiple  
7 states. For example, California has been allowed to institute stricter tailpipe emission standards  
8 since obtaining a Clean Air Act waiver in 1970, and other states are allowed to adopt California’s  
9 standards. As of 2019, 17 states and the District of Columbia, representing approximately 40  
10 percent of light duty vehicle sales in the United States, utilize California’s low-emission vehicle  
11 emission regulations.<sup>73</sup> As such, this informal coalition of states places significant market pressure  
12 on car manufacturers to simply have *all* new vehicles meet California emission standards rather  
13 than dealing with the logistical complexity of having two markets with two different sets of  
14 regulations in the United States.<sup>74</sup>

15  
16 Similarly, when the United States initially withdrew from the Paris Agreement, 24 states and 2  
17 territories representing approximately 50 percent of the United States population formed the United  
18 States Climate Alliance pledging to meet the US’s Paris Agreement goals under the Clean Power  
19 Plan. Other important state coalitions include the Regional Greenhouse Gas Initiative, the Western  
20 Climate Initiative, Inc., and the Midwestern Greenhouse Gas Reduction Accord which serve as  
21 major “cap-and-trade” markets for their respective regions.

22  
23 Other notable state-level actions in recent years include California’s Plastic Pollution Prevention  
24 and Packaging Producer Responsibility Act (requiring all packaging in the state to be recyclable or  
25 compostable by 2032), Illinois’ Climate and Equitable Jobs Act (requiring 100% renewable energy  
26 by 2050), and Wisconsin’s Office of Sustainability and Clean Energy (100% carbon-free electricity  
27 by 2050).

28  
29 As of writing, 35 of the 50 largest cities in the United States have published local climate action  
30 plans.<sup>75</sup> Similar to states, local governments and cities often tackle climate change through  
31 coalitions such as Climate Mayors, a collection of 470 mayors representing approximately 74  
32 million Americans committed to building political will for climate change policy. Many municipal  
33 climate plans echo those seen at the federal and state levels aiming to reduce greenhouse gas  
34 emissions, but they also provide insight into the unique issues facing different geographies. For  
35 example, the city of Miami has invested \$400 million into the Miami Forever bond to fund projects  
36 addressing sea-level rise and flood prevention,<sup>76</sup> and the city of Ann Arbor implemented the 10,000  
37 Trees Initiative to give away free trees and rebuild the city’s canopy.<sup>77</sup>

38  
39 AMA ACTIONS

40  
41 *Medical Society Consortium on Climate and Health (MSCCH)*

42  
43 The AMA is a member of the MSCCH. The Consortium works to facilitate the medical  
44 community’s awareness-raising efforts, by bringing together associations representing over  
45 600,000 clinical practitioners to carry three simple messages:

- 46 • Climate change is harming Americans today and these harms will increase unless we act;
- 47 • The way to slow or stop these harms is to decrease the use of fossil fuels and increase  
48 energy efficiency and use of clean energy sources; and
- 49 • These changes in energy choices will improve the quality of our air and water and bring  
50 immediate health benefits.

1 In 2019, the AMA signed on to the “Climate, Health, and Equity: A Policy Action Agenda,” which  
2 recognizes climate change is a public health emergency and outlines ten policy recommendations  
3 to provide a roadmap to develop coordinated strategies for simultaneously tackling climate change,  
4 health, and equity.<sup>3</sup> The agenda calls out 10 specific policy priorities, including the following:  
5

- 6 1. Meeting and strengthening greenhouse gas emission reduction commitments and  
7 supporting the Paris Agreement.
- 8 2. Transitioning rapidly away from the use of coal, oil and natural gas to clean, safe, and  
9 renewable energy and energy efficiency.
- 10 3. Emphasizing active transportation in the transition to zero-carbon transportation  
11 systems.
- 12 4. Promoting healthy, sustainable and resilient farms and food systems, forests, and  
13 natural lands.
- 14 5. Ensuring that all U.S. residents have access to safe and affordable drinking water and a  
15 sustainable water supply.
- 16 6. Investing in policies that support a just transition for workers and communities  
17 adversely impacted by climate change and the transition to a low-carbon economy.
- 18 7. Engaging the health sector voice in the call for climate action.
- 19 8. Incorporating climate solutions into all health care and public health system.
- 20 9. Building resilient communities in the face of climate change.
- 21 10. Investing in climate in a way that benefits health, and health in a way that doesn’t harm  
22 the climate.

23  
24 In January of 2020, the AMA joined the MSCCH in calling on President Trump to stop our  
25 withdrawal from the Paris Climate Agreement. The letter recognizes that climate change is a public  
26 health emergency. Rejoining the Paris Climate Agreement is not just about preventing the worst of  
27 the devastating health harms climate change will bring. It is also about seizing this public health  
28 crisis and turning it into a major public health opportunity.  
29

#### 30 *NAM Action Collaborative on Decarbonizing the Health Sector*

31  
32 The AMA is also a member of the National Academy of Medicine Action Collaborative on  
33 Decarbonizing the Health Sector as a member of the Steering Committee and co-lead of the Health  
34 Care Delivery Workgroup, which is working toward the following four goals:  
35

- 36 • Goal 1: Make the multi-faceted case for health systems and hospitals to minimize their  
37 carbon footprints and operate more sustainably
- 38 • Goal 2: Identify a set of policy and regulatory barriers preventing progress on  
39 decarbonization and resilience from accelerating, and identify solutions
- 40 • Goal 3: Identify a core set of sustainability metrics for hospitals and clinical practice
- 41 • Goal 4: Develop decarbonization playbooks and best practices for hospitals and health care  
42 delivery institutions, leveraging existing frameworks and success stories

#### 43 44 *AMA Litigation Center*

45  
46 The AMA has long advocated for upholding the Clean Power Plan through amicus briefs and most  
47 recently filed such a brief with the American Thoracic Society and dozens of leading medical  
48 organizations and public health leaders in *West Virginia v. EPA*. The AMA brief stated the  
49 importance of the EPA's authority to regulate carbon dioxide emissions from power plants in order  
50 to mitigate the health effects of climate pollutants and help address climate change as a threat to  
51 public health.

1 CONCLUSION

2  
3 It is now unequivocal that human influence has warmed the atmosphere, ocean and land. The scale  
4 of recent changes across the climate system are unprecedented over many centuries to thousands of  
5 years. Human-induced climate change is affecting weather and climate extremes in every region  
6 across the globe. The extent and magnitude of climate change impacts are larger than previously  
7 estimated and they are causing severe and widespread disruption in nature and in society; reducing  
8 our ability to grow nutritious food or provide enough clean drinking water, thus affecting people's  
9 health and well-being and damaging livelihoods. Limiting global warming to 1.5 degrees Celsius  
10 would require "rapid and far-reaching" transitions in land, energy, industry, buildings, transport,  
11 and cities.<sup>78</sup>

12  
13 Impacts from climate change on extreme weather, air quality, and the transmission of disease  
14 increasingly threaten the health and well-being of people in the U.S., and it is widely recognized  
15 that many of the impacts of warming will disproportionately impact the most vulnerable. The  
16 health effects of climate change include increased allergies, asthma, respiratory and cardiovascular  
17 disease; injuries and premature deaths related to extreme weather events; heat-related deaths due to  
18 continued warming; changes in the prevalence and geographical distribution of food- and water-  
19 borne illnesses and other infectious diseases, and threats to mental health.

20  
21 To meet the Paris Agreement goals and prevent catastrophic levels of global warming, global GHG  
22 emissions must be reduced by half within a decade. Emissions are declining too slowly or heading  
23 in the wrong direction in the highest emitting sectors. This delay in progress is contributing to  
24 millions of deaths each year. The U.S. health care sector is responsible for an estimated 8.5 percent  
25 of national carbon emissions. These emissions stem from the operations of health care facilities  
26 (scope 1), from both purchased sources of energy, heating, and cooling (scope 2) and from the  
27 supply chain of health care goods and services (scope 3). The U.S. health sector accounts for 25  
28 percent of global health sector emissions, the highest proportion attributable to any individual  
29 country's health sector. Physicians pledge to do no harm; it is time for the health sector to do the  
30 same by addressing the climate crisis and protecting public health.

31  
32 RECOMMENDATIONS

33  
34 The Council on Science and Public Health recommends that the following be adopted and the  
35 remainder of the report be filed.

36  
37 1. That Policy D-135.966, "Declaring Climate Change a Public Health Crisis" be amended by  
38 addition to read as follows:

39  
40 1. Our AMA declares climate change a public health crisis that threatens the health and well-being  
41 of all individuals. 2. Our AMA will protect patients by advocating for policies that: (a) limit global  
42 warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at a  
43 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, and (c) support rapid  
44 implementation and incentivization of clean energy solutions and significant investments in climate  
45 resilience through a climate justice lens. 3. Our AMA consider signing on to the Department of  
46 Health and Human Services Health Care Pledge or making a similar commitment to lower its own  
47 greenhouse gas emissions. 4. Our AMA encourages the health sector to lead by example in  
48 committing to carbon neutrality by 2050. 5. Our AMA will develop a strategic plan for how we  
49 will enact our climate change policies including advocacy priorities and strategies to decarbonize

1 physician practices and the health sector with report back to the House of Delegates at the 2023  
2 Annual Meeting. (Modify Current HOD Policy)

3  
4 2. That Policy H-135.938, “Global Climate Change and Human Health” be amended by addition  
5 and deletion to read as follows:

6  
7 Our AMA: 1. Supports ~~the findings of the Intergovernmental Panel on Climate Change's fourth~~  
8 ~~assessment report and concurs with the~~ scientific consensus that the Earth is undergoing adverse  
9 global climate change and that anthropogenic contributions are significant. These climate changes  
10 ~~have adversely affected the physical and mental health of people. will create conditions that affect~~  
11 ~~public health, with~~ We recognize that minoritized and marginalized populations, children, the  
12 elderly, rural communities, and those who are economically disadvantaged will suffer  
13 disproportionate impacts harms from of climate change on vulnerable populations, including  
14 children, the elderly, and the poor.

15 2. Supports educating the medical community on the ~~potential~~ adverse public health effects of  
16 global climate change and incorporating the health implications of climate change into the  
17 spectrum of medical education, including topics such as population displacement, heat waves and  
18 drought, flooding, infectious and vector-borne diseases, and potable water supplies.

19 3. (a) Recognizes the importance of physician involvement in policymaking at the state, national,  
20 and global level and supports efforts to search for novel, comprehensive, and economically  
21 sensitive approaches to mitigating climate change to protect the health of the public; and (b)  
22 recognizes that whatever the etiology of global climate change, policymakers should work to  
23 reduce human contributions to such changes.

24 4. Encourages physicians to assist in educating patients and the public on the physical and mental  
25 health effects of climate change and on environmentally sustainable practices, and to serve as role  
26 models for promoting environmental sustainability.

27 5. Encourages physicians to work with ~~local and state~~ health departments to strengthen the public  
28 health infrastructure to ensure that the ~~global~~ health effects of climate change can be anticipated  
29 and responded to more efficiently, and that adaptation interventions are equitable and prioritize the  
30 needs of the populations most at risk, and that the AMA's Center for Public Health Preparedness  
31 and Disaster Response assist in this effort.

32 6. Supports epidemiological, translational, clinical and basic science research necessary for  
33 evidence-based global climate change policy decisions related to health care and treatment.

34 7. Encourages physicians to assess for environmental determinants of health in patient history-  
35 taking and encourages the incorporation of assessment for environmental determinants of health in  
36 patient history-taking into physician training. (Modify Current HOD Policy)

37  
38 3. That Policy D-150.978, “Sustainable Food” be reaffirmed.

39  
40 Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care  
41 facilities that support and model a healthy and ecologically sustainable food system, which  
42 provides food and beverages of naturally high nutritional quality; (2) encourages the development  
43 of a healthier food system through tax incentive programs, community-level initiatives and federal  
44 legislation; and (3) will consider working with other health care and public health organizations to  
45 educate the health care community and the public about the importance of healthy and ecologically  
46 sustainable food systems. (Reaffirm HOD Policy)

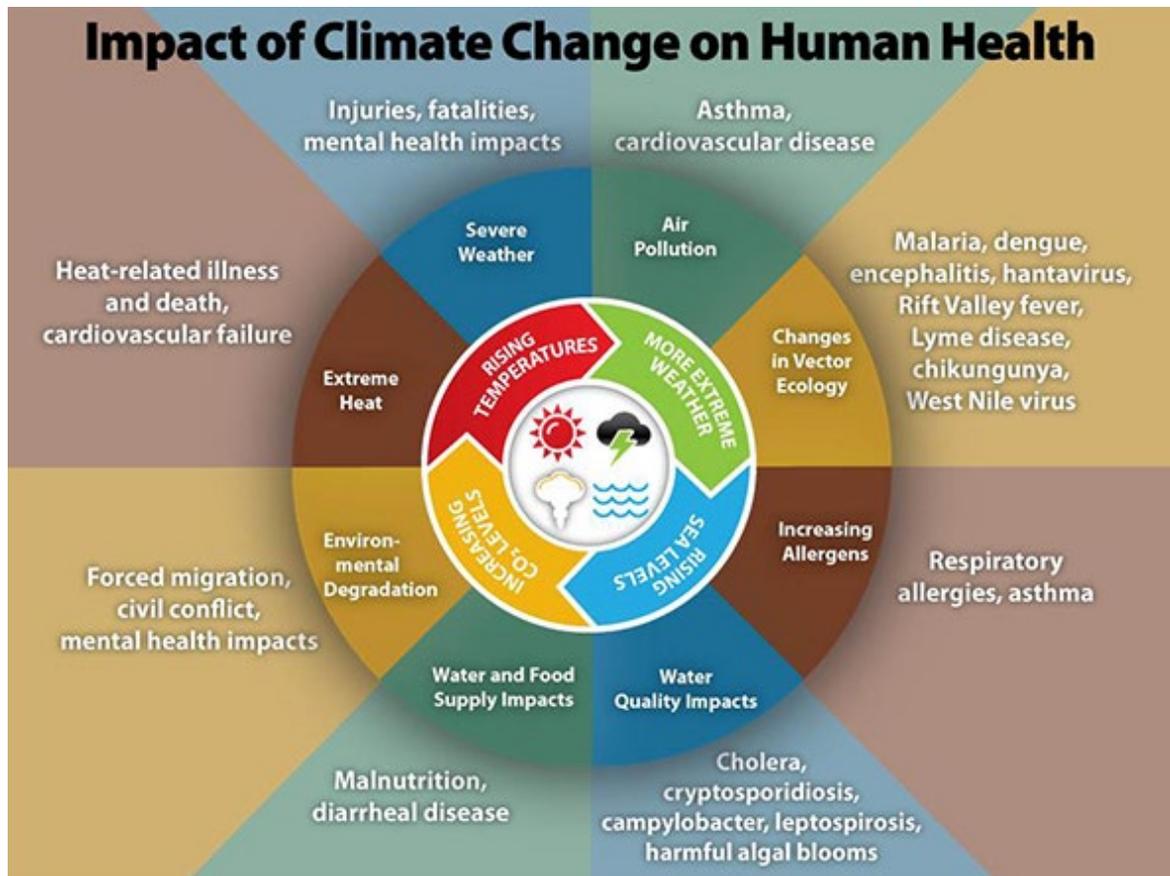
47  
48 4. That Policy H-135.977, “Global Climate Change - The "Greenhouse Effect"” be rescinded.

49  
50 Our AMA: (1) ~~endorses the need for additional research on atmospheric monitoring and climate~~  
51 ~~simulation models as a means of reducing some of the present uncertainties in climate forecasting;~~

- 1 ~~(2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization~~
- 2 ~~policy that will promote more efficient fuel use and energy production;~~
- 3 ~~(3) endorses increased recognition of the importance of nuclear energy's role in the production of~~
- 4 ~~electricity;~~
- 5 ~~(4) encourages research and development programs for improving the utilization efficiency and~~
- 6 ~~reducing the pollution of fossil fuels; and~~
- 7 ~~(5) encourages humanitarian measures to limit the burgeoning increase in world population.~~
- 8 (Rescind HOD Policy)

Fiscal Note: less than \$1,000

FIGURE 1



Source: Centers for Disease Control and Prevention

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 902  
(1-22)

Introduced by: Medical Student Section

Subject: Reducing the Burden of Incarceration on Public Health

Referred to: Reference Committee K

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- 1 Whereas, The United States has the highest incarceration rate in the world<sup>1</sup>; and  
2  
3 Whereas, Incarcerated individuals disproportionately have lower incomes and are more likely to  
4 be Black, male, and live in urban settings<sup>2</sup>; and  
5  
6 Whereas, In 2018, Black Americans represented 33% of the sentenced prison population,  
7 whites 30%, and Hispanic 23%, whereas these groups made up 12%, 63%, and 16% of the  
8 U.S. adult population, respectively<sup>3</sup>; and  
9  
10 Whereas, A 2009 study found that incarcerated people have higher rates of hypertension,  
11 arthritis, cervical cancer, and hepatitis than non-incarcerated individuals<sup>5</sup>; and  
12  
13 Whereas, Incarcerated individuals may also experience heightened challenges in transitions of  
14 care relative to the non-incarcerated population, including poor transfer of medical, laboratory  
15 and pharmacy records, poor communication among providers, variable access to care, limited  
16 family involvement, and inability to afford treatment<sup>6,7</sup>; and  
17  
18 Whereas, Many states have rules wherein Medicaid beneficiaries who are incarcerated are de-  
19 enrolled and must re-enroll in Medicaid upon release, which can have a significant lag time that  
20 frequently lasts up to several months<sup>8,9</sup>; and  
21  
22 Whereas, As of 2019, 43 states had implemented suspension of benefits rather than termination  
23 for certain prisons, and 42 had done this for certain jails, allowing inmates to immediately  
24 reinstate their Medicaid eligibility upon release<sup>10</sup>; and  
25  
26 Whereas, Federal rules prohibit Medical matching funds for being used for inmate health  
27 expenses with the exception of costs incurred due to inpatient hospitalization, creating  
28 additional coverage issues for the incarcerated population separate from eligibility<sup>11</sup>; and  
29  
30 Whereas, Federal Medicaid rules include a coverage exclusion “related to services for patients  
31 in Institutions for Mental Diseases, which include residential treatment facilities of over sixteen  
32 beds that are primarily engaged in the diagnosis, treatment, or care of persons with mental  
33 diseases”<sup>12</sup>; and  
34  
35 Whereas, The Medicaid Reentry Act of 2021 was introduced into the US House of  
36 Representatives and would allow for Medicaid payment for medical services rendered to  
37 incarcerated individuals during the 30-day period before the individual’s release<sup>13</sup>; and  
38  
39 Whereas, The Bureau of Justice Assistance awards grants for projects that create strategic,  
40 sustainable plans to facilitate successful reentry, ensure collaboration with the criminal justice

1 system and social services, and collect data to measure performance outcomes related to  
2 recidivism and service provision<sup>14</sup>; and

3  
4 Whereas, Individuals released from prison may legally be barred from pursuing opportunities in  
5 employment, social programs, and voting<sup>15-17</sup>; and

6  
7 Whereas, Pursuant to a report mandated by the Fair Chance to Compete for Jobs Act, the  
8 Bureau of Justice Statistics in the US Department of Justice found that 33% of persons did not  
9 find employment at any point during the 16 quarters after their release from prison from 2010 to  
10 2014<sup>18</sup>; and

11  
12 Whereas, Because the predominant source of insurance in the United States is through  
13 employment, lack of employment opportunities for formerly incarcerated individuals leads to a  
14 concomitant lack of access to health insurance, particularly in states that have not expanded  
15 Medicaid<sup>19</sup>; and

16  
17 Whereas, Homelessness and residential instability has been identified as one of the greatest  
18 challenges confronting ex-offenders and their chance to achieve successful reintegration, with  
19 some studies finding that formerly incarcerated individuals were 10 times more likely to be  
20 homeless than the general public<sup>20,21</sup>; and

21  
22 Whereas, Periods of homelessness have been shown to significantly increase the risk of  
23 recidivism for new convictions, revocations, and readmission to prison, suggesting the presence  
24 of a vicious cycle wherein incarceration increases the risk of homelessness which further  
25 increases the risk of subsequent incarceration<sup>20</sup>; and

26  
27 Whereas, The increased risk of homelessness among the formerly incarcerated population  
28 increases with the number of times an individual has been incarcerated, with people who have  
29 been to prison once experiencing homelessness at a rate 7 times greater than that of the  
30 general public and people who have been incarcerated more than once experiencing  
31 homelessness at a rate 13 times higher than the general public<sup>21</sup>; and

32  
33 Whereas, The AMA has extensive policy on reducing the poor health outcomes associated with  
34 incarceration (H-430.986 Health Care While Incarcerated), on the health impacts of  
35 homelessness (H-160.903 Eradicating Homelessness), on support for standard ongoing  
36 medical, psychiatric, and substance misuse care for inmates upon release from correctional  
37 facilities in order to prevent recidivism (H-430.997 Standards of Care for Inmates of Correctional  
38 Facilities), and on support for the National Commission on Correctional Health Care Standards  
39 and its efforts to improve the quality of health care services for incarcerated persons (D-430.997  
40 Support for Healthcare Services for Incarcerated Persons), but has no policy supporting or  
41 promoting access to stable employment and housing for former inmates; therefore be it

42  
43 RESOLVED, That our American Medical Association support efforts to reduce the negative  
44 health impacts of incarceration, such as: (1) implementation and incentivization of adequate  
45 funding and resources towards indigent defense systems; (2) implementation of practices that  
46 promote access to stable employment and laws that ensure employment non-discrimination for  
47 workers with previous non-felony criminal records; and (3) housing support for formerly  
48 incarcerated people, including programs that facilitate access to immediate housing after  
49 release from carceral settings (New HOD Policy); and be it further

1 RESOLVED, That our AMA partner with the American Public Health Association and other  
2 stakeholders to urge Congress, the Department of Justice, and the Department of Health  
3 and Human Services to minimize the negative health effects of incarceration by supporting  
4 programs that facilitate employment and housing opportunities for formerly incarcerated  
5 individuals as well as research into alternatives to incarceration. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 09/20/22

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**RELEVANT AMA POLICY**

**Health Care While Incarcerated H-430.986**

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.

4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the “inmate exclusion” of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community; (c) the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and (d) collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.
11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children’s Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.

CMS Rep. 02, I-16, Appended: Res. 417, A-19, Appended: Res. 420, A-19, Modified: Res. 216, I-19, Modified: Res. 503, A-21, Reaffirmed: Res. 229, A-21, Modified: Res. 127, A-22

#### **Standards of Care for Inmates of Correctional Facilities H-430.997**

Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance use disorder care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.

Res. 60, A-84, Reaffirmed by CLRPD Rep. 3 - I-94, Amended: Res. 416, I-99, Reaffirmed: CEJA Rep. 8, A-09, Reaffirmation I-09, Modified in lieu of Res. 502, A-12, Reaffirmation: I-12, Modified: CSAPH Rep. 1, A-22

#### **Disease Prevention and Health Promotion in Correctional Institutions H-430.989**

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, hepatitis, and other infectious diseases. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.

CSA Rep. 4, A-03, Modified: CSAPH Rep. 1, A-13, Modified: Alt. Res. 404, I-20

#### **Support for Health Care Services to Incarcerated Persons D-430.997**

Our AMA will:

- (1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;
- (2) encourage all correctional systems to support NCCHC accreditation;
- (3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;

- (4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;
- (5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and
- (6) support an incarcerated person's right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.

Res. 440, A-04, Amended: BOT Action in response to referred for decision Res. 602, A-00, Reaffirmation I-09, Reaffirmation A-11, Reaffirmed: CSAPH Rep. 08, A-16, Reaffirmed: CMS Rep, 02, I-16, Appended: Res. 421, A-19, Appended: Res. 426, A-19

#### **Compassionate Release for Incarcerated Patients H-430.980**

Our AMA supports policies that facilitate compassionate release for incarcerated patients on the basis of serious medical conditions and advanced age; will collaborate with appropriate stakeholders to develop clear, evidence-based eligibility criteria for timely compassionate release; and promote transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions.

BOT Rep. 10, I-20

#### **Dietary Intake of Incarcerated Populations D-430.995**

Our AMA: 1) urges the National Commission on Correctional Health Care, the American Correctional Association, and individual states to mandate adherence to the current Dietary Reference Intakes and Dietary Guidelines for Americans (with adjustments, as needed, for special populations) as a criterion for accreditation and/or standards compliance, until national dietary guidelines specific for adolescent and adult incarcerated populations becomes available; and 2) urges the Food and Nutrition Board of the Institute of Medicine to examine the nutrient status and dietary requirements of incarcerated populations and issue guidelines on menu planning for adolescent and adult incarcerated populations.

CSAPH Rep. 4, A-11, Reaffirmed: Res. 904, I-19

#### **Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of Incarcerated Persons H-430.985**

Our AMA: (1) supports the implementation of routine screening for Hepatitis C virus (HCV) in prisons; (2) will advocate for the initiation of treatment for HCV when determined to be appropriate by the treating physician in incarcerated patients with the infection who are seeking treatment; and (3) supports negotiation for affordable pricing for therapies to treat and cure HCV among correctional facility health care providers, correctional facility health care payors, and drug companies to maximize access to these disease-altering medications.

Res. 404, A-17

#### **Increased Oversight of Suicide Prevention Training for Correctional Facility Staff H-430.984**

1. Our AMA strongly encourages all state and local adult and juvenile correctional facilities to develop a suicide prevention plan that meets current National Commission on Correctional Health Care standards for accreditation.

2. Our AMA strongly encourages all state and local adult and juvenile correctional facility officers to undergo suicide prevention training annually.

Res. 408, A-17

#### **Medications for Opioid Use Disorder in Correctional Facilities H-430.987**

1. Our AMA endorses: (a) the medical treatment model of employing medications for opioid use disorder (OUD) as the standard of care for persons with OUD who are incarcerated; and (b) medications for persons with OUD who are incarcerated, an endorsement in collaboration with relevant organizations including but not limited to the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry.

2. Our AMA advocates for legislation, standards, policies and funding that require correctional facilities to increase access to evidence-based treatment of OUD, including initiation and continuation of medications for OUD, in conjunction with psychosocial treatment when desired by the person with OUD, in correctional facilities within the United States and that this apply to all individuals who are incarcerated, including individuals who are pregnant, postpartum, or parenting.

3. Our AMA advocates for legislation, standards, policies, and funding that require correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case

managers, social workers, and pharmacies in the communities where patients, including individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for OUD, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths, including naloxone (or any other medication that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose), and help ensure post-incarceration medical coverage and accessibility to mental health and substance use disorder treatments, that include medication and behavioral health and social supports for addiction treatment.

4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid withdrawal syndrome for all persons upon entry.

Res. 443, A-05, Reaffirmed: CSAPH Rep. 1, A-15, Appended: Res. 223, I-17, Modified: Res. 503, A-21

**Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional and Detention Facilities H-430.979**

1. Our AMA, in collaboration with state and national medical specialty societies and other relevant stakeholders, will advocate for the improvement of conditions of incarceration in all correctional and immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance.

2. Our AMA will advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities.

3. Our AMA will advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens.

4. Our AMA supports expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities.

5. Our AMA recognizes that detention center and correctional workers, incarcerated persons, and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation.

6. Our AMA will advocate: (a) for all employees working in a correctional facility or detention center to be up to date with vaccinations against COVID-19, unless there is a valid medical contraindication; (b) for all employees working in a correctional facility or detention center, not up to date with vaccination for COVID-19 to be COVID rapid tested each time they enter a correctional facility or detention center, as consistent with Centers for Disease Control and Prevention (CDC) or local public health guidelines; (c) for correctional facility or detention center policies that require non-employed, non-residents (e.g. visitors, contractors, etc.) to either show evidence of being up to date for COVID-19 vaccines or show proof of a negative COVID test when they enter a correctional facility or detention center as consistent with CDC or local public health guidelines, at no cost to the visitor; (d) that all people inside a correctional facility or detention center wear an appropriate mask at all times, except while eating or drinking or at a 6 ft. distance from anyone else if local transmission rate is above low risk as determined by the CDC; and (e) that correctional facilities or detention centers be able to request and receive all necessary funding for COVID-19 vaccination and testing, according to CDC or local public health guidelines.

Alt. Res. 404, I-20, Appended: Res. 406, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 904  
(I-22)

Introduced by: International Medical Graduates Section

Subject: Immigration Status Is a Public Health Issue

Referred to: Reference Committee K

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- 1 Whereas, There are 47 million foreign-born residents in the U.S. in 2022 (14.3% of the  
2 population) being the largest number ever recorded; and  
3  
4 Whereas, The Census Bureau projects the foreign-born share of the U.S. population to continue  
5 to increase reaching 69 million by 2060; and  
6  
7 Whereas, Immigration status is being increasingly recognized as a social determinant of health  
8 identifying the immigrant population as a vulnerable population that is at increased risk for poor  
9 physical, psychological and social health outcomes, and inadequate healthcare; and  
10  
11 Whereas, Poor health outcomes among immigrants are not only dependent on socioeconomic  
12 characteristics, but often determined by factors that are unique for this population – language  
13 barriers, difficulty navigating the healthcare system, stigmatization, marginalization, and  
14 discrimination within the healthcare system, inability to have medical coverage, poor  
15 understanding of specific immigrants’ health challenges by health professionals; and  
16  
17 Whereas, Healthcare inequities among immigrants include not only personal medical services  
18 but also public health services and programs; for example, immunizations, often due to  
19 institutional, structural, and systemic factors; therefore be it  
20  
21 RESOLVED, That our American Medical Association declare that immigration status is a public  
22 health issue that requires a comprehensive public health response and solution (Directive to  
23 Take Action); and be it further  
24  
25 RESOLVED, That our AMA recognize interpersonal, institutional, structural, and systemic  
26 factors that negatively affect immigrants’ health (New HOD Policy); and be it  
27  
28 RESOLVED, That our AMA promote the development and implementation of educational  
29 resources for healthcare professionals to better understand health and healthcare challenges  
30 specific for the immigrant population (Directive to Take Action); and be it further  
31  
32 RESOLVED, That our AMA support the development and implementation of public health  
33 policies and programs that aim to improve access to healthcare and minimize systemic health  
34 barriers for immigrant communities. (New HOD Policy)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 09/27/22

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7. Swift, J. (2021, November 17). Immigration Status: A Political Determinant of Health. Gender Policy Report. <https://genderpolicyreport.umn.edu/immigration-status-a-political-determinant-of-health/>
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 905  
(I-22)

Introduced by: Illinois

Subject: Minimal Age of Juvenile Justice Jurisdiction in the United States

Referred to: Reference Committee K

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- 1 Whereas, 27 states have no minimum age of juvenile adjudication; and  
2  
3 Whereas, Without a minimal age law, children of any age can be arrested; and  
4  
5 Whereas, Without minimal age law, children of any age can be charged with a juvenile violation;  
6 and  
7  
8 Whereas, Without minimal age law, children of any age can be potentially incarcerated; and  
9  
10 Whereas, Without minimal age law, racial injustice and health inequalities take place; and  
11  
12 Whereas, Without minimal age law, families and individuals suffer economic burden, social  
13 disgrace and stigmatization impacting future life and employment; and  
14  
15 Whereas, Evidence supports decriminalizing young children – providing them with appropriate  
16 support and avoiding handcuffs and cages – as a humane and productive approach with  
17 positive mental and physical health outcomes for the very young of society; and  
18  
19 Whereas, The United Nations Standard Minimum Rules for the Administration of Juvenile  
20 Justice (The Beijing Rules) Rules do not set a minimum age, however, they set forth the  
21 considerations when setting a minimum age, such as the emotional, mental and intellectual  
22 maturity of the child; and  
23  
24 Whereas, Research by the National Governors Association identifies 15 states that have set the  
25 minimum age at 10 years old for juvenile adjudication; therefore be it  
26  
27 RESOLVED, That our American Medical Association create a policy to establish minimal age of  
28 10 years for juvenile justice jurisdiction in the United States (New HOD Policy); and be it further  
29  
30 RESOLVED, That our AMA introduce legislation to establish minimal age of 10 for juvenile  
31 justice jurisdiction in the United States. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 09/27/22

**REFERENCES:**

<https://www.nga.org/center/publications/age-boundaries-in-juvenile-justice-systems/>

<https://www.ohchr.org/sites/default/files/Documents/ProfessionalInterest/beijingrules.pdf>

**RELEVANT AMA POLICY**

**Juvenile Justice System Reform H-60.919**

Our AMA:

1. Supports school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments rather than "zero tolerance" policies that mandate out-of-school suspension, expulsion, or the referral of students to the juvenile or criminal justice system.
2. Encourages continued research to identify programs and policies that are effective in reducing disproportionate minority contact across all decision points within the juvenile justice system.
3. Encourages states to increase the upper age of original juvenile court jurisdiction to at least 17 years of age.
4. Supports reforming laws and policies to reduce the number of youth transferred to adult criminal court.
5. Supports the re-authorization of federal programs for juvenile justice and delinquency prevention, which should include incentives for: (a) community-based alternatives for youth who pose little risk to public safety, (b) reentry and aftercare services to prevent recidivism, (c) policies that promote fairness to reduce disparities, and (d) the development and implementation of gender-responsive, trauma-informed programs and policies across juvenile justice systems.
6. Encourages juvenile justice facilities to adopt and implement policies to prohibit discrimination against youth on the basis of their sexual orientation, gender identity, or gender expression in order to advance the safety and well-being of youth and ensure equal access to treatment and services.
7. Encourages states to suspend rather than terminate Medicaid coverage following arrest and detention in order to facilitate faster reactivation and ensure continuity of health care services upon their return to the community.
8. Encourages Congress to enact legislation prohibiting evictions from public housing based solely on an individual's relationship to a wrongdoer, and encourages the Department of Housing and Urban Development and local public housing agencies to implement policies that support the use of discretion in making housing decisions, including consideration of the juvenile's rehabilitation efforts.

Citation: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16

**Youth Incarceration in Adult Facilities H-60.916**

1. Our AMA supports, with respect to juveniles (under 18 years of age) detained or incarcerated in any criminal justice facility: (a) early intervention and rehabilitation services, (b) appropriate guidelines for parole, and (c) fairness in the expungement and sealing of records.
2. Our AMA opposes the detention and incarceration of juveniles (under 18 years of age) in adult criminal justice facilities.

Citation: Alt. Res. 917, I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 906  
(I-22)

Introduced by: New York

Subject: Requirement for COVID-19 Vaccination in Public Schools Once Fully  
FDA-Authorized

Referred to: Reference Committee K

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- 1 Whereas, COVID-19 vaccination has demonstrated safety effectiveness in preventing  
2 hospitalization and death for children and adolescents;<sup>1</sup> and  
3  
4 Whereas, The risks of cardiac and thromboembolic complications from COVID-19 disease,  
5 including MIS-C, is far higher than the risk of myocarditis from vaccination;<sup>1,3</sup> and  
6  
7 Whereas, COVID-19 vaccines reduce the risk of significant morbidity, including “long COVID”  
8 and missed days from school and work;<sup>1</sup> and  
9  
10 Whereas, Children can serve as a pool for ongoing community spread of COVID-19 clusters  
11 and outbreaks;<sup>2</sup> and  
12  
13 Whereas, Vaccination has been demonstrated to reduce overall community transmission of  
14 COVID-19;<sup>1-3</sup> and  
15  
16 Whereas, Risk of exposure to COVID-19 poses significant concern for children with chronic  
17 medical conditions such as asthma, diabetes and developmental disorders;<sup>1,2</sup> therefore be it  
18  
19 RESOLVED, That our American Medical Association encourage states to make COVID-19  
20 vaccination a requirement for school attendance for children and college/university students  
21 once the FDA grants full approval for COVID-19 vaccination for all relevant age groups. (New  
22 HOD Policy)

Fiscal Note: Minimal – less than \$1,000

Received: 09/27/22

**REFERENCES:**

[https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/children-teens.html?s\\_cid=11368:age%20limit%20for%20covid%20vaccine.sem.ga:p:RG:GM:gen:PTN:FY21](https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/children-teens.html?s_cid=11368:age%20limit%20for%20covid%20vaccine.sem.ga:p:RG:GM:gen:PTN:FY21)  
<https://www.cdc.gov/coronavirus/2019-ncov/groups/families-children.html>  
<https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/fully-vaccinated-people.html>

## **RELEVANT AMA POLICY**

### **Education and Public Awareness on Vaccine Safety and Efficacy H-440.830**

1. Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; (f) supports state policies allowing minors to override their parent's refusal for vaccinations; and encourages state legislatures to establish comprehensive vaccine and minor consent policies; and (g) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths.

2. Our AMA: (a) supports the rigorous scientific process of the Advisory Committee on Immunization Practices as well as its development of recommended immunization schedules for the nation; (b) recognizes the substantial body of scientific evidence that has disproven a link between vaccines and autism; and (c) opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines.

Citation: Res. 9, A-15; Modified: CSAPH Rep. 1, I-15; Appended: Res. 411, A-17; Modified: Res. 011, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 907  
(I-22)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: A National Strategy for Collaborative Engagement, Study, and Solutions to Reduce the Role of Illegal Firearms in Firearm Related Injury

Referred to: Reference Committee K

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- 1 Whereas, The AMA declared gun violence in the United States a national public health crisis (PHC)  
2 in 2016; and
- 3 Whereas, From January 1, 2022, through September 27, 2022, there were 32,944 gun violence  
4 deaths in the United States<sup>1</sup>, including 15,124 homicides, murders, and unintentional deaths; and
- 5 Whereas, At least 13% of mass shootings involve the use of illegally purchased weapons<sup>2</sup>; and
- 6 Whereas, Over 80% of individuals who engage in K-12 school shootings stole firearms from family  
7 members<sup>2</sup>, and
- 8 Whereas, From January 1, 2022, through September 27, 2022, there were 29,518 gun violence  
9 survivors<sup>1</sup> that were injured; and
- 10 Whereas, The economic cost of firearm injury in the United States is estimated to be \$557 billion per  
11 year<sup>3</sup>, including immediate costs such as hospital treatment, ambulances, and the police response;  
12 subsequent costs such as long-term physical and mental health care, rehabilitation care, institutional  
13 care, forgone earnings from disability or death, and criminal justice costs; and quality-of-life costs for  
14 pain and suffering over a victim's life span<sup>4</sup>; and
- 15 Whereas, The AMA has extensive policy calling for expansion of national research and mitigation  
16 strategies from entities such as the Centers for Disease Control and Prevention, the National  
17 Institutes of Health, and the United States Surgeon General to address our national firearm injury  
18 PHC; and
- 19 Whereas, These entities have failed to produce timely research, recommendations, and mitigation  
20 strategies to address the national firearm injury PHC; and
- 21 Whereas, The US Congress has struggled to develop non-partisan conversations around firearm  
22 safety strategies, but has recently taken the first step by passing the *S.2938: Bipartisan Safer  
23 Communities Act*<sup>5</sup>; and
- 24 Whereas, The majority of community gun violence<sup>6</sup> and firearm related crime in the United States  
25 occurs through the use of and access to illegal firearms<sup>7-18</sup>; and
- 26 Whereas, The AMA can help reorient the public and the national conversation about the national  
27 firearm injury PHC around public health in a solutions-oriented, unbiased, and non-partisan manner;  
28 therefore be it
- 29 RESOLVED, That our American Medical Association support research looking at the major sources  
30 of illegal gun supply, as well as possible methods of decreasing the proliferation of illegal firearms in  
31 the United States (New HOD Policy); and be it further

- 1 RESOLVED, That our AMA work with key stakeholders including, but not limited to, firearm  
2 manufacturers, firearm advocacy groups, law enforcement agencies, public health agencies, firearm  
3 injury victims advocacy groups, healthcare providers, and state and federal government agencies to  
4 study and develop evidence-informed public health recommendations to mitigate the effects of  
5 violence committed with illegal firearms (Directive to Take Action); and be it further
- 6 RESOLVED, That our AMA convene national public forums including, but not limited to, online  
7 venues, national radio, and televised/streamed in-person town halls, that bring together key  
8 stakeholders and members of the general public to focus on finding common ground, non-partisan  
9 measures to mitigate the effects of illegal firearms in our firearm injury public health crisis (Directive  
10 to Take Action); and be it further
- 11 RESOLVED, That our AMA reaffirm House policies H-145.975, H-145.984, H-145.997, D-145.994,  
12 and D-145.999 calling for increased funding for national firearm violence research. (Reaffirm HOD  
13 Policy)

Fiscal Note: Not yet determined

Received: 09/28/22

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## **RELEVANT AMA POLICY**

### **Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975**

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
  2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
  3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.
- Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 3, A-21

### **Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997**

1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.  
Therefore, the AMA:
    - (A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
    - (B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
    - (C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
    - (D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
    - (E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
    - (F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
    - (G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
  2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.
- Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19

**Data on Firearm Deaths and Injuries H-145.984**

The AMA supports legislation or regulatory action that: (1) requires questions in the National Health Interview Survey about firearm related injury as was done prior to 1972; (2) mandates that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and (3) expands activities to begin tracking by the National Electronic Injury Surveillance System.

Citation: (Res. 811, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-13)

**Epidemiology of Firearm Injuries D-145.999**

Our AMA will: (1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; and (2) urge Congress to provide sufficient resources to enable the CDC to collect and analyze firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at large may be able to prevent injury, death and the other costs to society resulting from firearms.

Citation: Res. 424, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13; Reaffirmation: A-18

**Firearm Related Injury and Death: Adopt a Call to Action H-145.973**

Our AMA endorses the specific recommendations made by an interdisciplinary, inter-professional group of leaders from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, American Psychiatric Association, American Public Health Association, and the American Bar Association in the publication "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association," which is aimed at reducing the health and public health consequences of firearms and lobby for their adoption.

Citation: Res. 214, I-16

**Removing Restrictions on Federal Funding for Firearm Violence Research D-145.994**

Our AMA will provide an informational report on recent and current organizational actions taken on our existing AMA policies (e.g. H-145.997) regarding removing the restrictions on federal funding for firearms violence research, with additional recommendations on any ongoing or proposed upcoming actions.

Citation: Res. 201, I-16

**Physicians and the Public Health Issues of Gun Safety D-145.997**

Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths.

Citation: (Res. 410, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 908  
(I-22)

Introduced by: Senior Physicians Section

Subject: Older Adults and the 988 Suicide and Crisis Lifeline

Referred to: Reference Committee K

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- 1 Whereas, Suicide is the 12th leading cause of death in the United States (2020), and is a public  
2 health issue for individuals and for the communities they live in;<sup>1</sup> and  
3  
4 Whereas, While older adults comprise just 12% of the population, they make up approximately  
5 18% of all suicide deaths;<sup>2</sup> and  
6  
7 Whereas, Among people who attempt suicide, one in four seniors will succeed, compared to 1  
8 in 200 youths;<sup>3</sup> and  
9  
10 Whereas, The new mental health line, known as the 988 Suicide and Crisis Lifeline, was  
11 launched nationally on July 1, 2022; and  
12  
13 Whereas, The Department of Health and Human Services (HHS) through its Substance Abuse  
14 and Mental Health Services Administration, has awarded nearly \$105 million in grant funding,  
15 provided by the American Rescue Plan, to 54 states and territories in advance of the transition  
16 of the National Suicide Prevention Lifeline;<sup>4</sup> and  
17  
18 Whereas, With States having varying degrees of operational readiness, the success of 988 now  
19 is important to get activated; and  
20  
21 Whereas, The 988 number currently does not designate priority by age group; and  
22  
23 Whereas, Seniors who are homebound may lack the social connections they need and call  
24 centers are expected to be appropriately funded and staffed with properly trained operators to  
25 handle suicide risk; therefore be it  
26  
27 RESOLVED, That our American Medical Association, with other interested organizations,  
28 develop model legislation for use by states who wish to pursue funding for the 988 Suicide and  
29 Crisis Lifeline (Directive to Take Action); and be it further  
30  
31 RESOLVED, That our AMA advocate that the Department of Health and Human Services (HHS)  
32 prioritize education and outreach activities for use of the 988 Suicide and Crisis Lifeline to those  
who are at highest risk for suicide completion with a special emphasis on those over age 65.  
(Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 09/29/22

**REFERENCES:**

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4. U.S. Department of Health & Human Services. (2022, August). Press Release: U.S. Transition to 988 Suicide & Crisis Lifeline Begins Saturday. <https://www.hhs.gov/about/news/2022/07/15/us-transition-988-suicide-crisis-lifeline-begins-saturday.html>

**RELEVANT AMA POLICY**

**Awareness Campaign for 988 National Suicide Prevention Lifeline D-345.974**

Our AMA will: (1) utilize their existing communications channels to educate the physician community and the public on the new 9-8-8 National Suicide Prevention Lifeline program; (2) work with the Federation and other stakeholders to advocate for adequate federal and state funding for the 9-8-8 system; and (3) collaborate with the Substance Abuse and Mental Health Services Administration and the 9-8-8 partner community to strengthen suicide prevention and mental health crisis services.

Citation: Res. 423, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 909  
(I-22)

Introduced by: Senior Physicians Section  
Subject: Decreasing Gun Violence and Suicide in Seniors  
Referred to: Reference Committee K

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- 1 Whereas, Our AMA has recognized that gun violence is an urgent public health crisis; and  
2  
3 Whereas, While most media attention focuses on mass shootings, the majority (60%) of gun  
4 related deaths are in fact due to suicide;<sup>1</sup> and  
5  
6 Whereas, The prototypical gun related suicide happens in older, rural, white males;<sup>2</sup> and  
7  
8 Whereas, Suicide is often an impulsive act amenable to intervention; and  
9  
10 Whereas, New federal legislation facilitates universal adoption of Extreme Risk Protection  
11 Orders (Red Flag laws);<sup>3</sup> and  
12  
13 Whereas, One of the barriers to addressing this crisis is that clinicians are often hesitant to  
14 discuss and counsel about firearm safety;<sup>4</sup> therefore be it  
15  
16 RESOLVED, That our American Medical Association and other organizations develop and  
17 disseminate a formal educational program to enable clinicians to effectively and efficiently  
18 address suicides with an emphasis on seniors and firearms (Directive to Take Action); and be it  
19 further  
20  
21 RESOLVED, That our AMA develop with other interested organizations a toolkit for clinicians to  
22 use addressing Extreme Risk Protection Orders in their individual states (Directive to Take  
23 Action); and be it further  
24  
25 RESOLVED, That our AMA partner with other groups interested in firearm safety to raise public  
26 awareness of magnitude and interventions available regarding senior suicides and firearms.  
27 (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 09/29/22

**REFERENCES:**

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## **RELEVANT AMA POLICY**

### **Firearms and High-Risk Individuals H-145.972**

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.

Citation: CSAPH Rep. 04, A-18; Reaffirmed: BOT Rep. 11, I-18; Reaffirmed: CSAPH Rep. 3, I-21

### **Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975**

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 3, A-21

### **Ban on Handguns and Automatic Repeating Weapons H-145.985**

It is the policy of the AMA to:

(1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:

(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;

(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21;

(c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);

(d) the imposition of significant licensing fees for firearms dealers;

(e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and

(f) mandatory destruction of any weapons obtained in local buy-back programs.

(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.

(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.

(4) Oppose concealed carry reciprocity federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.

(5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.

Citation: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-14; Appended: Res. 427, A-18; Reaffirmation: A-18; Modified: Res. 244, A-18;

#### **Gun Violence as a Public Health Crisis D-145.995**

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and

(2) will actively lobby Congress to lift the gun violence research ban.

Citation: Res. 1011, A-16; Reaffirmation: A-18; Reaffirmation: I-18

#### **Firearm Availability H-145.996**

1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.

3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

Citation: Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 910  
(1-22)

Introduced by: Resident and Fellow Section

Subject: Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use

Referred to: Reference Committee K

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- 1 Whereas, Led by the Society of Pediatric Radiology (SPR), the Image Gently Alliance was  
2 formed in late 2006 with the goal of “changing practice by raising awareness of the opportunities  
3 to lower radiation dose in the imaging of children” (1); and  
4
- 5 Whereas, The SPR recruited other organizations/members of the imaging team into the alliance  
6 in 2007 including the American College of Radiology (ACR), American Association of Physicists  
7 in Medicine (AAPM), and American Society of Radiologic Technologists (ASRT) (1); and  
8
- 9 Whereas, The practice of shielding reproductive organs and in utero fetuses began in the 1950s  
10 given concerns about the long-term effects of radiation and the potential for passing on genetic  
11 mutations through genetic inheritance (2,3); and  
12
- 13 Whereas, In response to these concerns, state and federal laws and regulations have been  
14 created requiring the use of gonad shields in medical imaging studies (4,5); and  
15
- 16 Whereas, Through technological advances, medical physicists estimate the dose from routine  
17 diagnostic imaging to reproductive organs has been reduced by 95% without compromising  
18 diagnostic quality (2,3); and  
19
- 20 Whereas, Technological advances and optimization have resulted in marginal hereditary risk  
21 reduction from gonad shielding ranging from  $1 \times 10^{-6}$  in women and  $5 \times 10^{-6}$  in men (6); and  
22
- 23 Whereas, Research on radiation dosing has shown that routine diagnostic imaging does not  
24 produce harmful levels of radiation to patients and fetuses (2,3); and  
25
- 26 Whereas, Modern mechanisms to optimize imaging parameters such as automatic exposure  
27 control (AEC) are negatively affected by shielding (7); and  
28
- 29 Whereas, The gonad shield results in decreased activity on the detector, triggering AEC to  
30 increase radiation output, which results in increased exposure and patient dose along with the  
31 degradation of image quality (7); and  
32
- 33 Whereas, The gonad shield produces artifacts and can obscure relevant anatomy and  
34 diagnostic information (7); and  
35
- 36 Whereas, Non-diagnostic or obscured images may need to be repeated increasing patient dose  
37 when shields are used (7); and  
38
- 39 Whereas, The gonad surface shield is ineffective at reducing internal scatter (7); and

1 Whereas, Studies have shown that gonad shields are incorrectly placed for females in 91% of  
2 radiographs and for males in 66% of radiographs, rendering them ineffective (8,9); and  
3

4 Whereas, On January 12th, 2021, the National Council on Radiation Protection and  
5 Measurements (NCRP) issued a statement that the risks of utilizing gonad shields far outweigh  
6 the negligible benefits to reproductive organs and therefore they should not be routinely used  
7 (10); and  
8

9 Whereas, Similar statements opposing routine or mandatory use of gonadal shields were  
10 released by the ACR and the AAPM in 2019 and by the ASRT in 2021 (11,12); therefore be it  
11

12 RESOLVED, That our American Medical Association oppose mandatory use of gonad shields in  
13 medical imaging considering the risks far outweigh the benefits (New HOD Policy); and be it  
14 further  
15

16 RESOLVED, That our AMA advocate that the U.S. Food and Drug Administration amend the  
17 code of federal regulations to oppose the routine use of gonad shields in medical imaging  
18 (Directive to Take Action); and be it further  
19

20 RESOLVED, That our AMA, in conjunction with state medical societies, support model state and  
21 national legislation to oppose or repeal mandatory use of gonad shields in medical imaging  
22 (New HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 09/30/22

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4. [https://www.ecfr.gov/cgi-bin/text-idx?SID=c6fd98dfc8955d41420798f3e5357c66&mc=true&node=se21.8.1000\\_150&rgn=div8](https://www.ecfr.gov/cgi-bin/text-idx?SID=c6fd98dfc8955d41420798f3e5357c66&mc=true&node=se21.8.1000_150&rgn=div8)
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7. <https://www.aapm.org/org/policies/details.asp?id=468&type=PP&current=true>
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9. <https://pubmed.ncbi.nlm.nih.gov/28437549/>
10. <https://ncrponline.org/wp-content/themes/ncrp/PDFs/Statement13.pdf>
11. <https://www.acr.org/Advocacy-and-Economics/Advocacy-News/Advocacy-News-Issues/In-the-June-8-2019-Issue/ACR-Endorses-AAPM-Position-on-Patient-Gonadal-and-Fetal-Shielding>
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 911  
(I-22)

Introduced by: Society for Cardiovascular Angiography & Interventions

Subject: Critical Need for National Emergency Cardiac Care (ECC) System to Ensure Individualized, State-Wide, Care for ST Segment Elevation Myocardial Infarction (STEMI), Cardiogenic Shock (CS) and Out-of-Hospital Cardiac Arrest (OHCA), and to Reduce Disparities in Health Care for Patients with Cardiac Emergencies

Referred to: Reference Committee K

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- 1 Whereas, Cardiovascular Disease is the number one cause of death for men and women in the  
2 United States<sup>1</sup>, and  
3  
4 Whereas, The Acute Coronary Syndromes of unstable angina pectoris (USAP), Non-ST  
5 segment Elevation MI (NSTEMI) and STEMI are major causes of death and disability<sup>1,4,8</sup>, and  
6  
7 Whereas, Survival for uncomplicated STEMI patients has dramatically improved over the last 6  
8 decades (> 97% survival rate) with the implementation of systems of Emergency Cardiac Care  
9 (ECC), survival for STEMI with cardiogenic shock (CS) is unacceptably high<sup>2,3,4,8</sup>, and  
10  
11 Whereas, STEMI patients with cardiogenic shock (STEMI-CS) have mortality rates near 50%,  
12 except in some U.S. localities where the survival rates may be as high as 70% because of  
13 specialized medical centers that provide care teams and therapeutic modalities, like early use of  
14 Mechanical Circulatory Support (MCS), shock teams and coronary revascularization, through  
15 organized systems of ECC<sup>2,3,8</sup>, and  
16  
17 Whereas, Out-of-Hospital Cardiac Arrest (OHCA) is the fifth most common cause of death in the  
18 United States, accounting for more deaths than colon cancer, breast cancer, prostate cancer,  
19 influenza, pneumonia, HIV, firearms and house fires combined<sup>5,6,7</sup>, and  
20  
21 Whereas, 90% of OHCA occur in the home or workplace and these patients require intense and  
22 precisely orchestrated ECC on site, during transportation by Emergency Medical  
23 Technicians/Paramedics, and subsequent ECC as inpatients<sup>6</sup>, and  
24  
25 Whereas, Survival for patients with OHCA and refractory ventricular fibrillation is markedly  
26 improved, from less than 10% to over 40%, when systems of ECC include uniquely applied  
27 invasive procedures like emergent Extracorporeal Membrane Oxygenation (ECMO/ECPR)<sup>8</sup>, and  
28  
29 Whereas, Specialized systems of ECC, designed for coordinating and escalating cardiovascular  
30 care for patients with STEMI, STEMI-CS and OHCA, in some States, have produced significant  
31 improvements in survival for these catastrophic cardiovascular disorders<sup>4,8,14,17</sup>, and  
32  
33 Whereas, STEMI and STEMI-CS care is provided in a disparate manner to sociodemographic  
34 groups like the elderly, women, Black and Hispanic patients<sup>9,10</sup> with Black and Hispanic women  
35 having the highest mortality (29% and 46%, respectively), and

1 Whereas, Hospitals of different sizes, in diverse geographic and socioeconomic locations with  
2 varying clinical capabilities, provide different levels of ECC, and pre-hospital care can be quite  
3 variable<sup>11,12</sup>, there is a need to systematize ECC in the United States because standardization  
4 of systems of ECC<sup>13,14</sup>, results in improved treatment times and survival for patients with STEMI,  
5 STEMI-CS and OHCA<sup>4,5,7,8,13,14,15,17</sup>, and  
6

7 Whereas, The implementation of systems of care for ECC, with strict protocol adherence,  
8 diminishes treatment disparities between sociodemographic groups<sup>15,16</sup>, and  
9

10 Whereas, States that have addressed ECC solutions, unique to their State, some with laws<sup>18</sup>  
11 and others with State-wide clinical agreements between health systems and physicians<sup>19</sup>,  
12 therefore be it  
13

14 RESOLVED, That our American Medical Association encourage each state to standardize pre-  
15 hospital and inpatient care for cardiac emergencies, with individualized systems of Emergency  
16 Cardiac Care (ECC), specific for each state, to improve care and enhance survival for all  
17 patients, especially for those citizens who receive sociodemographically disparate care, when  
18 they present with cardiac emergencies (STEMI, STEMI-CS and OHCA) (New HOD Policy); and  
19 be it therefore,  
20

21 RESOLVED, That our AMA encourage states to designate hospitals as ECC Centers based on  
22 their individual capabilities to provide ECC, much like the designations and systems of care for  
23 Stroke and Trauma Centers. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 09/30/22

**Abbreviations:**

Acute Coronary Syndrome – ACS

Cardiogenic Shock – CS

Emergency Cardiac Care – ECC

Extracorporeal Membrane Oxygenation – ECMO

Extracorporeal Membrane Oxygenation facilitated Cardio-Pulmonary Resuscitation - ECPR

Mechanical Circulatory Support – MCS

Myocardial Infarction – MI

Out of Hospital Cardiac Arrest – OHCA

ST segment Elevation Myocardial Infarction – STEMI

ST segment Elevation Myocardial Infarction with Cardiogenic Shock – STEMI-CS

Unstable Angina Pectoris – USAP

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## **Not for consideration**

### **Resolutions not for consideration**

- 001 Updating Physician Job Description for Disability Insurance
- 004 Supporting Intimate Partner and Sexual Violence Safe Leave
- 204 Elimination of Seasonal Time Change
- 210 Elimination of Seasonal Time Changes and Establishment of Permanent Standard Time
- 212 SNAP Expansion for DACA Recipients
- 301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education
- 603 AMA House of Delegates Resolution Process Review
- 604 Solicitation Using the AMA Brand
- 901 Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies
- 903 Supporting Further Study of Kratom

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001  
(I-22)

Introduced by: Young Physicians Section  
Subject: Updating Physician Job Description for Disability Insurance  
Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, Many disability insurance products contain language and provisions such as “own  
2 occupation” and “own specialty” that may not be consistently defined and whose definitions are  
3 not readily available in marketing and policy paperwork; and  
4  
5 Whereas, The Department of Labor (DOL) developed the Dictionary of Occupational Titles  
6 (DOT), the main source of occupational information, in 1938; however, the DOL stopped  
7 updating the DOT in 1991;<sup>1</sup> and  
8  
9 Whereas, The DOL and Social Security Administration (SSA) are developing a new  
10 Occupational Information System (OIS),<sup>2</sup> which will replace the DOT as the primary source of  
11 occupational information that SSA staff and private insurers commonly use in the disability  
12 adjudication process; and  
13  
14 Whereas, This pandemic has led to many physicians contracting COVID-19 with health care  
15 workers and their families, representing up to one-sixth of hospitalized COVID-19 patients<sup>3</sup>; and  
16  
17 Whereas, Up to one-third of those infected with COVID-19 will develop Long COVID,<sup>4,5</sup> which  
18 can last for a year or more;<sup>6</sup> and  
19  
20 Whereas, Many with Long COVID cannot return to work on a full time basis<sup>7</sup> requiring reliance  
21 on long-term disability insurance to supplement income; and  
22  
23 Whereas, While the DOT contains discrete and well-established descriptions of the physical  
24 demands of occupations, it does not provide sufficiently specific information on associated  
25 mental and cognitive requirements; and  
26  
27 Whereas, Working with the US Bureau of Labor Statistics allows the SSA the unique opportunity  
28 to consider including descriptions of the mental and cognitive requirements of work in the new  
29 OIS; and  
30  
31 Whereas, In the absence of more specific definitions in the disability insurance application,  
32 many long-term disability insurers use a “national economy” standard to establish a job  
33 description; and  
34  
35 Whereas, Application of such a national standard may lead to long-term disability denials and  
36 financial hardship for physicians; therefore be it

1 RESOLVED, That our American Medical Association study the most effective approach to  
2 developing specialty-specific job descriptions that reflect the true physical and cognitive  
3 demands of each given specialty for use in the Occupational Information System under  
4 development by the Social Security Administration so as to ensure that physician disability  
5 policies are robust and protective if a coverage trigger occurs. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004  
(1-22)

Introduced by: Medical Student Section

Subject: Supporting Intimate Partner and Sexual Violence Safe Leave

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, Intimate partner violence (IPV) is defined as any preventable form of physical, sexual, or  
2 psychological aggression committed by current or former partners, including but not limited to  
3 stalking, sexual harassment, or sexual coercion<sup>1,2</sup>; and  
4

5 Whereas, 1 in 3 women and 1 in 4 men in the United States (U.S.) have experienced some form of  
6 IPV, with increased rates of injury and rape reported in sexual and ethnic minority populations<sup>3,4</sup>;  
7 and  
8

9 Whereas, Up to 61.1% of lesbian and bisexual cisgender women and 37.3% of gay and bisexual  
10 cisgender men report experiencing IPV compared to 35% and 29% of heterosexual cisgender  
11 women and men, respectively<sup>5</sup>; and  
12

13 Whereas, Transgender individuals disclose instances of physical and sexual IPV at 2.5 and 3.4  
14 times more frequently than individuals who do not self-identify with a sexual minority group<sup>5</sup>; and  
15

16 Whereas, National survey data from the Centers for Disease Control state that 53.8% of multiracial  
17 women, 46% of American Indian women, and 43.7% of Black women have experienced IPV,  
18 compared to 34.6% of non-Hispanic white women<sup>6</sup>; and  
19

20 Whereas, Individuals who experience IPV are also more likely to become victims of other forms of  
21 sexual violence and abuse such as stalking, workplace harassment, rape, and trafficking<sup>7,8</sup>; and  
22

23 Whereas, A surge in case numbers of IPV has been recorded, largely due to increased levels of  
24 societal stress, panic, and financial and emotional strain resulting from the COVID-19 pandemic<sup>9</sup>;  
25 and  
26

27 Whereas, IPV has acute effects on physical and mental health, including injury, unintended  
28 pregnancy, low fetal birth weight, preterm birth, disorders secondary to trauma, development of  
29 substance use disorders, and death by homicide<sup>10,11</sup>; and  
30

31 Whereas, Individuals who experience IPV have a 60% increased risk for asthma, 70% increased  
32 risk for heart disease, and 80% increased risk for stroke<sup>12</sup>; and  
33

34 Whereas, The healthcare-related costs due to IPV are estimated to be \$104,000 per female victim  
35 and \$23,000 per male victim, totaling to \$5.8 billion annually<sup>13,14</sup>; and  
36

37 Whereas, Lifetime economic burden from IPV for all survivors in the U.S. totals nearly \$3.6 trillion,  
38 which includes the financing of criminal justice proceedings and replacement of lost or damaged  
39 property<sup>13</sup>; and

1 Whereas, Survivors of IPV require sufficient funds to pay for frequent hospital and clinic visits,  
2 long-term treatment of physical and emotional injuries, mental health conditions, and substance  
3 use disorders, legal proceedings, childcare, and finding safety<sup>15</sup>; and  
4

5 Whereas, Job loss in the setting of IPV can propagate the cycle of violence, precipitating further  
6 reliance on the abuser for living expenses, childcare, and additional resources<sup>3,9,16</sup>; and  
7

8 Whereas, Close to 60% of IPV survivors report employment instability and job loss due to violence-  
9 related reasons, including but not limited to stigma, workplace discrimination due to the negative  
10 physical and mental effects of IPV, abuse recurrence, decreased productivity, and frequent  
11 absences<sup>3,16</sup>; and  
12

13 Whereas, 67% of those who have experienced or are experiencing IPV state that interactions with  
14 an abusive partner limited their ability to complete education or job training for future career  
15 growth, resulting in over 17% leaving the workforce<sup>3</sup>; and  
16

17 Whereas, On average, IPV survivors experience on average at least 7.2 days of lost productivity  
18 per year at work, leading to the loss of over 8 million days of paid work each year across all IPV  
19 survivors, thereby decreasing their chances of earning raises or promotions<sup>3,14</sup>; and  
20

21 Whereas, This loss in productivity and workforce attrition translates to an annual cost of over \$9.3  
22 billion to the United States<sup>14</sup>; and  
23

24 Whereas, 55% of companies do not have, publicize, or provide training for a workplace violence  
25 prevention policy offering protections in the event of IPV<sup>17</sup>; and  
26

27 Whereas, 33% of private sector jobs do not offer paid sick leave, and only 13% of jobs have paid  
28 family and medical leave<sup>18</sup>; and  
29

30 Whereas, A lack of access to paid leave causes employers and workers to lose \$22.5 billion  
31 annually in wages and profits<sup>20</sup>; and  
32

33 Whereas, Those who have experienced IPV remain more vulnerable to the detrimental  
34 consequences of lost wages from limited opportunities for paid leave, due to inability to afford daily  
35 costs of living and medical expenses<sup>18,20</sup>; and  
36

37 Whereas, Eleven states, including the District of Columbia, have enacted legislation offering “safe  
38 time provisions” that protect employees who are victims of IPV<sup>21,22</sup>; and  
39

40 Whereas, “Safe time provisions” encompass a list of employee rights emerging in the context of  
41 experienced violence, including but not limited to safe leave, protection from wrongful termination,  
42 and legal assistance stipends in the event of court proceedings<sup>21</sup>; and  
43

44 Whereas, Safe leave is defined as a period of paid or unpaid time allotted for physical, mental, and  
45 social healing from trauma relating to any form of violence, particularly IPV, stalking, and sexual  
46 harassment by non-partners<sup>22</sup>; and  
47

48 Whereas, Violence-related safe leave is distinct from personal medical or family leave in that it  
49 includes extended time for ensuring personal and familial safety from threat of abuse, protection  
50 from premature or wrongful termination of employment, stipends for legal aid, and connection to  
51 social work or supportive agencies that facilitate physical, mental, and social recovery<sup>22,23</sup>; and

1 Whereas, States, districts, and cities that have instituted paid or unpaid safe leave or paid family  
2 and medical leave policies inclusive of safe time provisions, including Sonoma, Seattle, New York,  
3 and Philadelphia, have not found negative economic effects, subsequent decreases in pay for  
4 other employees, or increases in unemployment<sup>18,21,22</sup>; and  
5

6 Whereas, Over \$1.1 billion could be saved in emergency department visits through paid safe  
7 leave, as its implementation increases the job and financial security of those experiencing IPV  
8 while decreasing dependence on the abuser<sup>20</sup>; and  
9

10 Whereas, The implementation of paid safe leave decreases the turnover of employees and  
11 healthcare costs for preventable conditions, simultaneously improving productivity and economic  
12 growth<sup>20,24</sup>; and  
13

14 Whereas, Survivors of IPV who had access to paid leave were better able to connect to family  
15 court, had increased job security, and retained greater protection against the recurrence of any  
16 harassment or abuse by current, former, or non-partners<sup>1,25</sup>; and  
17

18 Whereas, The AMA has policy (H-515.965) encouraging physicians to campaign against IPV and  
19 violence in all forms; and  
20

21 Whereas, The AMA has individual policies on family, medical, and sick leave (H-420.979, H-  
22 440.823), though they fall short of providing adequate time for the physical, emotional, and  
23 psychiatric healing required following an experience of IPV or non-partner sexual violence;  
24 therefore be it  
25

26 RESOLVED, That our American Medical Association recognize the positive impact of paid safe  
27 leave on public health outcomes and support legislation that offers paid and unpaid safe leave  
28 (New HOD Policy); and be it further  
29

30 RESOLVED, That our AMA amend policy H-420.979, "AMA Statement on Family and Medical  
31 Leave," to promote inclusivity by addition to read as follows:  
32

33 **AMA Statement on Family and Medical Leave, H-420.979**

34 Our AMA supports policies that provide employees with reasonable job security and  
35 continued availability of health plan benefits in the event leave by an employee becomes  
36 necessary due to documented medical conditions and/or concerns for safety. Such  
37 policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the  
38 employee, including pregnancy; (2) maternity leave for the employee-mother; (3) leave if  
39 medically appropriate to care for a member of the employee's immediate family, i.e., a  
40 spouse or children; ~~and~~ (4) leave for adoption or for foster care leading to adoption; and  
41 (5) safe leave provisions for those experiencing any instances of violence, including but  
42 not limited to intimate partner violence, sexual violence or coercion, and stalking. Such  
43 periods of leave may differ with respect to each of the foregoing classifications, and may  
44 vary with reasonable categories of employers. Such policies should encourage voluntary  
45 programs by employers and may provide for appropriate legislation (with or without  
46 financial assistance from government). Any legislative proposals will be reviewed through  
47 the Association's normal legislative process for appropriateness, taking into consideration  
48 all elements therein, including classifications of employees and employers, reasons for the  
49 leave, periods of leave recognized (whether paid or unpaid), obligations on return from  
50 leave, and other factors involved in order to achieve reasonable objectives recognizing the  
51 legitimate needs of employees and employers. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000

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## RELEVANT AMA POLICY

### Family and Intimate Partner Violence H-515.965

1. Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.

2. Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

3. The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (d) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (h) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (i) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.

4. Within the larger community, our AMA:

(a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.

(b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.

(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

5. With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of survivors' identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required;

(c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.

6. Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:

(a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.

(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.

(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.

(d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.

(e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence. CSA Rep. 7, I-00; Reaffirmed: CSAPH Rep. 2, I-09; Modified: CSAPH Rep. 01, A-19

#### **AMA Statement on Family and Medical Leave H-420.979**

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy; (2) maternity leave for the employee-mother; (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and (4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. BOT Rep. A, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: CMS Rep. 03, A-16

#### **Paid Sick Leave H-440.823**

Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; and (3) supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome. CMS Rep. 03, A-16; Reaffirmed: BOT Rep. 11, A-19

#### **Parental Leave H-405.954**

1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.

2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.

3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to

care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members.

4. Our AMA: (a) encourages key stakeholders to implement policies and programs that help protect against parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare; and (b) urges key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of health and childcare.

Citation: Res. 215, I-16; Appended: BOT Rep. 11, A-19; Appended: Res. 403, A-22;

### **Policies for Parental, Family and Medical Necessity Leave H-405.960**

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.

2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.

3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.

4. Our AMA encourages medical schools, residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.

5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.

6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.

7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

10. Physicians should be able to return to their practices or training programs after taking parental leave,

family leave, or medical leave without the loss of status.

11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.

13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

Citation: CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204  
(I-22)

Introduced by: Missouri  
Subject: Elimination of Seasonal Time Change  
Referred to: Reference Committee B

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- 1 Whereas, Multiple studies have demonstrated an increased risk for heart attacks, strokes, and  
2 fatal car crashes as negative health consequences of moving the clock forward in Spring for  
3 Daylight Savings Time; and  
4  
5 Whereas, The American Academy of Sleep Medicine officially recognizes Daylight Savings  
6 Time as a public health problem; and  
7  
8 Whereas, A survey of 2,000 adults found that 63% of people supported or strongly supported  
9 the elimination of a seasonal time change in favor of a national, fixed, year-round time, and only  
10 11% opposed; and  
11  
12 Whereas, Thirteen states in the past two years have written or enacted legislation to stay on  
13 one year-round time zone; therefore be it  
14  
15 RESOLVED, That our American Medical Association work with state medical associations to  
16 enact state legislation in support of remaining in the Standard Time Zone year-round (Directive  
17 to Take Action); and be it further  
18  
19 RESOLVED, That our AMA urge Congress to repeal the federal law establishing the annual  
20 advancement of time known as "Daylight Saving Time" and leave the U.S. on standard time  
21 year-round. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 09/07/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210  
(I-22)

Introduced by: Resident and Fellow Section

Subject: Elimination of Seasonal Time Changes and Establishment of Permanent Standard Time

Referred to: Reference Committee B

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- 1 Whereas, Originally conceived to conserve fuel and reduce power utilization, the annual switch  
2 to Daylight Savings Time (DST) has been practiced in the United States since 1918<sup>1</sup>; and  
3  
4 Whereas, For states that use DST, clocks typically “spring forward” one hour in March and then  
5 “fall back” one hour in November<sup>2</sup>; and  
6  
7 Whereas, The Uniform Time Act of 1966 established a system of uniform DST throughout the  
8 United States<sup>3</sup>; and  
9  
10 Whereas, Under federal law, states must currently obtain approval to adopt year-round DST<sup>1</sup>;  
11 and  
12  
13 Whereas, States choosing to observe year-round standard time, as Arizona and Hawaii do, are  
14 not subject to federal approval<sup>1</sup>; and  
15  
16 Whereas, In a response to an oil embargo, the US enacted a trial period of permanent DST  
17 from 1974-1975 in an attempt to conserve energy<sup>1</sup>; and  
18  
19 Whereas, Permanent DST proved unpopular in the 1970’s and was not ineffective in conserving  
20 oil, and federal law was changed to disallow permanent use of DST<sup>4,5</sup>; and  
21  
22 Whereas, The merits of using DST to reduce energy use are debatable<sup>2,4</sup>; and  
23  
24 Whereas, The controversy regarding DST has gained increasing notoriety and press coverage  
25 over the past several years with 18 states enacting legislation or passing resolutions to provide  
26 for permanent DST, should Congress eventually allow for such a change<sup>5</sup>; and  
27  
28 Whereas, On March 15, 2022, the US Senate passed the Sunshine Protection Act, which would  
29 move forward by one hour what is considered standard time within the US, effectively  
30 establishing the permanent use of Daylight Savings Time in November 2023<sup>6</sup>; and  
31  
32 Whereas, Under the Sunshine Protection Act, states would be forced to choose whether to  
33 operate either on standard or DST year-round<sup>5</sup>; and  
34  
35 Whereas, Studies have shown that the acute time change from standard time to DST has risks  
36 to the public health and safety, including increased risk of cardiovascular events, hospital  
37 admission, traffic fatalities, and medical errors<sup>8</sup>; and

1 Whereas, Most experts believe that standard time is more suited to the circadian rhythms of the  
2 human body than permanent DST<sup>7</sup>; and  
3

4 Whereas, Circadian misalignment has been associated with risks of depression, cardiovascular  
5 disease, metabolic syndrome<sup>8</sup>; and  
6

7 Whereas, The American Academy of Sleep Medicine has published a position statement in  
8 support of eliminating seasonal time changes and establishing year-round standard time<sup>7</sup>; and  
9

10 Whereas, A 2020 AASM survey found that 63% of adults support the elimination of seasonal  
11 time changes<sup>8</sup>; and  
12

13 Whereas, Our AMA has multiple policies related to fatigue and sleep, including H-15.958, H-  
14 135.932, and H-60.930; and  
15

16 Whereas, The stance of our AMA on this subject matter may prove influential in public policy  
17 deliberations; therefore be it  
18

19 RESOLVED, That our American Medical Association support the elimination of seasonal time  
20 changes (New HOD Policy); and be it further  
21

22 RESOLVED, That our AMA support the adoption of year-round standard time. (New HOD  
23 Policy)

Fiscal Note: Minimal – less than \$1,000

Received: 09/14/22

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#### RELEVANT AMA POLICY

##### **Fatigue, Sleep Disorders, and Motor Vehicle Crashes H-15.958**

Our AMA: (1) recognizes sleepiness behind the wheel as a major public health issue and continues to encourage a national public education campaign by appropriate federal agencies and relevant advocacy groups;

(2) recommends that the National Institutes of Health and other appropriate organizations support research projects to provide more accurate data on the prevalence of sleep-related disorders in the general population and in motor vehicle drivers, and provide information on the consequences and natural history of such conditions;

(3) recommends that the U.S. Department of Transportation (DOT) and other responsible agencies continue studies on the occurrence of highway crashes and other adverse occurrences in transportation that involve reduced operator alertness and sleep;

- (4) encourages continued collaboration between the DOT and the transportation industry to support research projects for the devising and effectiveness- testing of appropriate countermeasures against driver fatigue, including technologies for motor vehicles and the highway environment;
- (5) urges responsible federal agencies to improve enforcement of existing regulations for truck driver work periods and consecutive working hours and increase awareness of the hazards of driving while fatigued. If changes to these regulations are proposed on a medical basis, they should be justified by the findings of rigorous studies and the judgments of persons who are knowledgeable in ergonomics, occupational medicine, and industrial psychology;
- (6) recommends that physicians: (a) become knowledgeable about the diagnosis and management of sleep-related disorders; (b) investigate patient symptoms of drowsiness, wakefulness, and fatigue by inquiring about sleep and work habits and other predisposing factors when compiling patient histories; (c) inform patients about the personal and societal hazards of driving or working while fatigued and advise patients about measures they can take to prevent fatigue-related and other unintended injuries; (d) advise patients about possible medication-related effects that may impair their ability to safely operate a motor vehicle or other machinery; (e) inquire whether sleepiness and fatigue could be contributing factors in motor vehicle-related and other unintended injuries; and (f) become familiar with the laws and regulations concerning drivers and highway safety in the state(s) where they practice;
- (7) encourages all state medical associations to promote the incorporation of an educational component on the dangers of driving while sleepy in all drivers education classes (for all age groups) in each state.
- (8) recommends that states adopt regulations for the licensing of commercial and private drivers with sleep-related and other medical disorders according to the extent to which persons afflicted with such disorders experience crashes and injuries;
- (9) reiterates its support for physicians' use of E-codes in completing emergency department and hospital records, and urges collaboration among appropriate government agencies and medical and public health organizations to improve state and national injury surveillance systems and more accurately determine the relationship of fatigue and sleep disorders to motor vehicle crashes and other unintended injuries.
- Citation: CSA Rep. 1, A-96; Appended: Res. 418, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: CSAPH Rep. 01, A-19; Reaffirmation: A-22

### **Light Pollution: Adverse Health Effects of Nighttime Lighting H-135.932**

Our AMA:

1. Supports the need for developing and implementing technologies to reduce glare from vehicle headlamps and roadway lighting schemes, and developing lighting technologies at home and at work that minimize circadian disruption, while maintaining visual efficiency.
2. Recognizes that exposure to excessive light at night, including extended use of various electronic media, can disrupt sleep or exacerbate sleep disorders, especially in children and adolescents. This effect can be minimized by using dim red lighting in the nighttime bedroom environment.
3. Supports the need for further multidisciplinary research on the risks and benefits of occupational and environmental exposure to light-at-night.
4. That work environments operating in a 24/7 hour fashion have an employee fatigue risk management plan in place.

Citation: CSAPH Rep. 4, A-12; Reaffirmation: A-22; Reaffirmed: CSAPH Rep. 1, A-2

### **Insufficient Sleep in Adolescents H-60.930**

1. Our AMA identifies adolescent insufficient sleep and sleepiness as a public health issue and supports education about sleep health as a standard component of care for adolescent patients.
2. Our AMA: (a) encourages school districts to aim for the start of middle schools and high schools to be no earlier than 8:30 a.m., in order to allow adolescents time for adequate sleep; (b) encourages physicians, especially those who work closely with school districts, to become actively involved in the education of parents, school administrators, teachers, and other members of the community to stress the importance of sleep and consequences of sleep deprivation among adolescents, and to encourage school districts to structure school start times to accommodate the biologic sleep needs of adolescents; and (c) encourages continued research on the impact of sleep on adolescent health and academic performance.

Citation: Res. 503, A-10; Appended: CSAPH Rep. 06, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212  
(I-22)

Introduced by: Medical Student Section

Subject: SNAP Expansion for DACA Recipients

Referred to: Reference Committee B

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- 1 Whereas, The policy known as Deferred Action for Childhood Arrivals (DACA) has allowed  
2 undocumented immigrants brought to the US as minors to remain in this country, receive work  
3 authorization, and participate in the Social Security Program<sup>1</sup>; and  
4
- 5 Whereas, As of 2021 there were 649,070 active DACA recipients in the US<sup>1</sup>; and  
6
- 7 Whereas, The Department of Homeland Security considers more than 200,000 DACA recipients  
8 as “essential critical infrastructure workers” contributing to the fields of health care, education,  
9 and food-related industries<sup>2</sup>; and  
10
- 11 Whereas, Data provided by the Department of Homeland Security showed an estimated 96% of  
12 DACA recipients were born in the Caribbean and Latin American countries<sup>3</sup>; and  
13
- 14 Whereas, An estimated range of 30 to 60% of immigrants in the US report food insecurity, and  
15 the largest and fastest growing subgroup is foreign-born Latinxs as compared to US-born non-  
16 Latinx Whites<sup>4</sup>; and  
17
- 18 Whereas, Food insecurity is defined by the US Department of Agriculture (USDA) as a  
19 household-level economic and social condition of limited or uncertain access to adequate food<sup>5</sup>;  
20 and  
21
- 22 Whereas, DACA recipients’ ineligibility for federal aid increases risk for food insecurity while  
23 complicating budgeting and meal preparation<sup>6</sup>; and  
24
- 25 Whereas, DACA recipients viewed affordable food as unhealthy and limited their intake in order  
26 to obtain healthier food<sup>6</sup>; and  
27
- 28 Whereas, Children of immigrant Latinx mothers are at the greatest risk for food insecurity and  
29 this population comprises much of the DACA program<sup>7</sup>; and  
30
- 31 Whereas, The expansion of immigration enforcement has been associated with increased food  
32 insecurity among Latinx immigrant families<sup>8</sup>; and  
33
- 34 Whereas, The percentage of families reporting very low food security has increased by 20%  
35 since the COVID-19 pandemic began<sup>9</sup>; and  
36
- 37 Whereas, A 2019 study estimated that the median county-level cost of healthcare associated  
38 with food insecurity was \$4,433,000 per year<sup>10</sup>; and

1 Whereas, Undocumented immigrants in the United States contribute an estimated \$11.6 billion  
2 taxes annually, but they remain largely ineligible for public benefits including social security and  
3 SNAP<sup>11</sup>; and  
4

5 Whereas, The Supplemental Nutrition Assistance Program (SNAP) is the most important tool  
6 used in the US to alleviate food insecurity and its subsequent negative health consequences<sup>12</sup>;  
7 and  
8

9 Whereas, SNAP participation is associated with economic benefits including lower healthcare  
10 costs<sup>13</sup>; and  
11

12 Whereas, US Citizenship and Immigration services reports that California has a DACA  
13 population of 183,460, as of March 2020<sup>14</sup>; and  
14

15 Whereas, In 2021, California state legislators proposed opening the state-funded food stamp  
16 program to all income-eligible Californians, regardless of immigration status, which would cost  
17 about \$550 million a year<sup>15</sup>; and  
18

19 Whereas, The food pantry system was initially designed to serve only during emergency  
20 scenarios to address starvation<sup>16</sup>; and  
21

22 Whereas, People with very low food security who rely on food pantries have a significantly  
23 higher incidence of obesity often attributed to acquired foods that are high in sodium and sugar,  
24 while low in fiber, vitamins, and minerals<sup>17</sup>; and  
25

26 Whereas, food pantry recipients are shown to have insufficient intake of up to 16 different key  
27 nutrients such as calcium, potassium, and fiber<sup>18</sup>; and  
28

29 Whereas, Those with food insecurity incur greater health care expenditures resulting in an  
30 additional \$77.5 billion in healthcare spending annually<sup>19</sup>; therefore be it  
31

32 RESOLVED, That our American Medical Association actively support expansion of SNAP to  
33 Deferred Action Childhood Arrivals (DACA) recipients who would otherwise qualify. (Directive to  
34 Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 09/20/22

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## RELEVANT AMA POLICY

### Opposition to Regulations that Penalize Immigrants for Accessing Health Care Services D-440.927

Our AMA will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition.

Res. 254, A-18

### Improvements to Supplemental Nutrition Programs H-150.937

(1)Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.(2) Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC. (3) Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.

Res. 414, A-10, Reaffirmation A-12, Reaffirmation A-13, [Appended: CSAPH Rep. 1, I-13](#), Reaffirmation A-14, Reaffirmation I-14, Reaffirmation A-15, [Appended: Res. 407, A-17, Appended: Res. 233, A-18](#)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301  
(I-22)

Introduced by: Resident and Fellow Section

Subject: Increasing Musculoskeletal Education in Primary Care Specialties and  
Medical School Education Through Inclusion of Osteopathic Manual Therapy  
Education

Referred to: Reference Committee C

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- 1 Whereas, According to the American Osteopathic Association, osteopathic manipulative  
2 medicine/treatment (OMM/OMT) is special training for the musculoskeletal system that doctors  
3 of osteopathy receive to provide care that involves using the hands to diagnose, treat, and  
4 prevent illness or injury; and  
5  
6 Whereas, The evidence basis for OMT is quite broad and spans many disease processes and  
7 organ systems and supports its use as an adjunct treatment in a variety of conditions; and  
8  
9 Whereas, In order to train residents in osteopathic practice and principles (OPP) and  
10 osteopathic manipulative treatment (OMT), faculty must be available and qualified; and  
11  
12 Whereas, Osteopathic Recognition (OR) is a “designation conferred by the ACGME’s  
13 Osteopathic Principles Committee upon ACGME-accredited programs that demonstrate,  
14 through a formal application process, the commitment to teaching and assessing Osteopathic  
15 Principles and Practice (OPP) at the graduate medical education level”; and  
16  
17 Whereas, Programs must meet criteria laid out by that committee and apply for recognition<sup>1</sup>;  
18 and  
19  
20 Whereas, Residents in a recognized program must be assessed for OPP knowledge and “skill  
21 proficiency in OMT as applicable to [their] specialty”<sup>2</sup>; and  
22  
23 Whereas, As of the 2021-2022 academic year there are approximately 250 PGY-1 GME  
24 programs with osteopathic recognition out of the 4,780 available programs (roughly 5%)<sup>11</sup>;  
25 therefore be it  
26  
27 RESOLVED, That our American Medical Association continue to support equal treatment of  
28 osteopathic students, trainees and physicians in the residency application cycle and workplace  
29 through continued education on the training of osteopathic physicians (New HOD Policy); and  
30 be it further  
31  
32 RESOLVED, That our AMA encourage education on the benefits of evidence-based  
33 Osteopathic Manual Therapy for musculoskeletal conditions in medical education of allopathic  
34 students and in primary care residencies. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 09/14/22

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2. Miller T, Jarvis J, Waterson Z, Clements D, Mitchell K. Osteopathic Recognition: When, What, How and Why? *Ann Fam Med*. 2017;15(1):91-91.
3. ACGME - Accreditation Data System (ADS). <https://apps.acgme.org/ads/Public/Reports>. Accessed April 11, 2022.

#### RELEVANT AMA POLICY

##### **Definition of a Physician H-405.969**

1. The AMA affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine. 2. AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree. 3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign. Citation: CME Rep. 4-A-94; Reaffirmed by Sub. Res. 712, I-94; Reaffirmed and Modified: CME Rep. 2, A-04; Res. 846, I-08; Reaffirmed in lieu of Res. 235, A-09; Reaffirmed: Res. 821, I-09; Appended: BOT Rep. 9, I-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-13; Reaffirmation A-15; Reaffirmed in lieu of: Res. 225, A-17; Reaffirmed: Res. 228, A-19

##### **Definition and Use of the Term Physician H-405.951**

Our AMA: 1. Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency. 2. Will, in conjunction with the Federation, aggressively advocate for the definition of physician to be limited as defined above: a. In any federal or state law or regulation including the Social Security Act or any other law or regulation that defines physician; b. To any federal and state legislature or agency including the Department of Health and Human Services, Federal Aviation Administration, the Department of Transportation, or any other federal or state agency that defines physician; and c. To any accrediting body or deeming authority including the Joint Commission, Health Facilities Accreditation Program, or any other potential body or authority that defines physician. 3. Urges all physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and to not let the term physician be used by any other organization or person involved in health care. 4. Ensure that all references to physicians by government, payers, and other health care entities involving contracts, advertising, agreements, published descriptions, and other communications at all times distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term provider. 5. Policy requires any individual who has direct patient contact and presents to the patient as a doctor, and who is not a physician, as defined above, must specifically and simultaneously declare themselves a non-physician and define the nature of their doctorate degree. 6. Will review and revise its own publications as necessary to conform with the House of Delegates' policies on physician identification and physician reference and will refrain from any definition of physicians as providers that is not otherwise covered by existing Journal of the American Medical Association (JAMA) Editorial Governance Plan, which protects the editorial independence of JAMA. 7. Actively supports the Scope of Practice Partnership in the Truth in Advertising campaign  
Citation: Res. 214, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603  
(1-22)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: AMA House of Delegates Resolution Process Review

Referred to: Reference Committee F

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1 Whereas, Submission of resolutions as items of business is an important process at our AMA  
2 House of Delegates (HOD); and  
3  
4 Whereas, The number of resolutions submitted has increased over time; and  
5  
6 Whereas, The rules for submission of resolutions have not been changed in many years  
7 including definitions for on time, late and emergency resolutions; and  
8  
9 Whereas, There are multiple exceptions to the “on time” resolution definition including  
10 resolutions from AMA sections and societies who meet after the “on time” deadline; and  
11  
12 Whereas, The Saturday/Sunday tote contains a significant amount of new resolutions each  
13 year; and  
14  
15 Whereas, The resolutions in the Saturday/Sunday tote cannot be adequately reviewed and  
16 vetted by all delegations and delegation staff; and  
17  
18 Whereas, For the past 2 years, all delegations and sections have met virtually and have been  
19 able to work asynchronously to discuss and vote on potential resolutions to submit to the AMA  
20 HOD; and  
21  
22 Whereas, According to Bylaws 2.11.3.1, “To be considered as regular business, each resolution  
23 must be introduced by a delegate or organization represented in the House of Delegates and  
24 must have been submitted to the AMA not later than 30 days prior to the commencement of the  
25 meeting at which it is to be considered”; and  
26  
27 Whereas, According to Bylaws 2.11.3.1.3, “Late resolutions may be presented by a delegate  
28 prior to the recess of the opening session of the House of Delegates, and will be accepted as  
29 business of the House of Delegates only upon two-thirds vote of delegates present and voting”;  
30 and  
31  
32 Whereas, According to Bylaws 2.11.3.1.4 Emergency Resolutions, “resolutions of an  
33 emergency nature may be presented by a delegate any time after the opening session of the  
34 House of Delegates is recessed. Emergency resolutions will be accepted as business only upon  
35 a three-fourths vote of delegates present and voting, and if accepted shall be presented to the  
36 House of Delegates without consideration by a reference committee. A simple majority vote of  
37 the delegates present and voting shall be required for adoption”; and

- 1 Whereas, The ability to meet virtually and work asynchronously has been enhanced during the  
2 pandemic to the point where it is potentially more efficient and convenient for delegations and  
3 sections; therefore be it  
4
- 5 RESOLVED, That our American Medical Association review the entire process of resolution  
6 submission including re-evaluating the definitions of “on time,” late, and emergency resolutions  
7 and current exceptions with a report back at the Interim 2023 meeting (Directive to Take Action);  
8 and be it further  
9
- 10 RESOLVED, That the review committee consider changing the policy so that all on time  
11 resolutions must be submitted to the HOD by the same deadlines so that the only resolutions in  
12 the Saturday/Sunday tote would be emergency and late resolutions to be voted on for  
13 acceptance by the HOD (Directive to Take Action); and be it further  
14
- 15 RESOLVED, That the review committee consider changing the rule so that all sections of the  
16 AMA will submit their “on time” resolutions by the same deadlines as the rest of the HOD, with  
17 only emergency resolutions to be submitted after Section meetings during the week before the  
18 annual or interim meetings (Directive to Take Action); and be it further  
19
- 20 RESOLVED, That our AMA facilitate virtual meetings of the sections prior to the resolution  
21 deadline so that all resolutions can be submitted, reviewed, and discussed prior to the deadline.  
22 (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000

Received: 09/28/22

**References:**

AMA Constitution and Bylaws: <https://www.ama-assn.org/system/files/ama-constitution-and-bylaws.pdf>

**RELEVANT AMA POLICY**

**House of Delegates**

**Procedure. B-2.11**

**2.11.1** Order of Business. The Order of Business will be proposed by the Speaker and approved by the House of Delegates.

At any meeting, the House of Delegates, by majority vote, may change the order of business.

**2.11.2** Privilege of the Floor. The House of Delegates, by a two-thirds vote of delegates present and voting, may extend to any person an invitation to address the House.

**2.11.3** Introduction of Business.

**2.11.3.1** Resolutions. To be considered as regular business, each resolution must be introduced by a delegate or organization represented in the House of Delegates and must have been submitted to the AMA not later than 30 days prior to the commencement of the meeting at which it is to be considered, with the following exceptions.

**2.11.3.1.1** Exempted Resolutions. If any member organization's house of delegates or primary policy making body, as defined by the organization, adjourns during the 5-week period preceding commencement of an AMA House of Delegates meeting, the organization is allowed 7 days after the close of its meeting to submit resolutions to the AMA. All such resolutions must be received by noon of the day before the commencement of the AMA House of Delegates meeting. The presiding officer of the organization shall certify that the resolution was adopted at its just concluded meeting and that the body directed that the resolution be submitted to the AMA House of Delegates.

**2.11.3.1.2** AMA Sections. Resolutions presented from the business meetings of the AMA Sections may be presented for consideration by the House of Delegates no later than the recess of the House of Delegates opening session to be accepted as regular business.

Resolutions presented after the recess of the opening session of the House of Delegates will be accepted in accordance with Bylaw 2.11.3.1.4.

**2.11.3.1.3** Late Resolutions. Late resolutions may be presented by a delegate prior to the recess of the opening session of the House of Delegates, and will be accepted as business of the House of Delegates only upon two-thirds vote of delegates present and voting.

**2.11.3.1.4** Emergency Resolutions. Resolutions of an emergency nature may be presented by a delegate any time after the opening session of the House of Delegates is recessed. Emergency resolutions will be accepted as business only upon a three-fourths vote of delegates present and voting, and if accepted shall be presented to the House of Delegates without consideration by a reference committee. A simple majority vote of the delegates present and voting shall be required for adoption.

**2.11.3.1.5** Withdrawal of Resolutions. A resolution may be withdrawn by its sponsor at any time prior to its acceptance as business by the House of Delegates.

**2.11.3.1.6** Resolutions not Accepted. Late resolutions and emergency resolutions not accepted as business by the House of Delegates may be submitted for consideration at a future meeting in accordance with the procedure in Bylaw 2.11.3.

**2.11.3.2** Business from the Board of Trustees. Reports, recommendations, resolutions or other new business, may be presented by the Board of Trustees at any time during a meeting. Items of business presented before the recess of the opening session of the House of Delegates will be accepted as regular business. Items of business presented after the recess of the opening session of the House of Delegates will be accepted as emergency business and shall be presented to the House of Delegates without consideration by a reference committee. A two-thirds vote of the delegates present and voting shall be required for adoption.

**2.11.3.3** Business from the Councils. Reports, opinions or recommendations from a council of the AMA or a special committee of the House of Delegates may be presented at any time during a meeting. Items of business presented before the recess of the opening session of the House of Delegates will be accepted as regular business. Items of business presented after the recess of the opening session of the House of Delegates will be accepted as emergency business and shall be presented to the House of Delegates without consideration by a reference committee. A two-thirds vote of the delegates present and voting shall be required for adoption.

**2.11.3.4** Informational Reports of Sections. Informational reports may be presented by the AMA Sections on an annual basis.

**2.11.4** Referral to Reference Committee. Reports, recommendations, resolutions or other new business presented prior to the recess of the opening session of the House of Delegates shall be referred to an appropriate reference committee for hearings and report, subject to acceptance as business of the House of Delegates. Items of business presented after the recess of the opening session are not referred to reference committee, but rather heard by the House of Delegates as a whole, subject to acceptance as business of the House of Delegates. Informational items are not referred to a reference committee.

**2.11.6** Quorum. A majority of the voting members of the House of Delegates Official Call shall constitute a quorum.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604  
(I-22)

Introduced by: Resident and Fellow Section

Subject: Solicitation Using the AMA Brand

Referred to: Reference Committee F

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1 Whereas, Some physicians are turned off by third party solicitation material mailed with the  
2 AMA brand, such as regarding disability insurance or student loan refinancing, potentially  
3 harming the AMA's reputation and costing physician membership; and  
4

5 Whereas, Financial literacy websites such as White Coat Investor detail the flaws in the AMA  
6 branded third party disability insurance plan<sup>1</sup>; and  
7

8 Whereas, There is a financial and environmental cost to printed solicitation; and  
9

10 Whereas, Associating the AMA brand to specific third-party products may or may not be in the  
11 best interest of the AMA or current and potential AMA members; therefore be it  
12

13 RESOLVED, That our American Medical Association study the use of AMA branded solicitation  
14 material mailed to physicians, the impact it has on the perception of our AMA by current and  
15 potential physician members, and the merits of continuing to use these materials in future  
16 communications (Directive to Take Action); and be it further  
17

18 RESOLVED, That our AMA study our membership on the preferred method to receive third  
19 party solicitation material (mail, phone, email, social media) and provide a method to opt-out of  
20 certain methods if not desired. (Directive to Take Action)

Fiscal Note: Minimal – less than \$1,000

Received: 09/30/22

**References:**

1. [AMA's Disability Insurance: You Get What You Pay For - White Coat Investor](#)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 901  
(I-22)

Introduced by: Medical Student Section

Subject: Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies

Referred to: Reference Committee K

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- 1 Whereas, While imprisoned, able-bodied incarcerated people are often required to work and  
2 assigned duties if they have not already identified a job for themselves<sup>1</sup>; and  
3  
4 Whereas, Incarcerated people can work in a variety of positions<sup>4</sup>; and  
5  
6 Whereas, Refusal to perform involuntary prison labor can be punished through various means,  
7 including solitary confinement, revocation of family visitation, loss of earned “good behavior”  
8 time<sup>2,3</sup>; and  
9  
10 Whereas, Work programs operate in 88% of prisons in the United States and employ  
11 approximately 775,000 prisoners<sup>5</sup>; and  
12  
13 Whereas, The prison system was hit especially hard during the initial waves of the COVID-19  
14 pandemic in 2020 and since the primary defense against infection is vaccines, which did not  
15 reach incarcerated people until 2021, and given prisons’ notoriously crowded environments,  
16 COVID-19 rates in prisons soared<sup>6</sup>; and  
17  
18 Whereas, Staff shortages during this time meant that there were also fewer nurses and guards  
19 to ensure the incarcerated people’s health and physical well-being<sup>7</sup>; and  
20  
21 Whereas, Despite the infection rates, many prison systems did not follow protocols to prevent  
22 the spread of COVID-19 and still expected incarcerated workers to work in similar conditions to  
23 those prior to the pandemic<sup>8</sup>; and  
24  
25 Whereas, For example, in the Washington Department of Corrections (WDOC), the prison  
26 managers did not enforce post-exposure isolation and did not provide adequate hand sanitizer  
27 or social distancing measures<sup>8</sup>; and  
28  
29 Whereas, California also kept their prison factories running through the pandemic, even as  
30 infection rates rose, and incarcerated people report being threatened that their chances for  
31 release from prison would be put into jeopardy if they refused to attend work because of  
32 COVID-19 safety concerns because although prison representatives report that adequate  
33 measures to address COVID-19 were put into place, interviews from across the United States  
34 show otherwise<sup>9,10</sup>; and  
35  
36 Whereas, As of February 10th, 2022, more than 476,000 people incarcerated in prisons have  
37 had confirmed cases of COVID-19 and over 2,900 people have died from COVID-19 behind  
38 bars<sup>11</sup>; and

1 Whereas, During the COVID-19 pandemic, prison labor was used to assist front line workers in  
2 a national response<sup>12</sup>; and  
3

4 Whereas, States such as New York, Missouri, Louisiana, and others, made use of this prison  
5 labor to quickly and cheaply make needed products and prisoners were forced to make  
6 products used by front-line workers such as hand sanitizer, gowns, masks and even products  
7 such as toilet paper, which did not benefit first responders directly, were produced by these  
8 workers and wages for this work were far below minimum wage, but many were not paid at all;  
9 and  
10

11 Whereas, The prison-workplaces did not implement social distancing measures on par with  
12 equivalent workplaces in non-carceral settings; and  
13

14 Whereas, The Occupational Safety and Health Act of 1970 (OSH Act) requires that employers  
15 provide employees with safe working conditions that are free of serious recognized hazards and  
16 in compliance with Occupational Safety and Health Administration (OSHA)'s safety and health  
17 standards<sup>13</sup>; and  
18

19 Whereas, In addition to an employer's "general duty" to provide a safe workplace, OSHA sets in  
20 place specific safety standards for certain workplaces, such as providing personal protective  
21 equipment (PPE) and limiting exposure to toxic substances such as lead and asbestos and  
22 OSHA can inspect private workplaces and workers can file complaints with OSHA regarding  
23 unsafe working conditions with protection against retaliation; and  
24

25 Whereas, However, the definition of "employer" in the OSH Act specifically excludes States and  
26 political subdivisions of States - meaning that federal and state prisons employing prisoners are  
27 exempted from the OSH Act<sup>14</sup>; and  
28

29 Whereas, In federal prisons, the Bureau of Prisons [provides](#) health and safety requirements for  
30 incarcerated workers through its occupational health and safety program<sup>15</sup>; and  
31

32 Whereas, This policy [includes](#) annual safety [training](#) for incarcerated workers, [investigations](#) into  
33 work-related injuries, and [compensation](#) for lost wages due to workplace injuries while injury  
34 compensation, is [restricted](#) to individuals working through the [Federal Prison Industries](#) and  
35 work assignments related to the maintenance of the facility; and  
36

37 Whereas, For state prison workers, safety standards are left to the discretion of the state, with  
38 some states not granting many protections at all<sup>14,16</sup>; and  
39

40 Whereas, For example, Pennsylvania provides compensation for lost wages for inmate workers  
41 who suffer work-related injuries, while Texas explicitly [excludes](#) incarcerated workers from  
42 receiving work-related injury compensation in their statute while in another example, the  
43 California Prison Industry Authority (CALPIA) is a state agency that oversees the prison work  
44 programs in the country's second largest prison system<sup>17</sup>; and  
45

46 Whereas, In California, inmate workers cannot receive workers' compensation while still  
47 incarcerated. Furthermore, the shortage of federal regulations has led to a lack of data related  
48 to workplace conditions and injuries in corrections facilities and for policymakers to understand  
49 the full extent of existing workplace safety standards in prisons, there must be a standard of  
50 reporting<sup>18</sup>; and

1 Whereas, The issue of prison labor is an ethically nuanced topic with multiple points to consider.  
2 There are benefits to providing incarcerated people with jobs, such as providing them a sense of  
3 community and purpose because participating in meaningful work can help develop professional  
4 skills that can benefit them once released and these jobs also potentially help incarcerated  
5 people earn money to support themselves while incarcerated and after release; and  
6

7 Whereas, Prison labor can be ethically appropriate when done in the best interest of the  
8 prisoner without coercion or influence from exploitative purposes and incarcerated people must  
9 be fairly compensated for their work to avoid said exploitation and provide them meaningful  
10 resources as a result; and  
11

12 Whereas, While it has been the policy to have imprisoned individuals do dangerous tasks, such  
13 as working in crowded environments during the COVID-19 pandemic, at times it has been done  
14 with inadequate protection and in the case of a pandemic, decreased protection due to  
15 inadequate PPE and work conditions inconsistent with guidelines from the CDC and NIH would  
16 constitute exploitative labor in addition to prisoners working in prisons where there was a  
17 statistically higher level of COVID cases throughout the course of the pandemic, leading to a  
18 five-fold greater risk of infection and 30% greater risk of death from infection compared to the  
19 general population<sup>19</sup>; and  
20

21 Whereas, Further, incarcerated people are often not protected by regulatory health and safety  
22 standards, such as OSHA, practiced in the non-incarcerated context and without these  
23 regulatory mechanisms, it is difficult to ascertain the extent of dangerous working conditions in  
24 prisons and offer avenues for recourse for unsafe working conditions; and  
25

26 Whereas, If the work being done by prisoners could be considered “essential” then they too  
27 would be owed increased compensation<sup>20</sup>; and  
28

29 Whereas, Whether wildfires or a pandemic, no emergency justifies labor exploitation of a  
30 population made vulnerable by the state, and any need for labor must also offer fair  
31 compensation, preferential benefits (such as official certification and paths to further job  
32 opportunities), and of course safety guarantees that are satisfactory with standard workplace  
33 safety laws and regulatory bodies<sup>21,22</sup>; and  
34

35 Whereas, Current AMA policy sets a strong precedent for protecting incarcerated populations  
36 from communicable diseases and has advocated for stronger protections for incarcerated  
37 populations against COVID-19 during the early stages of the pandemic when outbreaks in  
38 prisons were commonplace; and  
39

40 Whereas, The AMA advocates for safe working conditions for all people through OSHA  
41 regulation (D-135.935, D-135.974, H-135.935, H-490.413) and acknowledges that people who  
42 are incarcerated are a vulnerable population (H-430.986); and  
43

44 Whereas, The AMA supports access to healthcare while incarcerated, programs to help  
45 incarcerated people transition to care once released, and promotes acceptable living conditions  
46 (H-430.986, H-430.997); and  
47

48 Whereas, While current policy addresses the need for healthcare and acknowledges exposure  
49 risks related to incarceration itself, there is not a clear policy advocating for protection against  
50 work-related exposures while incarcerated because clear gap in policy exists and AMA  
51 advocacy could meaningfully improve prison workplace conditions to prevent further exploitation  
52 of incarcerated peoples; therefore be it

- 1 RESOLVED, That our American Medical Association oppose the use of forced or coercive labor  
2 practices for incarcerated populations (New HOD Policy); and be it further  
3  
4 RESOLVED, That our AMA support that any labor performed by incarcerated individuals or  
5 other captive populations should include adequate workplace safety and fairness standards  
6 similar to those outside of carceral institutions and support their reintegration into the workforce  
7 after incarceration. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

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## **RELEVANT AMA POLICY**

### **Support Stricter OSHA Silica Permissible Exposure Limit Standard D-135.974**

Our AMA: (1) supports the Department of Labor's Occupational Safety and Health Administration's (OSHA's) proposed rule to establish a stricter permissible exposure limit (PEL) for respirable crystalline silica; (2) supports OSHA's proposed rule to establish a stricter standard of exposure assessment and medical surveillance requirements to identify adverse health effects in exposed populations of workers; and (3) will submit comments, in collaboration with respiratory and occupational health medical societies, in support of a stricter silica PEL.

Res. 916, I-13

### **Advocating for Heat Exposure Protections for All Workers D-135.967**

Our AMA: (1) will advocate for all workers to have access to preventive cool-down rest periods in shaded, ventilated, and/or cooled areas for prevention of injury from sun exposure and heat injury as well as appropriate access to emergency services when signs and symptoms of heat exposure injury; (2) will advocate for legislation that creates federal standards for protections against heat stress and sun exposure specific to the hazards of the workplace; (3) supports policy change at the federal level via legislation or administrative rule changes by the Occupational Safety and Health Administration (OSHA) that would require that workers receive health educational materials about prevention and recognition of heat exhaustion and heat exposure injury that is in the worker's primary language; (4) will work with the United States Department of Labor, OSHA, and other appropriate federal stakeholders to develop and enforce evidence-based policies, guidelines, and protections against heat injury for workers independent of legal status; and (5) recognizes there are particular medical conditions and medications, including but not limited to psychotropics, which increase an individual's vulnerability to the negative impacts of heat and sun exposure and advocate for recognition of this, as well as additional protections as part of any guidelines, legislation or other policies.

Res. 502, I-21

### **OSHA Standards for Lead H-135.935**

Our AMA will advocate with American College of Occupational and Environmental Medicine and other professional organizations to change the Occupational Safety & Health Administration legal standard for temporary medical removal from all lead work environments, regardless of the airborne lead concentrations, which result in workers' blood lead levels exceeding 20 mcg/dL on any two consecutive blood tests, or any single value exceeding 30 mcg/dL, as recommended by a subgroup of an expert panel convened by the Association of Occupational and Environmental Clinics (2007) and by Cal/OSHA (2009).

Res. 423, A-10, Reaffirmed: CSAPH Rep. 01, A-20

### **Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional and Detention Facilities H-430.979**

1. Our AMA, in collaboration with state and national medical specialty societies and other relevant stakeholders, will advocate for the improvement of conditions of incarceration in all correctional and immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance.
2. Our AMA will advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities.
3. Our AMA will advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens.
4. Our AMA supports expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities.
5. Our AMA recognizes that detention center and correctional workers, incarcerated persons, and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation.
6. Our AMA will advocate: (a) for all employees working in a correctional facility or detention center to be up to date with vaccinations against COVID-19, unless there is a valid medical contraindication; (b) for all employees working in a correctional facility or detention center, not up to date with vaccination for COVID-19 to be COVID rapid tested each time they enter a correctional facility or detention center, as consistent with Centers for Disease Control and Prevention (CDC) or local public health guidelines; (c) for correctional facility or detention center policies that require non-employed, non-residents (e.g. visitors, contractors, etc.) to either show evidence of being up to date for COVID-19 vaccines or show proof of a negative COVID test when they enter a correctional facility or detention center as consistent with CDC or local public health guidelines, at no cost to

the visitor; (d) that all people inside a correctional facility or detention center wear an appropriate mask at all times, except while eating or drinking or at a 6 ft. distance from anyone else if local transmission rate is above low risk as determined by the CDC; and (e) that correctional facilities or detention centers be able to request and receive all necessary funding for COVID-19 vaccination and testing, according to CDC or local public health guidelines.

Alt. Res. 404, I-20, Appended: Res. 406, A-22

#### **Health Care While Incarcerated H-430.986**

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the “inmate exclusion” of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community; (c) the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and (d) collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.
11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children’s Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.

CMS Rep. 02, I-16, Appended: Res. 417, A-19, Appended: Res. 420, A-19, Modified: Res. 216, I-19, Modified: Res. 503, A-21, Reaffirmed: Res. 229, A-21, Modified: Res. 127, A-22

#### **Standards of Care for Inmates of Correctional Facilities H-430.997**

Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance use disorder care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.

Res. 60, A-84, Reaffirmed by CLRPD Rep. 3 - I-94, Amended: Res. 416, I-99, Reaffirmed: CEJA Rep. 8, A-09, Reaffirmation I-09, Modified in lieu of Res. 502, A-12, Reaffirmation: I-12, Modified: CSAPH Rep. 1, A-22

**Smoke-Free and Vape-Free Environments and Workplaces H-490.913**

On the issue of the health effects of environmental tobacco smoke (ETS), passive smoke, and vape aerosol exposure in the workplace and other public facilities, our AMA: (1) (a) supports classification of ETS as a known human carcinogen; (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease; (c) encourages physicians and medical societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry; and (d) encourages the concept of establishing smoke-free and vape-free campuses for business, labor, education, and government; (2) (a) honors companies and governmental workplaces that go smoke-free and vape-free; (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking and vaping in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of ETS in the workplace, preferably by banning smoking and vaping in the workplace; (c) encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking and vaping around the public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces; and (d) will update draft model state legislation to prohibit smoking and vaping in public places and businesses, which would include language that would prohibit preemption of stronger local laws; (3) (a) encourages state medical societies to: (i) support legislation for states and counties mandating smoke-free and vape-free schools and eliminating smoking and vaping in public places and businesses and on any public transportation; (ii) enlist the aid of county medical societies in local anti-smoking and anti-vaping campaigns; and (iii) through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking and anti-vaping coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking and anti-vaping control measures; (b) urges all restaurants, particularly fast food restaurants, and convenience stores to immediately create a smoke-free and vape-free environment; (c) strongly encourages the owners of family-oriented theme parks to make their parks smoke-free and vape-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy life style for children; (d) encourages state or local legislation or regulations that prohibit smoking and vaping in stadia and encourages other ball clubs to follow the example of banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others; (e) urges eliminating cigarette, pipe and cigar smoking and vaping in any indoor area where children live or play, or where another person's health could be adversely affected through passive smoking inhalation; (f) urges state and county medical societies and local health professionals to be especially prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a nonsmoking or non-vaping ordinance is introduced and to become directly involved in community tobacco control activities; and (g) will report annually to its membership about significant anti-smoking and anti-vaping efforts in the prohibition of smoking and vaping in open and closed stadia; (4) calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking and no vaping policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking and vaping in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts; (5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking, vaping, and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools; (6) will work with the Department of Defense to explore ways to encourage a smoke-free and vape-free environment in the military through the use of mechanisms such as health education, smoking and vaping cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities; and (7) collaborates with local and state medical societies and tobacco control coalitions to work with (a) Native American casino and tribal leadership to voluntarily prohibit smoking and vaping in their casinos; and (b) legislators and the gaming industry to support the prohibition of smoking and vaping in all casinos and gaming venues.

CSA Rep. 3, A-04, Appended: Sub. Res. 426, A-04, Modified: CSAPH Rep. 1, I-07, Reaffirmation I-14, Reaffirmation I-15, Modified: Res. 902, I-19, Modified: Res. 417, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 903  
(1-22)

Introduced by: Medical Student Section

Subject: Supporting Further Study of Kratom

Referred to: Reference Committee K

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1 Whereas, *Mitragyna speciosa* is a plant species commonly known as “Kratom” which is  
2 characterized by analgesic, anxiolytic, and stimulatory properties depending on the strain and  
3 dose, and is commonly used in Southeast Asia as a remedy for common ailments such as fever  
4 and cough, as a stimulant to combat fatigue, and as a social drink<sup>1-3</sup>; and

5  
6 Whereas, Kratom acts on mu-opioid receptors to produce analgesia and euphoria<sup>4</sup>; and

7  
8 Whereas, Millions of Americans currently use Kratom as an alternative to opioids for its pain-  
9 relieving and mood-altering effects<sup>5</sup>; and

10  
11 Whereas, A cross-sectional survey of 59,714 U.S. adults found an estimated 0.8% past-year  
12 prevalence, with Kratom users having an above-average substance abuse profile<sup>6</sup>; and

13  
14 Whereas, A systematic review on the mental health effects of Kratom found that Kratom  
15 withdrawal is relatively mild compared to opioids while still significant enough that some users  
16 found difficulty maintaining abstinence<sup>7</sup>; and

17  
18 Whereas, One study surveyed 500 patients with substance use disorder and found that 68.9%  
19 of the respondents were using Kratom to reduce or replace opioid use, suggesting that Kratom  
20 may have potential as a harm-reducing agent for substance use disorder<sup>1</sup>; and

21  
22 Whereas, One study found that the risk of mortality from Kratom overdose is over 1,000 times  
23 less than the risk of mortality from overdose with other opioids, and found that other substances  
24 like heroin and methamphetamine were usually present in Kratom users who had experienced  
25 significant adverse side effects<sup>8</sup>; and

26  
27 Whereas, Between 2011 and 2017, there were 11 deaths associated with Kratom exposure,  
28 including two deaths associated with Kratom use alone, and 7 reported neonatal exposures with  
29 5 neonates experiencing withdrawal symptoms<sup>9</sup>; and

30  
31 Whereas, A retrospective review identified 2,312 Kratom exposures reported to the National  
32 Poison Control Centers between 2011 and 2018, with 935 cases involving Kratom alone, with  
33 serious side effects reported including seizure (6.1%), withdrawal (6.1%), hallucinations (4.8%),  
34 respiratory depression (2.8%), coma (2.3%), and cardiac or respiratory arrest (0.6%)<sup>10</sup>; and

35  
36 Whereas, Research has shown that Kratom can lead to various organ toxicities, including acute  
37 liver failure, acute kidney failure, seizure, brain injury, and cardiovascular toxicities<sup>11,12</sup>; and

38  
39 Whereas, Kratom can be purchased on the internet from vendors, often without age  
40 verification<sup>13</sup>; and

1 Whereas, As of 2022, Kratom is legal in 44 states and explicitly banned in six states<sup>14</sup>; and  
2  
3 Whereas, Several states are considering banning or regulating Kratom to various degrees<sup>14</sup>;  
4 and  
5  
6 Whereas, The Controlled Substance Act (CSA) established five tiers of drugs based upon eight  
7 distinct criteria, determined primarily by the Drug Enforcement Administration<sup>15</sup>; and  
8  
9 Whereas, The first tier, “Schedule 1”, is defined to include “drugs with no currently accepted  
10 medical use, has a high potential for abuse, and that there is a lack of accepted safety for the  
11 use of the drug under medical supervision”<sup>16</sup>; and  
12  
13 Whereas, Prescriptions may only be written for Schedule II through V drugs, with Schedule I  
14 drugs only available for research purposes<sup>17,18</sup>; and  
15  
16 Whereas, Drug Enforcement Administration (DEA) scheduling of Kratom could impact  
17 physicians’ prescribing habits and limit patient access to Kratom, should it be determined to  
18 have medical utility, as evidenced by scheduling adjustments of other substances<sup>19,20</sup>; and  
19  
20 Whereas, One study found that within six months of rescheduling hydrocodone, a 20% decline  
21 in prescribing and dispensing was observed in the U.S and Australia<sup>20</sup>; and  
22  
23 Whereas, In the UK, scheduling of mephedrone in 2011 led to a 49% of mephedrone users  
24 increasing MDMA use, a 40% increase in purchasing of mephedrone from illicit sources, and an  
25 increase in mephedrone-related deaths from 2011-2015<sup>20,21</sup>; and  
26  
27 Whereas, Research on Schedule I drugs requires completing an application and registration  
28 with the DEA<sup>22</sup>; and  
29  
30 Whereas, Schedule I drugs may be difficult to obtain for research as manufacturers and custom  
31 synthesis companies are sparse or prohibitively expensive<sup>23</sup>; and  
32  
33 Whereas, Funding for the study of Schedule I drugs is limited, with a significant portion of the  
34 research focused on potential harms rather than potential clinical applications<sup>23</sup>; and  
35  
36 Whereas, LSD was extensively studied for potential in psychotherapy before classification as a  
37 Schedule I drug; however, following the scheduling of LSD, research declined sharply<sup>23</sup>; and  
38  
39 Whereas, Research into whether the positive characteristics of Kratom use outweigh the  
40 potential adverse effects is currently insufficient to draw general conclusions<sup>24</sup>; and  
41  
42 Whereas, Scheduling Kratom prior to robust research showing that the harms outweigh the  
43 potential benefits would limit the conduct of future studies that might identify novel therapies for  
44 substance use disorder<sup>1,2,7,8,23,24</sup>; therefore be it

1 RESOLVED, That our American Medical Association amend policy H-95.934, "Kratom and its  
2 Growing Use Within the United States," by addition and deletion to read as follows:  
3

4 Kratom and its Growing Use Within the United States, H-95.934  
5 Our AMA: supports legislative or regulatory efforts to prohibit the sale or distribution of  
6 Kratom in the United States which do not inhibit proper scientific research efforts to  
7 further study the clinical uses, benefits, and potential harms of Kratom, and oppose  
8 efforts that may restrict research. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000

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## **RELEVANT AMA POLICY**

### **Kratom and its Growing Use Within the United States H-95.934**

Our AMA supports legislative or regulatory efforts to prohibit the sale or distribution of Kratom in the United States which do not inhibit proper scientific research.  
Res. 509, A-16

### **Cannabis and Cannabinoid Research H-95.952**

1. Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.
2. Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.
3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support.
4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding.
5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use.
6. Our AMA will advocate for urgent regulatory and legislative changes necessary to fund and perform research related to cannabis and cannabinoids.
7. Our AMA will create a Cannabis Task Force to evaluate and disseminate relevant scientific evidence to health care providers and the public.

CSA Rep. 10, I-97; Modified: CSA Rep. 6, A-01; Modified: CSAPH Rep. 3, I-09; Modified in lieu of Res. 902, I-10; Reaffirmed in lieu of Res. 523, A-11; Reaffirmed in lieu of Res. 202, I-12; Reaffirmed: CSAPH Rep. 2, I-13; Modified: CSAPH Rep. 05, I-17; Reaffirmed in lieu of: Res. 434, A-19; Appended: Res. 913, I-19; Appended: Res. 913, I-19; Reaffirmation: A-22

### **FDA H-100.992**

1. Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.
2. The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision-making process in the course of FDA devising either general or product specific drug regulation.
3. It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history.

Res. 119, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-06; Appended: Sub. Res. 509, A-06; Reaffirmation I-07; Reaffirmation I-09; Reaffirmation I-10; Modified: CSAPH Rep. 02, I-18; Modified: CSAPH Rep. 02, I-19; Reaffirmed: BOT Rep. 5, I-20

**Drugs of Choice H-100.997**

Our AMA opposes any proposal that would establish a classification of drugs of choice for any specific clinical entity through governmental regulation.

Res. 117, A-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

**Dietary Supplements and Herbal Remedies H-150.954**

- (1) Our AMA supports efforts to enhance U.S. Food and Drug Administration (FDA) resources, particularly to the Office of Dietary Supplement Programs, to appropriately oversee the growing dietary supplement sector and adequately increase inspections of dietary supplement manufacturing facilities.
- (2) Our AMA supports the FDA having appropriate enforcement tools and policies related to dietary supplements, which may include mandatory recall and related authorities over products that are marketed as dietary supplements but contain drugs or drug analogues, the utilization of risk-based inspections for dietary supplement manufacturing facilities, and the strengthening of adverse event reporting systems.
- (3) Our AMA supports continued research related to the efficacy, safety, and long-term effects of dietary supplement products.
- (4) Our AMA will work with the FDA to educate physicians and the public about FDA's Safety Reporting Portal (SRP) and to strongly encourage physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's efforts to create a database of adverse event information on these forms of alternative/complementary therapies.
- (5) Our AMA strongly urges physicians to inquire about patients' use of dietary supplements and engage in risk-based conversations with them about dietary supplement product use.
- (6) Our AMA continues to strongly urge Congress to modify and modernize the Dietary Supplement Health and Education Act to require that:
  - (a) dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy;
  - (b) dietary supplements meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling;
  - (c) FDA establish a mandatory product listing regime that includes a unique identifier for each product (such as a QR code), the ability to identify and track all products produced by manufacturers who have received warning letters from the FDA, and FDA authorities to decline to add labels to the database if the label lists a prohibited ingredient or new dietary ingredient for which no evidence of safety exists or for products which have reports of undisclosed ingredients; and
  - (d) regulations related to new dietary ingredients (NDI) are clarified to foster the timely submission of NDI notifications and compliance regarding NDIs by manufacturers.
- (7) Our AMA supports FDA postmarketing requirements for manufacturers to report adverse events, including drug interactions; and legislation that declares metabolites and precursors of anabolic steroids to be drug substances that may not be used in a dietary supplement
- (8) Our AMA will work with the Federal Trade Commission (FTC) to support enforcement efforts based on the FTC Act and current FTC policy on expert endorsements and supports adequate funding and resources for FTC enforcement of violations of the FTC Act.
- (9) Our AMA strongly urges that criteria for the rigor of scientific evidence needed to support a structure/function claim on a dietary supplement be established by the FDA and minimally include requirements for robust human studies supporting the claim.
- (10) Our AMA strongly urges dietary supplement manufacturers and distributors to clearly label all products with truthful and not misleading information and for the product labeling to:
  - (a) not include structure/function claims that are not supported by evidence from robust human studies;
  - (b) not contain prohibited disease claims;
  - (c) eliminate "proprietary blends" and list and accurately quantify all ingredients contained in the product;
  - (d) require advisory statements regarding potential supplement-drug and supplement-laboratory interactions and risks associated with overuse and special populations; and
  - (e) include accurate and useful disclosure of ingredient measurement.
- (11) Our AMA supports and encourages the FDA's regulation and enforcement of labeling violations and FTC's regulation and enforcement of advertisement violations of prohibited disease claims made on dietary supplements and herbal remedies.
- (12) Our AMA urges that in order to protect the public, manufacturers be required to investigate and obtain data under conditions of normal use on adverse effects, contraindications, and possible drug interactions, and that such information be included on the label.
- (13) Our AMA will continue its efforts to educate patients and physicians about the risks associated with the use of dietary supplements and herbal remedies and supports efforts to increase patient, healthcare

practitioner, and retailer awareness of resources to help patients select quality supplements, including educational efforts to build label literacy.

Res. 513, I-98; Reaffirmed: Res. 515, A-99; Amended: Res. 501 & Reaffirmation I-99; Reaffirmation A-00; Reaffirmed: Sub. Res. 516, I-00; Modified: Sub. Res. 516, I-00; Reaffirmed: Sub. Res. 518, A-04; Reaffirmed: Sub. Res. 504, A-05; Reaffirmation A-05; Reaffirmed in lieu of Res. 520, A-05; Reaffirmation I-09; Reaffirmed in lieu of Res. 501, A-10; Reaffirmation A-11; Reaffirmation I-14; Modified: Res. 511, A-16; Reaffirmation: A-17; Reaffirmation: A-19; Modified: CSAPH Rep. 3, I-20

## **Informational Reports**

### **BOT Report(s)**

- 06 Informal Inter-Member Mentoring
- 10 Redefining the AMA's Position on ACA and Healthcare Reform
- 11 2022 AMA Advocacy Efforts

### **CEJA Opinion(s)**

- 01 Amendment to E-9.3.2, "Physician Responsibilities to Colleagues with Illness, Disability or Impairment"

### **CEJA Report(s)**

- 04 Research Handling of De-Identified Patient Information

### **CMS Report(s)**

- 03 Health System Consolidation

REPORT OF THE BOARD OF TRUSTEES

B of T Report 6-I-22

Subject: Informal Inter-Member Mentoring

Presented by: Sandra Adamson Fryhofer, MD, Chair

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

3  
4 To implement the policy, our AMA has convened a Mentorship Steering Committee consisting of  
5 representatives from each of the AMA sections (see appendix). Given the sections’ role as the  
6 place for members to become more actively involved in the AMA and their focus on leadership  
7 development, the sections are a natural home for this initiative. As the work of the Steering  
8 Committee and organization continues, we will continue to be broadly inclusive of the diversity of  
9 experiences and needs across our membership.

10  
11 The Mentorship Steering Committee has been charged with identifying mentorship opportunities  
12 and best practices within individual sections and more broadly across the organization. The  
13 Committee has discussed the importance of creating informal, organic opportunities for mentors  
14 and mentees to identify one another and connect, as opposed to establishing more formal programs  
15 with assigned mentors/mentees.

16  
17 Discussions about the most appropriate format for such interaction continue and will guide  
18 management in its exploration of scalable mechanisms to achieve the aim of the policy. Your  
19 Board will provide a progress report at the 2023 Annual Meeting.

Fiscal Note: Modest - between \$1,000 and \$5,000

Appendix: Inaugural Membership of the Mentorship Steering Committee

Neel Shah, MD, Academic Physicians Section  
Kamalika Roy, MD, International Medical Graduates Section  
Donna Smith, MD, Integrated Physician Practice Section  
Carl Streed, MD, Advisory Committee on LGBTQ Issues  
Samantha Lopez, MD, Minority Affairs Section  
Danielle Rivera, Medical Student Section  
Nancy Mueller, MD, Organized Medical Staff Section  
Carolyn Francavilla, MD, Private Practice Physicians Section  
Breyen Coffin, MD, Resident and Fellow Section  
Louise Andrew, MD, Senior Physicians Section  
Aleesha Shaik, MD, Women Physicians Section  
Laura Gephart, MD, Young Physicians Section

# REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-I-22

Subject: Redefining AMA’s Position on ACA and Healthcare Reform

Presented by: Sandra Adamson Fryhofer, MD, Chair

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

10

## 11 IMPROVING THE AFFORDABLE CARE ACT

12

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

20

21 Our AMA continues to advocate for policies that would allow patients and physicians to be able to  
22 choose from a range of public and private coverage options with the goal of providing coverage to  
23 all Americans. Specifically, our AMA has been working with Congress, the Administration, and  
24 states to advance our plan to cover the uninsured and improve affordability as included in the  
25 “2022 and Beyond: AMA’s Plan to Cover the Uninsured.” The COVID-19 pandemic initially led  
26 to many people losing their employer-based health insurance. This only increased the need for  
27 significant improvements to the Affordable Care Act. Recent data indicate that the uninsured rate  
28 has decreased during the COVID-19 pandemic, due to the temporary ACA improvements included  
29 in the American Rescue Plan Act, continuous Medicaid enrollment, state Medicaid expansions, and  
30 the 2021 special enrollment period for ACA marketplaces.

31

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

34

35 Our AMA has been advocating for the following policy provisions:

36

### 37 Cover Uninsured Eligible for ACA’s Premium Tax Credits

38

- 39 • Our AMA advocates for increasing the generosity of premium tax credits to improve premium  
40 affordability and incentivize tax credit eligible individuals to get covered. Currently, eligible

1 individuals and families with incomes between 100 and 400 percent federal poverty level  
2 (FPL) (133 and 400 percent in Medicaid expansion states) are being provided with refundable  
3 and advanceable premium tax credits to purchase coverage on health insurance exchanges.

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

#### 18 19 Cover Uninsured Eligible for Medicaid or Children’s Health Insurance Program

20  
21 Before the COVID-19 pandemic, in 2018, 6.7 million of the nonelderly uninsured were eligible for  
22 Medicaid or the Children’s Health Insurance Program (CHIP). Reasons for this population  
23 remaining uninsured include lack of awareness of eligibility or assistance in enrollment.

- 24  
25 • Our AMA has been advocating for increasing and improving Medicaid/CHIP outreach and  
26 enrollment, including auto enrollment.
- 27 • Our AMA has been opposing efforts to establish Medicaid work requirements. The AMA  
28 believes that Medicaid work requirements would negatively affect access to care and lead to  
29 significant negative consequences for individuals’ health and well-being.

#### 30 31 Make Coverage More Affordable for People Not Eligible for ACA’s Premium Tax Credits

32  
33 Before the COVID-19 pandemic, in 2018, 5.7 million of the nonelderly uninsured were ineligible  
34 for financial assistance under the ACA, either due to their income, or because they have an offer of  
35 “affordable” employer-sponsored health insurance coverage. Without the assistance provided by  
36 ACA’s premium tax credits, this population can continue to face unaffordable premiums and  
37 remain uninsured.

- 38  
39 • Our AMA advocates for eliminating the subsidy “cliff,” thereby expanding eligibility for  
40 premium tax credits beyond 400 percent FPL.
- 41 • Our AMA has been advocating for the establishment of a permanent federal reinsurance  
42 program, and the use of Section 1332 waivers for state reinsurance programs. Reinsurance  
43 plays a role in stabilizing premiums by reducing the incentive for insurers to charge higher  
44 premiums across the board in anticipation of higher-risk people enrolling in coverage. Section  
45 1332 waivers have also been approved to provide funding for state reinsurance programs.
- 46 • Our AMA also is advocating for lowering the threshold that determines whether an employee’s  
47 premium contribution is “affordable,” allowing more employees to become eligible for  
48 premium tax credits to purchase marketplace coverage.
- 49 • Our AMA has been strongly advocating for the Internal Revenue Service (IRS) proposed  
50 regulation on April 7, 2022 that would fix the so-called “family glitch” under the ACA,

1       whereby families of workers remain ineligible for subsidized ACA marketplace coverage even  
2       though they face unaffordable premiums for health insurance coverage offered through  
3       employers. The proposed regulation would fix the family glitch by extending eligibility for  
4       ACA financial assistance to only the family members of workers who are not offered  
5       affordable job-based family coverage. Our AMA is urging the Biden Administration to finalize  
6       the proposed rule as soon as possible.

#### 7 8       EXPAND MEDICAID TO COVER MORE PEOPLE

9  
10       Before the COVID-19 pandemic, in 2018, 2.3 million of the nonelderly uninsured found  
11       themselves in the coverage gap—not eligible for Medicaid, and not eligible for tax credits because  
12       they reside in states that did not expand Medicaid. Without access to Medicaid, these individuals  
13       do not have a pathway to affordable coverage.

- 14  
15       •     Our AMA has been encouraging all states to expand Medicaid eligibility to 133 percent FPL.

16  
17       New policy adopted by the AMA HOD during the November 2021 Special Meeting seeks to assist  
18       more than 2 million nonelderly uninsured individuals who fall into the “coverage gap” in states that  
19       have not expanded Medicaid—those with incomes above Medicaid eligibility limits but below the  
20       FPL, which is the lower limit for premium tax credit eligibility. The new AMA policy maintains  
21       that coverage should be extended to these individuals at little or no cost, and further specifies that  
22       states that have already expanded Medicaid coverage should receive additional incentives to  
23       maintain that status going forward.

#### 24 25       AMERICAN RESCUE PLAN OF 2021

26  
27       On March 11, 2021, President Biden signed into law the American Rescue Plan (ARPA) of 2021.  
28       This legislation included the following ACA-related provisions that will:

- 29  
30       •     Provide a temporary (two-year) 5 percent increase in the Federal Medical Assistance  
31       Percentage (FMAP) for Medicaid to states that enact the Affordable Care Act’s Medicaid  
32       expansion and covers the new enrollment period per requirements of the ACA.
- 33       •     Invest nearly \$35 billion in premium subsidy increases for those who buy coverage on the  
34       ACA marketplace.
- 35       •     Expand the availability of ACA advanced premium tax credits (APTCs) to individuals whose  
36       income is above 400 percent of the FPL for 2021 and 2022.
- 37       •     Give an option for states to provide 12-month postpartum coverage under State Medicaid and  
38       CHIP.

39  
40       ARPA represents the largest coverage expansion since the Affordable Care Act. Under the ACA,  
41       eligible individuals, and families with incomes between 100 and 400 percent of the FPL (between  
42       133 and 400 percent FPL in Medicaid expansion states) have been provided with refundable and  
43       advanceable premium credits that are inversely related to income to purchase coverage on health  
44       insurance exchanges. However, consistent with Policy H-165.824, “Improving Affordability in the  
45       Health Insurance Exchanges,” ARPA eliminated ACA’s subsidy “cliff” for 2021 and 2022. As a  
46       result, individuals and families with incomes above 400 percent FPL (\$51,520 for an individual  
47       and \$106,000 for a family of four based on 2021 federal poverty guidelines) are eligible for  
48       premium tax credit assistance. Individuals eligible for premium tax credits include individuals who  
49       are offered an employer plan that does not have an actuarial value of at least 60 percent or if the  
50       employee share of the premium exceeds 9.83 percent of income in 2021.

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

8  
9 In addition, individuals and families with incomes between 100 and 250 percent FPL (between 133  
10 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they  
11 select a silver plan, which reduces their deductibles, out-of-pocket maximums, copayments, and  
12 other cost-sharing amounts.

#### 13 14 LEGISLATIVE EXTENSION OF ARPA PROVISIONS

15  
16 On August 16, President Biden signed into law the Inflation Reduction Act of 2022 through the  
17 highly partisan budget reconciliation process, which allows both the House and Senate to pass the  
18 bill with limits on procedural delays. Most significantly, reconciliation allows the Senate to bypass  
19 the filibuster and pass legislation with a 50-vote threshold so long as it meets a series of budgetary  
20 requirements. The Inflation Reduction Act includes provisions that would extend for three years to  
21 2025 the aforementioned ACA premium subsidies authorized in ARPA.

22  
23 The Inflation Reduction Act does not include provisions to close the Medicaid “coverage gap” in  
24 the states that have not chosen to expand.

#### 25 26 ACA ENROLLMENT

27  
28 According to the U.S. Department of Health and Human Services (HHS), 14.5 million Americans  
29 have signed up for or were automatically re-enrolled in the 2022 individual market health insurance  
30 coverage through the marketplaces since the start of the 2022 Marketplace Open Enrollment Period  
31 (OEP) on November 1, 2021, through January 15, 2022. That record-high figure includes nearly 2  
32 million new enrollees, many of whom qualified for reduced premiums granted under ARPA. In  
33 August, the Department of Health and Human Services issued a report noting that the uninsured  
34 rate in the U.S. had dropped to an all-time low of 8 percent.

#### 35 36 *TEXAS VS. AZAR* SUPREME COURT CASE

37  
38 The Supreme Court agreed on March 2, 2020, to address the constitutionality of the ACA for the  
39 third time, granting the petitions for certiorari from Democratic Attorneys General and the House  
40 of Representatives. Oral arguments were presented on November 10, 2020, and a decision was  
41 expected before June 2021. The AMA filed an amicus brief in support of the Act and the  
42 petitioners in this case.

43  
44 On February 10, 2021, the U.S. Department of Justice under the new Biden Administration  
45 submitted a letter to the Supreme Court arguing that the ACA’s individual mandate remains valid,  
46 and, even if the court determines it is not, the rest of the law can remain intact.

47  
48 This action reversed the Trump Administration’s brief it filed with the Court asking the justices to  
49 overturn the ACA in its entirety. The Trump Administration had clarified that the Court could  
50 choose to leave some ACA provisions in place if they do not harm the plaintiffs, but as legal  
51 experts pointed out, the entire ACA would be struck down if the Court rules that the law is

1 inseparable from the individual mandate—meaning that there would be no provisions left to  
2 selectively enforce.

3  
4 On June 17, 2021, the Supreme Court in a 7-2 decision ruled that neither the states nor the  
5 individuals challenging the law have a legal standing to sue. The Court did not touch the larger  
6 issue in the case: whether the entirety of the ACA was rendered unconstitutional when Congress  
7 eliminated the penalty for failing to obtain health insurance.

8  
9 With its legal status now affirmed by three Supreme Court decisions, and provisions such as  
10 coverage for preventive services and pre-existing conditions woven into the fabric of U.S. health  
11 care, the risk of future lawsuits succeeding in overturning the ACA is significantly diminished.

#### 12 13 *KELLEY VS. BECERRA* FEDERAL COURT CASE

14  
15 A case before a federal district court judge in the Northern District of Texas, *Kelley v. Becerra*,  
16 would eliminate the ACA requirement that most health insurance plans cover preventive services  
17 without copayments. Those filing the case object to paying for coverage that they do not want or  
18 need, particularly for those items or services that violate their religious beliefs, such as  
19 contraception or PrEP drugs. If the case is successful, health plan enrollees will also lose access to  
20 full coverage for more than 100 preventive health services, including vaccinations and screenings  
21 for breast cancer, colorectal cancer, cervical cancer, heart disease, and other diseases and medical  
22 conditions.

23  
24 The AMA and 61 national physician specialty organizations issued a joint statement on July 25,  
25 sounding the alarm about the millions of privately insured patients who would be affected by an  
26 adverse ruling.

#### 27 28 SGR REPEAL

29  
30 The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 repealing and replacing  
31 the SGR was signed into law by President Obama on April 16, 2015.

32  
33 The AMA is now working on unrelated new Medicare payment reduction threats and is currently  
34 advocating for a sustainable, inflation-based, automatic positive update system for physicians.

#### 35 36 INDEPENDENT PAYMENT ADVISORY BOARD REPEAL

37  
38 The Bipartisan Budget Act of 2018 signed into law by President Trump on February 9, 2018,  
39 included provisions repealing IPAB. Currently, there are not any legislative efforts in Congress to  
40 replace the IPAB.

#### 41 42 CONCLUSION

43  
44 Our American Medical Association will remain engaged in efforts to improve the health care  
45 system through policies outlined in Policy D-165. 938 and other directives of the House of  
46 Delegates.

REPORT 11 OF THE BOARD OF TRUSTEES (I-22)  
2022 AMA Advocacy Efforts  
(Informational)

EXECUTIVE SUMMARY

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* decision to overturn *Roe v. Wade* 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 our policy on these issues and many more that are updated in this report.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-I-22

Subject: 2022 AMA Advocacy Efforts

Presented by: Sandra Adamson Fryhofer, MD, Chair

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1 BACKGROUND

2  
3 Policy G-640.005, “AMA Advocacy Analysis,” calls on the Board of Trustees (the Board) to  
4 provide a report to the House of Delegates (HOD) at each Interim Meeting highlighting the year’s  
5 advocacy activities and should include efforts, successes, challenges, and recommendations/actions  
6 to further optimize advocacy efforts. The Board has prepared the following report to provide an  
7 update on American Medical Association (AMA) advocacy activities for the year. (Note: This  
8 report was prepared in August based on approval deadlines, so more recent developments may not  
9 be reflected in it.)

10  
11 DISCUSSION OF 2022 ADVOCACY EFFORTS

12  
13 Numerous advocacy challenges emerged in 2022, but once again, our AMA rose to the moment  
14 and achieved significant progress on the issues most important to America’s physicians and  
15 patients. While the COVID-19 public health emergency (PHE) has subsided to a certain degree, it  
16 persists. The AMA has stood by America’s physicians and patients throughout the pandemic,  
17 securing billions in relief to protect private practices; reducing reporting burdens and penalties;  
18 advancing telehealth; enabling investments in therapeutics and vaccines to end the pandemic;  
19 standing up for health equity to achieve optimal health for all; and strongly advocating for science  
20 in the halls of power. At the same time, the AMA has been advocating extensively on other issues  
21 critical to physicians and patients.

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24 targeting some of the toughest issues physicians face today—on both professional and personal  
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27 • Reforming Medicare payment to promote thriving physician practices and innovation;  
28 • Stopping scope creep that threatens patient safety;  
29 • Fixing prior authorization to reduce the burden on practices and minimize patient care delays;  
30 • Supporting telehealth to maintain coverage and payment; and  
31 • Reducing physician burnout and addressing the stigma around mental health.

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34 interruptions and shutdowns they have faced in the last two years.

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37 arisen that need heightened advocacy efforts, too. The mass shootings in Buffalo, NY, and Uvalde,  
38 TX, forced policymakers to finally come to the table and consider some initial steps to halt such  
39 massacres. Further, the *Dobbs v. Jackson Women’s Health Organization* (hereafter *Dobbs*)  
40 decision to overturn *Roe v. Wade* (hereafter *Roe*) allows lawmakers to invade the exam room in

1 ways not seen in decades and has created a whirlwind of clinical questions facing physicians trying  
2 to provide the best care while avoiding legal liability.

3  
4 The AMA is fighting to advance AMA policy on these issues and many more that are updated in  
5 this report.

### 6 7 *Medicare Payment Reform*

8  
9 The AMA is focused on reforming our nation's Medicare physician payment system. The Medicare  
10 Access and CHIP Reauthorization Act of 2015 (MACRA) made needed improvements to the  
11 system including eliminating the Sustainable Growth Rate (SGR), but time has revealed significant  
12 statutory flaws. The promise of a viable glide path to voluntary participation in alternative payment  
13 models (APMs) never materialized, with 30 physician-proposed models being rejected for  
14 implementation. Meanwhile, the increasingly aggressive financial incentives to participate in  
15 APMs continue. The quality and reporting programs for physicians in the Merit-based Incentive  
16 Payment System (MIPS) are burdensome and lack clinical relevance. The Medicare fee schedule is  
17 chronically underfunded. No annual updates will be provided for physician services for several  
18 years, and those received over the past two decades have collectively fallen well below the rising  
19 costs of medical practice.  
20

21 The 2023 Medicare payment schedule proposed rule released in July fails to account for inflation in  
22 practice costs and COVID-related challenges to practice sustainability and also includes a  
23 significant and damaging across-the-board reduction in payment rates. Such a move would create  
24 long-term financial instability in the Medicare physician payment system and threaten patient  
25 access to Medicare-participating physicians. The AMA is working with Congress to prevent this  
26 harmful outcome in the short term and to advance more comprehensive reform in coming sessions.  
27

28 To achieve the needed level of reform, the AMA and 120 Federation groups have agreed on the  
29 following ["Characteristics of a Rational Medicare Payment System"](#) and will be advocating to see  
30 these principles implemented by Congress and the Administration.  
31

### 32 Simplicity, relevance, alignment, and predictability, for physician practices and the Centers for 33 Medicare & Medicaid Services.

- 34
- 35 • Ensuring financial stability and predictability
    - 36 ○ Provide financial stability through a baseline positive annual update reflecting inflation in
    - 37 practice costs, and eliminate, replace, or revise budget neutrality requirements to allow for
    - 38 appropriate changes in spending growth.
    - 39 ○ Recognize fiscal responsibility. Payment models should invest in and recognize
    - 40 physicians' contributions in providing high-value care and the associated savings and
    - 41 quality improvements across all parts of Medicare and the health care system (e.g.,
    - 42 preventing hospitalizations).
    - 43 ○ Encourage collaboration, competition, and patient choice rather than consolidation through
    - 44 innovation, stability, and reduced complexity by eliminating the need for physicians to
    - 45 choose between retirement, selling their practices or suffering continued burnout.
  - 46 • Promoting value-based care
    - 47 ○ Reward the value of care provided to patients, rather than administrative activities, such as
    - 48 data entry, that may not be relevant to the service being provided or the patient receiving
    - 49 care.
    - 50 ○ Encourage innovation, so that practices and systems can be redesigned and continuously
    - 51 refined to provide high-value care and include historically non-covered services that

- 1 improve care for all or a specific subset of patients (e.g., COPD, Crohn’s Disease), as well  
2 as for higher risk and higher cost populations.
- 3 ○ Offer a variety of payment models and incentives tailored to the distinct characteristics of  
4 different specialties and practice settings. Participation in new models must be voluntary  
5 and continue to be incentivized. A fee-for-service payment model must also remain a  
6 financially viable option.
  - 7 ○ Provide timely, actionable data. Physicians need timely access to analyses of their claims  
8 data, so they can identify and reduce avoidable costs. Though Congress took action to give  
9 physicians access to their data, they still do not receive timely, actionable feedback on their  
10 resource use and attributed costs in Medicare. Physicians should be held accountable only  
11 for the costs that they control or direct.
  - 12 ○ Recognize the value of clinical data registries as a tool for improving quality of care, with  
13 their outcome measures and prompt feedback on performance.
  - 14 ● Safeguarding access to high-quality care
    - 15 ○ Advance health equity and reduce disparities. Payment model innovations should be risk-  
16 adjusted and recognize physicians’ contributions to reducing health disparities, addressing  
17 social drivers of care, and tackling health inequities; physicians need support as they care  
18 for historically marginalized, higher risk, hard to reach or sicker populations.
    - 19 ○ Support practices where they are by recognizing that high-value care is provided by both  
20 small practices and large systems, and in both rural and urban settings.

21  
22 For the near term, AMA and the Federation are asking Congress to take the following steps before  
23 the end of the year to address cuts that are scheduled to take effect in 2023:  
24

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

33  
34 *Scope of Practice*

35  
36 The AMA defends the practice of medicine against inappropriate scope of practice expansions,  
37 supports physician-led team care, and ensures patients have access to physicians for their health  
38 care. All health care professionals play a critical role in caring for patients and are important  
39 members of the care team; however, their skillsets are not interchangeable with that of a fully  
40 trained physician. At the state level, the AMA works in strong collaboration and coordination with  
41 the state medical associations and national medical specialty societies. This includes sharing  
42 resources, reviewing, and advising on legislative language/strategy, testifying before state  
43 legislatures, submitting letters of opposition to lawmakers, and amplifying calls to action. The  
44 AMA also has a comprehensive library of resources to support our scope of practice campaign,  
45 including GEOMAPS, education and training modules, patient surveys, media toolkit, and one-  
46 pagers. These provide data and talking points to address the most common arguments to preserve  
47 physician-led care and refute assertions made by non-physicians. Since 2007 the AMA’s Scope of  
48 Practice Partnership (SOPP) has played a key role in bringing organized medicine together on this  
49 issue, including by providing grants to SOPP members to support state efforts. There are currently  
50 108 members of the SOPP and more than \$2.7 million in grants have been awarded to date.

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

3 Highlights to date include:

- 4
- 5 • In Colorado, Louisiana and South Dakota, physician assistant bills were defeated;
  - 6 • Truth in advertising legislation was enacted in Indiana;
  - 7 • Kentucky and Tennessee rejected efforts to expand nurse practitioner prescriptive authority;
  - 8 • Louisiana, Mississippi, Missouri, and Wisconsin defeated efforts to pass advanced practice  
9 registered nurse (APRN) expansion bills; and
  - 10 • Alabama and Missouri defeated legislation that would have expanded pharmacist scope of  
11 practice.

12

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

23

#### 24 *Prior Authorization*

25

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

35

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

- 38
- 39 • 93% of physicians report care delays;
  - 40 • 82% percent of physicians report that prior authorization can sometimes lead to treatment  
41 abandonment;
  - 42 • 34% of respondents report that prior authorization has led to a serious adverse event for a  
43 patient (including hospitalization, life-threatening event, or disability);
  - 44 • On average, practices complete 41 prior authorizations per physician per week;
  - 45 • Physicians/staff spend approximately 13 hours each week completing prior authorizations; and
  - 46 • 40% of physicians have staff dedicated to working exclusively on prior authorization.

47

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

- 49
- 50 • The “Improving Seniors’ Timely Access to Care Act of 2021” (H.R. 8487/S. 3018), which  
51 would require Medicare Advantage (MA) plans to implement a streamlined electronic prior

1 authorization (PA) process; increase transparency for beneficiaries and providers; enhance  
2 oversight by the Centers for Medicare & Medicaid Services (CMS) on the processes used for  
3 PA; ensure that care and treatments that routinely receive PA approvals are not subjected to  
4 unnecessary delays through real-time decisions by MA plans; and mandate that MA plans meet  
5 certain beneficiary protection standards. This legislation passed the House Ways and Means  
6 Committee in July.

- 7 • The “Getting Over Lengthy Delays in Care as Required by Doctors” (GOLD CARD) Act (H.R.  
8 7995) of 2022, which would exempt physicians from MA plan prior authorization requirements  
9 so long as 90% of a physician’s prior authorization requests were approved in the preceding 12  
10 months. The MA plan-issued gold cards would only be applicable to items and services  
11 (excluding drugs) and remain in effect for at least a year. The federal legislation is based on a  
12 similar law enacted in Texas that took effect in 2021.

13  
14 The AMA is also continuing to advocate at the state level where several states have enacted  
15 comprehensive reform legislation while others are at earlier stages in the legislative process. In  
16 2022, strong legislation has been enacted in Georgia, Iowa, Louisiana, and Michigan. The AMA  
17 also worked with members of the Federation to push Aetna to stop requiring prior authorization for  
18 cataract surgery. Aetna recently changed this policy with the exceptions of Florida and Georgia  
19 Medicare Advantage patients.

#### 20 21 *Telehealth*

22  
23 The AMA has long supported making telehealth services widely available to patients, but prior to  
24 the COVID-19 pandemic and the resulting loss of access to in-person medical care, most patients  
25 could not access telehealth services from their regular physicians. Due to restrictions in the  
26 Medicare statute, the Medicare program only covered telehealth services for patients in rural areas  
27 and, even then, the patient had to go to a medical facility to receive the telehealth services from a  
28 physician at another site. While private plans may not have had the same geographic restrictions,  
29 they often had limitations on coverage and payment of services provided via telehealth, as well as  
30 acceptable modalities. Many plans also often limited or incentivized patients to receive telehealth  
31 only from a separate telehealth company, not their regular physicians. Early in the pandemic, with  
32 strong support from the AMA, the restrictions on coverage for telehealth services were lifted by  
33 Medicare and other health plans. State laws and state Medicaid policies were also modified to  
34 permit widespread use of telehealth during the pandemic.

35  
36 The AMA has prioritized making the telehealth expansion permanent. As an intermediate step, the  
37 AMA successfully urged Congress to extend the telehealth expansion through five months after the  
38 public health emergency ends. Further, CMS has also proposed to extend payment for a number of  
39 services that were added to the Medicare Telehealth List for an additional 5 months after the public  
40 health emergency ends.

41  
42 And in July, the full House passed H.R. 4040, a bill that would extend telehealth payment and  
43 regulatory flexibilities for an additional two years, through the end of 2024, on a bipartisan vote of  
44 416-12.

45  
46 At the state level, the AMA has updated its model state telehealth legislation and continues to  
47 support state efforts to advance telehealth legislation and policy to ensure patient access to high  
48 quality care.

1 *Physician Wellness*

2  
3 Prior to the COVID-19 pandemic, physician burnout, depression and suicide already were major  
4 challenges for the U.S. health care system, impacting nearly every aspect of clinical care as well as  
5 being a heavy burden for physicians and their families. Physicians are very resilient, but the  
6 environments in which physicians work drive these high levels of burnout. Compounding the  
7 problems are medical licensing applications, employment and credentialing applications, and  
8 professional liability insurance applications. The problem is when these contain questions that  
9 include problematic and potentially illegal questions requiring disclosure of whether a potential  
10 licensee or applicant has ever been diagnosed or received treatment for a mental illness or  
11 substance use disorder (SUD) or even sought counseling for a mental health or wellness issue.  
12 These questions about past diagnosis or treatment are strongly opposed by the AMA, Federation of  
13 State Medical Boards, The Joint Commission, the Federation of State Physician Health Programs,  
14 and The Dr. Lorna Breen Heroes' Foundation.

15  
16 At the federal level, the AMA strongly advocated for the Dr. Lorna Breen Health Care Provider  
17 Protection Act (H.R. 1667), named for a physician who died by suicide in 2020. The bill provides  
18 grants to help create evidence-based strategies to reduce burnout and the associated secondary  
19 mental health conditions related to job stress. It includes a national campaign to encourage health  
20 professionals to prioritize their mental health and to use available mental and behavioral health  
21 services. It also establishes grants for employee education and peer-support programming.

22  
23 AMA advocacy and partnership with state medical associations has also helped enact state laws in  
24 Arizona, Indiana, South Dakota, and Virginia to provide strong confidentiality protections for  
25 physicians and medical students who seek care for burnout and wellness-related issues. The AMA  
26 is also continuing to urge state medical boards to remove stigmatizing questions that  
27 inappropriately ask about past diagnoses. In addition, the AMA is working with key stakeholders to  
28 bolster state physician health programs as well as identify health systems and others who can play a  
29 powerful role in removing stigma and supporting physicians' health and wellness.

30  
31 *Surprise Billing*

32  
33 The AMA is taking a two-pronged approach to the No Surprises Act of 2021 (NSA). The AMA is  
34 educating physicians on how to comply with the NSA while also advocating for implementation of  
35 the law as Congress intended. Specifically, the AMA has:

- 36  
37 • Initiated litigation (along with the American Hospital Association) arguing that the  
38 government's interim final rule is contrary to the law and exceeds statutory authority by  
39 creating a rebuttable presumption that the arbiter in the Independent Dispute Resolution (IDR)  
40 process considers the "qualifying payment amount" (essentially the median in-network rate) as  
41 the appropriate out-of-network payment amount. (The Texas Medical Association has also  
42 filed litigation and secured a positive initial ruling.);
- 43 • Released an [initial toolkit](#) (PDF) on the implementation of the No Surprises Act and a [second](#)  
44 [toolkit](#) (PDF) on implementation of the billing process for certain out-of-network care under  
45 the No Surprises Act. We have also [compiled](#) a number of other resources, including regulatory  
46 summaries and comment letters;
- 47 • Held two national webinars on the No Surprises Act, the [first](#) on its implementation and the  
48 [second](#) on the payment process for physicians and other providers in surprise medical billing  
49 situations;

- 1 • Continues to advocate for a fair IDR process, recently arguing in a letter to the Administration  
2 that a balanced IDR process is not anti-patient, pushing back on payer and employer efforts to  
3 undermine the process;
- 4 • Working with other stakeholders to develop recommendations on the good faith estimate and  
5 advanced EOB requirements, to highlight administrative burdens and ensure minimal  
6 workflow disruption;
- 7 • Working directly with CMS to address operational challenges with additional physician and  
8 provider resources—CMS has already held two physician-focused webinars on the good faith  
9 estimate provisions and notice and consent and enforcement. A webinar on the payment  
10 process is expected soon; and
- 11 • Calling on CMS to conduct more physician outreach and education which CMS has agreed to  
12 do.

#### 13 14 *COVID-19 Response and Monkeypox Outbreak*

15  
16 As mentioned above, the AMA continues to mount a multi-pronged effort advocating for a  
17 comprehensive response to the COVID-19 public health emergency (PHE) as the virus continues to  
18 evolve and different variants continue to thwart recovery efforts. The AMA steadfastly supports  
19 financial relief for physician practices still negatively affected by the pandemic; robust testing to  
20 limit spread; vaccination in line with U.S. Centers for Disease Control and Prevention  
21 recommendations including for children; and permanent implementation of the telehealth  
22 expansion granted during the PHE. For a full list of AMA activities on this topic please visit this  
23 [website](#). More specifically the AMA produces a [regular video segment](#) update on recent  
24 developments with COVID-19 and other public health issues.

25  
26 One recent development is that the Health Resources and Services Administration (HRSA) has  
27 announced that it will set up a process for physicians who received funds from the Provider Relief  
28 Fund to contest recoupment of the relief funds. Physicians receiving \$10,000 or more from the  
29 program are required to spend the funds within a year and report how the relief funds were spent.  
30 These requirements have been difficult for many practices to fulfill during the continued instability  
31 caused by the pandemic. The AMA pressed HRSA for this decision and is pleased that HRSA will  
32 work with physicians to ensure the intent of the relief program is achieved.

33  
34 The AMA is also active in the courts defending the authority of public health agencies. The  
35 Litigation Center of the American Medical Association and State Medical Societies and Wisconsin  
36 Medical Society filed an amicus brief supporting state and local officials and their authority to  
37 issue emergency orders during a public health crisis. The Wisconsin Supreme Court sided with  
38 public health officials in a [4-3 vote](#) which was a win for organized medicine.

39  
40 Finally, the AMA is closely monitoring monkeypox and its progression throughout the U.S. and is  
41 ready to respond as needed. The AMA is [posting clinical information](#) for physicians as the virus  
42 spreads and has established a new CPT code for monkeypox vaccines.

#### 43 44 *Reproductive Health*

45  
46 When the Supreme Court of the United States issued its ruling in the *Dobbs* case overturning *Roe*,  
47 AMA President Jack Resneck Jr., MD, stated “The American Medical Association is deeply  
48 disturbed by the U.S. Supreme Court’s decision to overturn nearly a half century of precedent  
49 protecting patients’ right to critical reproductive health care—representing an egregious allowance  
50 of government intrusion into the medical examination room, a direct attack on the practice of  
51 medicine and the patient-physician relationship, and a brazen violation of patients’ rights to

1 evidence-based reproductive health services. States that end legal abortion will not end abortion—  
2 they will end safe abortion, risking devastating consequences, including patients' lives." The AMA  
3 filed an amicus brief in the case when it first came before the Supreme Court stating our opposition  
4 to overturning this established right.

5  
6 In a post-*Roe* landscape, the AMA is pursuing multiple strategies to address the broad spectrum of  
7 issues that the *Dobbs* decision created. At the federal level, the AMA immediately called for  
8 greater digital privacy for patients out of concern that minimal oversight of data use by digital apps  
9 could place women in jeopardy in states seeking to enforce abortion restrictions. The AMA in  
10 conjunction with the American College of Obstetricians and Gynecologists (ACOG) also called for  
11 the removal or revision of the Risk Evaluation and Mitigation Strategies (REMS) and Elements to  
12 Assure Safe Use (ETASU) requirements for mifepristone, to eliminate medically unsupported and  
13 unnecessary barriers for physicians, patients, and pharmacies. The Biden Administration also  
14 reminded hospitals and health care providers of their obligation to comply with the provisions of  
15 the Emergency Medical Treatment and Labor Act (EMTALA) that preempt any state laws that  
16 restrict access to stabilizing medical treatment, including abortion procedures and other treatments  
17 that may result in the termination of a pregnancy. Dr. Resneck also testified to the Subcommittee  
18 on Oversight and Investigations for the House Committee on Energy and Commerce at a hearing  
19 titled, "Roe Reversal: The Impacts of Taking Away the Constitutional Right to an Abortion" and  
20 discussed the impact that the *Dobbs* case is having on patients and physicians.

21  
22 At the state level, the AMA is working with the Federation to determine how to best protect  
23 patients and physicians from aggressive legislative intrusions into the exam room. Some states are  
24 seeking to create new protections for patients while others are pressing for tougher abortion bans  
25 and other restrictions. The legal situation for physicians and their practices is very muddled in  
26 many states. The AMA is collecting information and conducting legislative analyses to help states  
27 sort through their best paths forward. We are also preparing to be very active on both the legislative  
28 and litigation fronts as the country works through this new set of legislative realities.

### 29 *Firearm Violence*

30  
31  
32 "Gun violence is a plague on our nation. It's a public health crisis, and much of it is preventable,"  
33 then-AMA President Gerald E. Harmon, MD, said in remarks to the House of Delegates at the  
34 2022 AMA Annual Meeting. With over 45,000 firearm-related deaths in 2020 and a continuing  
35 string of mass shootings, this public health crisis needs heightened efforts and new strategies.  
36 Congress did take a positive step by passing the first piece of major firearm legislation in over 30  
37 years with the Bipartisan Safer Communities Act, which the AMA supported and President Biden  
38 signed on June 25. Key provisions of the bill include:

- 39  
40
- 41 • Providing grants for states to establish or strengthen extreme risk protection orders;
  - 42 • Adding convicted domestic violence abusers in dating relationships to the National Instant  
43 Criminal Background Check System (NICS);
  - 44 • Requiring the Federal Bureau of Investigation National Instant Criminal Background Check  
45 System to contact authorities to see whether an individual under the age of 21 has a  
46 "disqualifying" juvenile record for buying a firearm;
  - 47 • Making it a federal crime to buy a firearm on behalf of an individual who is prohibited from  
48 doing so; and
  - Including new spending for school security and mental health treatment.

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

9  
10 *Maternal Mortality*

11  
12 The AMA continues to be very active advocating for improved maternal health in 2022 with a  
13 particular focus on the inequitable impact seen by Black women. The AMA has lobbied the  
14 Congressional Healthy Future Task Force Security Subcommittee to focus on this issue; called on  
15 Congress to increase funding in fiscal year 2023 for federal programs at the Health Resources  
16 Services Administration (HRSA), the U.S. Centers for Disease Control and Prevention (CDC), and  
17 the National Institutes of Health; and focused our comments on maternal health equity issues in the  
18 Hospital Inpatient Prospective Payment Systems (IPPS) Rule. Additionally, the House of  
19 Representatives passed the TRIUMPH for New Moms Act as part of the Restoring Hope for  
20 Mental Health and Well-Being Act of 2022, a bipartisan mental health and substance abuse  
21 package that would reauthorize key programs within the Substance Abuse and Mental Health  
22 Services Administration. The AMA previously wrote letters to the House of Representatives and  
23 Senate encouraging the passage of TRIUMPH, which would create a Task Force on Maternal  
24 Mental Health to identify, evaluate and make recommendations to coordinate and improve federal  
25 responses to maternal mental health conditions, as well as create a national strategic plan for  
26 addressing maternal mental health disorders.

27  
28 At the state level, CMS approved California, Florida, Kentucky, and Oregon actions to expand  
29 Medicaid and Children’s Health Insurance Program coverage to 12 months postpartum. This  
30 extension provides over 120,000 more families with guaranteed coverage as they navigate this  
31 critical postpartum period. The AMA supports the extension of Medicaid coverage to 12 months  
32 postpartum and has provided comments on the importance of the matter.

33  
34 *Drug Overdose*

35  
36 Ending the nation’s drug-related overdose and death epidemic—as well as improving care for  
37 patients with pain, mental illness or substance use disorder—requires partnership, collaboration,  
38 and commitment to individualized patient care decision-making to implement impactful changes.  
39 Due to AMA and Federation advocacy, there were several positive steps in 2022:

- 40  
41 • CDC proposed removing arbitrary prescribing thresholds from its 2022 revised guideline—per  
42 AMA recommendations to CDC;
- 43 • Arizona, New Mexico, and Wisconsin are three of the states that AMA has helped enact  
44 legislation to decriminalize fentanyl test strips; several other states have passed bills in one  
45 house and are continuing to consider these bills;
- 46 • More than a dozen states have enacted legislation or other policies to help ensure that opioid  
47 litigation settlement funds are focused on public health efforts;
- 48 • AMA worked closely with the Rhode Island Medical Society to help develop regulations  
49 implementing the nation’s first legally authorized harm reduction center;

- 1 • The National Association of Insurance Commissioners (NAIC) continues to develop [tools and](#)  
2 [resources](#) to help state departments of insurance and the U.S. Department of Labor better  
3 enforce state and federal parity laws—at the urging of the AMA and our partner medical  
4 societies; and
- 5 • The AMA continues to work closely with the Administration on policies to increase access to  
6 harm reduction efforts and reduce barriers to medications for opioid use disorder (MOUD),  
7 including support for federal funding for states to purchase fentanyl test strips, mobile  
8 methadone vans and retain telehealth flexibilities that allow for audio-only induction of  
9 buprenorphine.

10  
11 The AMA also supports S. 445/H.R. 1384, the Mainstreaming Addiction Treatment (MAT) Act in  
12 the Senate Health, Education, Labor and Pensions Committee (HELP). The MAT Act would  
13 increase access to evidence-based treatment for opioid use disorder and end longstanding  
14 administrative barriers to prescribing buprenorphine in-office for the treatment of opioid use  
15 disorder.

#### 16 17 *Access*

18  
19 The AMA works tirelessly to preserve health care access and coverage for Americans across the  
20 nation—especially the country’s most vulnerable patient populations. The 2022 updates include:

- 21  
22 • Successfully urged the Biden Administration to take action to fix the “family glitch” and  
23 provide affordable health care coverage;
- 24 • Working with health care stakeholder groups, urged the Administration to maintain the public  
25 health emergency that expands coverage for care and extends key regulatory flexibilities until  
26 there is an extended period of greater stability (the nationwide uninsured rate has dropped to  
27 8%);
- 28 • Advocating to Congress to make the Affordable Care Act (ACA) subsidy expansions  
29 permanent (extended for three years in Senate Reconciliation bill); and
- 30 • Successfully urged adoption of stronger network adequacy rules for Qualified Health Plans and  
31 Medicare Advantage plans.

32  
33 The AMA is also sounding the alarm that a federal court case could cause millions of Americans to  
34 lose access to preventive services. *Kelley v. Becerra*, a lawsuit before a federal district court judge  
35 in the Northern District of Texas, threatens the section of the Affordable Care Act (ACA) requiring  
36 insurers and group health plans to cover more than 100 preventive health services—with no  
37 additional cost to consumers. One of the ACA’s most popular and widely recognized benefits, the  
38 provision resulted in an estimated 151.6 million people receiving preventive care without cost  
39 sharing in 2020 alone.

#### 40 41 *Drug Pricing*

42  
43 As Congress prepared to leave Washington for its August recess, Senate negotiators reached  
44 agreement on a reconciliation package passed by the Senate that addressed a number of important  
45 issues, including provisions that promise to rein in the escalating costs of prescription drugs.  
46 Specifically, the legislation would allow Medicare to negotiate its purchasing prices for drugs, with  
47 the first 10 negotiated prices set to take effect in 2026. The legislation would also cap drug price  
48 increases at the annual rate of inflation and end a Trump-era drug rebate rule. All of these  
49 provisions promise to save money for both Medicare and for patients, although there are concerns  
50 about the impact of lower prices on the amount practices receive for the acquisition of physician-

1 administered drugs under the average sales price (ASP) +6 percent payment methodology,  
2 particularly for small physician practices. The AMA will work with affected specialties during the  
3 implementation period to assess the impact and identify and advocate for solutions that preserve  
4 access to these drugs in physician offices.

5  
6 *Tobacco*

7  
8 The AMA supported the U.S. Food and Drug Administration’s (FDA) proposal to ban menthol-  
9 flavored cigarettes, a move that will save hundreds of thousands of lives in the coming decades  
10 while reducing health inequities. If the sale of menthol-flavored cigarettes is indeed banned, the  
11 FDA projects a 15.1% drop in smoking within 40 years, which would help save between 324,000  
12 to 654,000 lives. The agency also projects the ban would stop between 92,000 and 238,000  
13 smoking-related deaths among African Americans—that is up to 6,000 Black lives saved each year.

14  
15 The AMA has also warned of the dangers of electronic nicotine delivery systems and long called  
16 for these products to have the same marketing and sales restrictions that are applied to tobacco  
17 cigarettes, including bans on TV advertising. This year the AMA successfully pressured social  
18 media companies to reject advertisements of e-cigarettes to youth. The AMA also recently  
19 applauded the FDA’s decision ordering the removal of all JUUL Labs Inc. e-cigarette products  
20 from the U.S. market, recognizing that for too long, companies like JUUL have been allowed to  
21 sell e-cigarettes that appeal to our nation’s youth—ultimately creating another generation of young  
22 people hooked on tobacco products.

23  
24 *Gender-Affirming Care*

25  
26 Despite the evidence base and consensus in the medical community that supports gender-affirming  
27 care for transgender youth, some state legislators have pursued legislation to prohibit physicians  
28 and other health care professionals from providing such care to minors. The AMA has worked with  
29 the Federation to mitigate the harm these bills could have on patients.

30  
31 To date, two states, Alabama and Arkansas, have enacted laws that prohibit gender-affirming  
32 medical care for all minors, including puberty suppressing medication, hormone therapy, and  
33 surgery. Both laws are currently tied up with legal challenges. Two additional states, Arizona and  
34 Tennessee, have enacted legislation prohibiting surgery on minors and hormone therapy prior to  
35 puberty, respectively. Because these interventions are not recommended for the age groups  
36 specified, Arizona’s and Tennessee’s laws essentially—and unnecessarily—codify existing  
37 standards of care.

38  
39 In addition to legislation, two states have sought to prohibit access to gender-affirming care  
40 through executive action. In February 2022, the Texas Attorney General issued an opinion deeming  
41 puberty suppressing drugs, hormone therapy, and surgeries child abuse. Shortly thereafter, Texas  
42 Governor Greg Abbott directed the Texas Department of Family and Protective Services to  
43 investigate any reported instances of minors receiving gender-affirming treatments. The directive  
44 was blocked by a Texas District Court. Lastly, in April 2022 the Florida Department of Health  
45 issued guidance stating that social gender transition, puberty blockers, hormone therapy, and  
46 gender reassignment surgery should not be treatment options for children or adolescents. The  
47 Florida guidance is not law or regulation and therefore is not legally enforceable. However,  
48 following a report by the Florida Agency for Health Care Administration finding insufficient  
49 evidence that medical intervention for the treatment for gender dysphoria is safe and effective, the  
50 Florida Board of Medicine began the rulemaking process in August 2022 to establish a new  
51 standard of care for the treatment of minors with gender dysphoria.

1 *Public Service Loan Forgiveness Program*

2  
3 The AMA is calling on the U.S. Department of Education (DOE) to make improvements to the  
4 Public Service Loan Forgiveness (PSLF) program. In 2021, the DOE announced a change to the  
5 PSLF program rules for a limited time as a result of COVID-19 that made millions of non-profit  
6 and government employees eligible for loan forgiveness or additional credit through the [Limited](#)  
7 [PSLF Waiver](#). This waiver ends on October 31, 2022, but the AMA has called for an extension.  
8 Further, the AMA is urging the DOE to amend the program to assist California and Texas  
9 physicians because those states' bans on the corporate practice of medicine interfere with  
10 participation in the program. The AMA is also advocating for 501(c)(6) employers to potentially  
11 qualify for the program as well. These changes would directly assist physicians with their loan  
12 burdens and would encourage more physicians to practice in underserved areas.

13  
14 *Immigration*

15  
16 The AMA continues to fight for equitable treatment of physicians, residents, and students  
17 immigrating to the U.S. The AMA wrote to the U.S. House of Representatives Committee on the  
18 Judiciary Subcommittee on Immigration and Citizenship urging lawmakers to seek bipartisan  
19 policy solutions that will ensure that patients are provided the best care and that immigration  
20 barriers are addressed to resolve the physician workforce shortage and preserve patient access to  
21 care. The AMA also submitted comments on the Temporary Increase of the Automatic Extension  
22 Period of Employment Authorization and Documentation for Certain Renewal Applicants  
23 temporary final rule. With the growing backlog of cases within the Department of Homeland  
24 Security (DHS) negatively impacting both immigrants and U.S. businesses, the AMA applauded  
25 the temporary final rule (TFR) and asked that this same extension be provided to physicians so that  
26 they can maintain their lawful immigration status while DHS is working on streamlining their  
27 extensions for employment authorization.

28  
29 The AMA sent a letter strongly opposing any rules, regulations, or policies that would deter  
30 immigrants, nonimmigrants, and their dependents from seeking visas or from utilizing noncash  
31 public benefits including, but not limited to, Medicaid, Supplemental Nutrition Assistance Program  
32 (SNAP), and housing assistance. Impeding access to non-cash public benefits for these individuals  
33 and families could undermine population health.

34  
35 AMA ADVOCACY ONGOING UPDATES

36  
37 The AMA offers several ways to stay up to date on our advocacy efforts:

- 38  
39 • Sign up for AMA Advocacy Update—a biweekly newsletter that provides updates on AMA  
40 legislative, regulatory, and private sector efforts. Subscribers can read [stories from previous](#)  
41 [editions here](#) and those looking to subscribe can use this [link](#).  
42 • Join the [Physicians Grassroots Network](#) for updates on AMA calls to action on federal  
43 legislative issues. And if you have connections with members of Congress, or are interested in  
44 developing one, the [Very Influential Physician \(VIP\) program](#) can help grow these  
45 relationships.  
46 • Connect with the Physicians Grassroots Network on [Facebook](#), [Twitter](#), [LinkedIn](#) and  
47 [Instagram](#).

1 CONCLUSION

2

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

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS\*

CEJA Opinion 1-I-22

Subject: Amendment to E-9.3.2, “Physician Responsibilities to Colleagues with Illness, Disability or Impairment”

Presented by: Peter A. Schwartz, MD, Chair

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1 INTRODUCTION

2  
3 At the 2022 Annual Meeting, the American Medical Association House of Delegates adopted the  
4 recommendations of Council on Ethical and Judicial Affairs Report 3-A-22, “Amendment to E-  
5 9.3.2, “Physician Responsibilities to Colleagues with Illness, Disability or Impairment.” The  
6 Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the  
7 next print edition of the *Code of Medical Ethics*.

8  
9 E-9.3.2 - Physician Responsibilities to Colleagues with Illness, Disability or Impairment

10  
11 Providing safe, high-quality care is fundamental to physicians’ fiduciary obligation to promote  
12 patient welfare. Yet a variety of physical and mental health conditions—including physical  
13 disability, medical illness, and substance use—can undermine physicians’ ability to fulfill that  
14 obligation. These conditions in turn can put patients at risk, compromise physicians’  
15 relationships with patients, as well as colleagues, and undermine public trust in the profession.  
16 While some conditions may render it impossible for a physician to provide care safely, with  
17 appropriate accommodations or treatment many can responsibly continue to practice, or resume  
18 practice once those needs have been met. In carrying out their responsibilities to colleagues,  
19 patients, and the public, physicians should strive to employ a process that distinguishes  
20 conditions that are permanently incompatible with the safe practice of medicine from those that  
21 are not and respond accordingly.

22  
23 As individuals, physicians should:

- 24  
25 (a) Maintain their own physical and mental health, strive for self-awareness, and promote  
26 recognition of and resources to address conditions that may cause impairment.  
27  
28 (b) Seek assistance as needed when continuing to practice is unsafe for patients, in keeping  
29 with ethics guidance on physician health and competence.  
30  
31 (c) Intervene with respect and compassion when a colleague is not able to practice safely.  
32 Such intervention should strive to ensure that the colleague is no longer endangering

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\* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

1 patients and that the individual receive appropriate evaluation and care to treat any  
2 impairing conditions.

3  
4 (d) Protect the interests of patients by promoting appropriate interventions when a  
5 colleague continues to provide unsafe care despite efforts to dissuade them from  
6 practice.

7  
8 (e) Seek assistance when intervening, in keeping with institutional policies, regulatory  
9 requirements, or applicable law.

10  
11 Collectively, physicians should nurture a respectful, supportive professional culture by:

12  
13 (f) Encouraging the development of practice environments that promote collegial mutual  
14 support in the interest of patient safety.

15  
16 (g) Encouraging development of inclusive training standards that enable individuals with  
17 disabilities to enter the profession and have safe, successful careers.

18  
19 (h) Eliminating stigma within the profession regarding illness and disability.

20  
21 (i) Advocating for supportive services, including physician health programs, and  
22 accommodations to enable physicians and physicians-in-training who require  
23 assistance to provide safe, effective care.

24  
25 (j) Advocating for respectful and supportive, evidence-based peer review policies and  
26 practices to ensure fair, objective, and independent assessment of potential impairment  
27 whenever and by whomever assessment is deemed appropriate to ensure patient safety  
28 and practice competency. (II)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 4-I-22

Subject: Research Handling of De-Identified Patient Information

Presented by: Peter A. Schwartz, MD, Chair

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1 Policy [D-315.969](#) adopted in November 2021 directs the Council on Ethical and Judicial Affairs to  
2 “consider re-examining existing guidance relevant to the confidentiality of patient information,  
3 striving to preserve the benefits of widespread use of de-identified patient data for purposes of  
4 promoting quality improvement, research, and public health while mitigating the risks of re-  
5 identification of such data.”  
6  
7 Independently, at its August 2021 meeting the Council concluded that in light of the complex  
8 issues arising with the rapid development of data science and increasing research use of large  
9 health-related data sets, along with recent changes in the Common Rule governing research with  
10 human participants, it would reconsider guidance in Opinion [7.3.7](#), “Safeguards in the Use of DNA  
11 Databanks” and would in addition review other existing guidance on confidentiality last updated in  
12 2016 as part of the overall project to modernize the *AMA Code of Medical Ethics*.  
13  
14 This review is ongoing. The Council anticipates submitting its preliminary report to the House of  
15 Delegates at the June 2023 Annual Meeting.

REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (I-22)  
Health System Consolidation  
Informational Report

EXECUTIVE SUMMARY

There are two types of integration for firms to pursue when merging with or acquiring other firms. Horizontal consolidation occurs when one entity acquires or merges with another entity at the same level in an industry. An example of horizontal integration in health care would be two hospitals merging with one another. Vertical consolidation occurs when one entity acquires or merges with another entity at a different level of industry. In health care, an example of vertical consolidation would be a hospital or health system acquiring a physician practice.

Firms' market shares are a critical metric in the assessment of the competitive effects of mergers and acquisitions. In general, firms with larger market shares may be more able to engage in anticompetitive conduct. Market concentration can be measured by calculating the Herfindahl-Hirschman Index (HHI), which is a useful indicator of market power and serves as a signal of the likely impact of a merger on competition. The Department of Justice (DOJ) and the Federal Trade Commission (FTC) use the HHI as an aid in assessing the potential for anticompetitive effects of proposed horizontal mergers. They may also consider market shares and market concentration in the evaluation of vertical mergers. Over half (55 percent) of US health care markets experienced an increase in concentration between 2013 and 2017.

Consolidation in health care is under increased scrutiny by antitrust authorities and state regulators. At the federal level, the FTC is tasked with reviewing mergers involving hospitals and physicians. While a handful of mergers have been blocked in recent years, health care markets continue to become more consolidated. A challenge arises because such transactions mostly fall under the threshold required for FTC/DOJ notification and review. Thus, they can proceed without antitrust scrutiny that could otherwise assess and weigh their benefits and harms.

Hospital and hospital-physician mergers are shown to increase health care prices and spending. The impact of hospital and hospital-physician mergers on the quality of health care and patient outcomes is limited and inconclusive at this time. The American Medical Association (AMA) has robust policy and guidelines on hospital and hospital-physician mergers and acquisitions. In accordance with Policy D-215.984, the Council will continue to review and report back to the House of Delegates any new data that become available, especially with regards to the impact of these mergers on health care prices and quality of care.

This report is the first in a series on this and related topics. Potential future topics may include physician satisfaction and burnout associated with mergers, acquisitions, and consolidation; anti-trust issues; hurdles physicians face when starting a private practice; quality of care; and impacts on patient outcomes and mortality.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-22

Subject: Health System Consolidation

Presented by: Lynn Jeffers, MD, MBA, Chair

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1 At the 2022 Annual Meeting, the House of Delegates adopted Policy D-215.984, “Health System  
2 Consolidation,” which was sponsored by the Private Practice Physicians Section. Policy D-215.984  
3 asks the American Medical Association (AMA) to (1) “study nationwide health system and  
4 hospital consolidation for the benefit of patients and physicians who face an existential threat from  
5 health care consolidation,” and (2) “regularly review and report back on these issues to keep the  
6 House of Delegates apprised on relevant changes that may impact the practice of medicine, with  
7 the first report no later than A-23.” This report, which is presented for the information of the  
8 House of Delegates, summarizes hospital and hospital-physician group merger and acquisition  
9 activity, including background and trends on hospital and hospital-physician group consolidation.  
10 This is the first report of a series the Council will be working on addressing this and related topics.

11  
12 The Council notes that this report specifically addresses hospital and hospital-physician group  
13 consolidation, regardless of ownership model. Further information on the corporate practice of  
14 medicine and private equity investment in health care can be found in CMS Report 2-I-22, which is  
15 before the House at this meeting. A primary purpose of this report is to provide background and  
16 baseline knowledge for upcoming reports on this topic. A glossary of common terms and  
17 abbreviations can be found in Appendix A.

18  
19 **BACKGROUND**

20  
21 *Horizontal and Vertical Integration*

22  
23 There are two types of integration for firms to pursue when merging with or acquiring other firms.  
24 Horizontal consolidation occurs when one entity acquires or merges with another entity at the same  
25 level in an industry. An example of horizontal integration in health care would be two hospitals  
26 merging with one another. Vertical consolidation occurs when one entity acquires or merges with  
27 another entity at a different level of industry. In health care, an example of vertical consolidation  
28 would be a hospital or health system acquiring a physician practice.

29  
30 A critical question is whether mergers and acquisitions are beneficial or harmful to society.  
31 Theoretically, both types of integration can result in both benefits and harms. Horizontal  
32 integration can lead to economies of scale, which could reduce the cost of production and lower  
33 prices, but it can also lead to the exercise of market power and increase prices or lower quality.  
34 Horizontal integration could also lead to potential loss of physician autonomy. Vertical integration  
35 between physicians and hospitals has several potential benefits, including improved care  
36 coordination, improved alignment of provider incentives through the “internalization” of  
37 externalities, less duplication of services, and economies of scale for administrative functions such  
38 as deployment of health records, which reduce prices or improve quality. However, vertical  
39 integration could also hurt merging parties’ competitors by inhibiting them from accessing needed  
40 supplies for production or raising their costs. Moreover, Medicare billing practices could make

1 hospital-based outpatient care more expensive than that based in a physician office. In these cases,  
2 vertical integration could lead to higher prices or spending. In short, each type of integration could  
3 lead to different outcomes and could have different impacts on price, quality, and/or spending.

#### 4 5 *Market Definition, Market Shares, and the Herfindahl-Hirschman Index (HHI)*

6  
7 Firms' market shares are a critical metric in the assessment of the competitive effects of mergers  
8 and acquisitions. In general, firms with larger market shares may be more able to engage in  
9 anticompetitive conduct. One way to assess the level of market competition is by determining the  
10 level of market concentration. Market concentration can be measured by calculating the HHI,  
11 which is a useful indicator of market power and serves as a signal of the likely impact of a merger  
12 on competition. The Department of Justice (DOJ) and the Federal Trade Commission (FTC) use  
13 the HHI as an aid in assessing the potential for anticompetitive effects of proposed horizontal  
14 mergers. They may also consider market shares and market concentration in the evaluation of  
15 vertical mergers. The HHI is the sum of the squared market shares for all firms in a market. As an  
16 example, a market with 4 firms that each held 25 percent of the market share would have an HHI of  
17 2,500. The largest value HHI can reach is 10,000, indicating a monopoly, where one entity holds  
18 the entire market share. A higher HHI indicates greater concentration and suggests lower market  
19 competition.<sup>1</sup>

20  
21 Health care markets are generally considered to be local, as health care consumers need to travel to  
22 obtain care. Studies typically define hospital geographic markets as metropolitan statistical areas  
23 (MSAs). Markets that are very large (e.g., New York, Chicago), can be defined as smaller parts of  
24 those MSAs called metropolitan divisions. The HHI is calculated for each MSA. Using data from  
25 2013, 2016, and 2017, one study found that in 95 percent of MSA-level markets in the United  
26 States, at least one hospital (or hospital system) had a market share of 30 percent or greater in those  
27 years. Seventy-two percent of markets had one hospital (or hospital system) with a share of 50  
28 percent or more in 2016 and 2017. Additionally, in 40 percent of markets, a single hospital (or  
29 hospital system) had a market share of 70 percent or more in 2016 and 2017.<sup>2</sup> Over half (55  
30 percent) of markets experienced an increase in concentration between 2013 and 2017. In 17 percent  
31 of markets, the HHI equaled 10,000 in both of those years, indicating a monopoly. In 2017, the  
32 average HHI across markets was 3,853 and 92 percent of markets were considered highly  
33 concentrated.<sup>3</sup> It is crucial to note that the study cited here considers the potential weakness with  
34 HHI calculation and looked only at comparable hospitals within a market when calculating market  
35 concentration. The study specifically outlines this when explaining the data and methods used in  
36 calculating HHI for these markets.

#### 37 38 *Changes in Practice Ownership and Physician Employment*

39  
40 The COVID-19 pandemic put tremendous strain on the health care industry, particularly on smaller  
41 practices. With smaller practices finding it difficult to continue to operate independently, larger  
42 health systems had an opportunity to acquire them. The Coronavirus Aid, Relief, and Economic  
43 Security Act and the Paycheck Protection Program and Health Care Enhancement Act allocated  
44 \$175 billion for grants to providers that were partly intended to make up for revenue lost due to  
45 coronavirus, but analysis shows that the first \$50 billion in grants were not targeted to providers  
46 most vulnerable to revenue losses.<sup>4</sup> The resulting economic pressure on physicians could  
47 potentially lead to more mergers or closing of private practices, resulting in physicians then seeking  
48 employment within a hospital or health system.

49  
50 However, changes in physician practice arrangements were already underway prior to the COVID-  
51 19 pandemic. According to the AMA's 2020 Physician Practice Benchmark Survey, almost 40

1 percent of physicians worked directly for a hospital or for a practice that was at least partially  
2 owned by a hospital or health system—up from 29 percent in 2012. In 2020, 50.2 percent of  
3 physicians were employed, compared to 41.8 percent in 2012, and 44 percent had an ownership  
4 stake in their practice—lower than the 53.2 percent who were owners in 2012. In fact, 2020 was  
5 the first year in which less than half (49.1 percent) of physicians worked in practices that were  
6 wholly owned by physicians (i.e., private practice).<sup>5</sup> This percentage includes the physicians who  
7 are private practice owners (38.4 percent of all physicians), the employed physicians who work for  
8 them (8.2 percent), and the physicians who are on contract with the practice (2.5 percent).<sup>6</sup> As the  
9 number of physicians in private practice has fallen, the share of physicians who work directly for a  
10 hospital or for a practice at least partially owned by a hospital or health system has increased.

### 11 *Antitrust Enforcement and Regulation*

12  
13  
14 Consolidation in health care is under increased scrutiny by antitrust authorities and state  
15 regulators.<sup>7</sup> At the federal level, the FTC is tasked with reviewing mergers involving hospitals and  
16 physicians. While a handful of mergers have been blocked in recent years, health care markets  
17 continue to become more consolidated. The FTC cites several constraints on their ability to enforce  
18 antitrust laws in the health care sector. Most notably, the FTC and DOJ antitrust division budgets  
19 have remained flat, even as the pace of mergers has increased.<sup>8</sup> It is important to note that vertical  
20 integration is a particular challenge to regulate. For example, this would include a hospital or health  
21 system acquiring a physician practice. A challenge arises because such transactions mostly fall  
22 under the threshold required for FTC/DOJ notification and review. Thus, they can proceed without  
23 antitrust scrutiny that could otherwise assess and weigh their benefits and harms. Another noted  
24 challenge is the inability of the FTC to enforce antitrust rules on non-profit hospitals (although it  
25 can review mergers that involve a non-profit hospital). In 2019, 66 percent of hospital and health  
26 system mergers and acquisitions involved a non-profit entity purchasing another non-profit entity,  
27 putting these transactions out of the scope of FTC review.<sup>9</sup>

28  
29 In 2013, the FTC and state of Idaho sued St Luke’s Health System and Saltzer Medical Group for  
30 violating the Clayton Act and state antitrust laws. The complaint alleged anticompetitive effects in  
31 the primary care market. According to the complaint, the combination of St. Luke’s and Saltzer  
32 would give it the market power to demand higher rates for health care services provided by primary  
33 care physicians in Nampa, Idaho and surrounding areas, leading to higher costs for health care  
34 consumers.<sup>10</sup> The district court did note that they believed that St. Luke’s and Saltzer genuinely  
35 intended to move towards a better health care system, but ultimately found that the “huge market  
36 share” of the post-merger entity “creates a substantial risk of anticompetitive price increases” in the  
37 primary care market in Nampa, Idaho, where the facilities are located. The ruling was appealed and  
38 upheld in 2015, resulting in the unwinding of the merger of these two entities.<sup>11</sup>

39  
40 States play a significant role in regulating hospital markets. States have their own antitrust laws,  
41 and state attorneys general and other regulators have access to the local market level data needed to  
42 oversee and challenge proposed mergers in their states. In addition to challenging hospital mergers  
43 outright, state strategies to address consolidation include all-payer rate setting for hospitals  
44 (Maryland, Pennsylvania, and Vermont) and the Massachusetts Health Policy Commission.

### 45 *Summary of Recent Transactions*

46  
47  
48 The 2021 Health Care Services Acquisition Report highlights hospital merger and acquisition  
49 activities for the past five years. Hospital merger and acquisition activity dropped off in 2020 as the  
50 coronavirus pandemic swept the United States and hospitals’ finances were ravaged as a result.<sup>12</sup>  
51 Sixty-five of the 79 hospital merger and acquisition deals announced in 2020 were United States-

1 only targets that were not involved in bankruptcy proceedings.<sup>13</sup> These deals covered 119 hospitals  
 2 and 15,996 beds. The total acquired revenue figure for 2020 was nearly \$16.4 billion.<sup>14</sup> Full details  
 3 on all hospital and health system mergers and acquisitions can be found in the 2021 Health Care  
 4 Services Acquisition Report (Twenty-Seventh Edition). The table below shows notable hospital  
 5 transactions in the United States in 2020:<sup>15</sup>

**Notable US Hospital Transactions, 2020**

<b>Acquirer</b>	<b>Target</b>	<b>Price</b>	<b>Hospitals</b>	<b>Beds</b>
<b>Novant Health</b>	New Hanover Regional Medical Center	\$1,500,000,000	1	677
<b>Prime Healthcare Services</b>	St. Francis Medical Center	\$275,000,000	1	344
<b>Banner Health</b>	Wyoming Medical Center	\$207,000,000	1	212
<b>Carle</b>	2 Advocate Aurora hospitals	\$190,000,000	2	231
<b>Orlando Health</b>	Bayfront Health St. Petersburg	\$147,135,471	1	343
<b>Chan Soon-Shiong Family Foundation</b>	St. Vincent Medical Center	\$135,000,000	1	320
<b>LCMC Health</b>	East Jefferson General Hospital	\$90,000,000	1	309
<b>Iron Stone Real Estate Partners</b>	St. Christopher’s Hospital for Children	\$65,000,000	1	188

*Source: HealthCareMandA.com, January 2021. Health Care Services Acquisition Report (Twenty-Seventh Edition. Does not include transactions that took place outside of the United States.)*

6 The table below shows the largest physician medical group transactions from 2016-2020:<sup>15</sup>

**Notable US Physician Medical Group Transactions, 2020**

<b>Acquirer</b>	<b>Target</b>	<b>Price</b>	<b>Year</b>
<b>KKR &amp; Co. L.P.</b>	Envision Healthcare Corporation	\$9,900,000,000	2018
<b>Envision Healthcare Holdings, Inc.</b>	AmSurg Corp.	\$6,726,000,000	2016
<b>The Blackstone Group</b>	TeamHealth Holdings, Inc.	\$6,100,000,000	2016
<b>Optum</b>	DaVita Medical Group	\$4,340,000,000	2017
<b>Optum</b>	Surgical Care Affiliates, Inc.	\$3,277,410,000	2017
<b>West Street Capital Partners VII</b>	Capital Vision Services LP	\$2,700,000,000	2019
<b>Partners Group</b>	EyeCare Partners	\$2,200,000,000	2019
<b>Summit Partners</b>	Sound Inpatient Physicians Holdings, LLC	\$2,150,000,000	2018
<b>Ares Management L.P.</b>	DuPage Medical Group	\$1,450,000,000	2017
<b>Aspen Dental Management, Inc.</b>	Clear Choice Management Services	\$1,100,000,000	2020

*Source: HealthCareMandA.com, January 2021. Health Care Services Acquisition Report (Twenty-Seventh Edition. Does not include transactions that took place outside of the United States.)*

1 *Impacts on Health Care Price and Quality*

2  
3 Previous studies show that both horizontal and vertical integration impact the price of health care.  
4 However, research on the impact of hospital and hospital-physician consolidation on quality of care  
5 is limited and inconclusive. Research suggests that horizontal and vertical integration among  
6 providers is associated with higher health care prices paid by private insurers. In Medicare,  
7 payment policies protect Medicare from increased prices due to horizontal consolidation but have  
8 led to higher Medicare costs in the case of vertical integration.

9  
10 In the case of horizontal integration, the 2020 Medicare Payment Advisory Commission reviewed  
11 published research on hospital consolidation and concluded that the “preponderance of evidence  
12 suggests that hospital consolidation leads to higher prices.” An analysis of data from employer-  
13 sponsored coverage found that hospitals that do not have any competitors within a 15-mile radius  
14 have prices that are 12 percent higher than hospitals in markets with four or more competitors.  
15 Furthermore, a separate analysis of hospital mergers over a 5-year period found that mergers of two  
16 hospitals within five miles of one another resulted in an average price increase of 6.2 percent and  
17 that price increases continued in the two years following the merger.<sup>16</sup>

18  
19 There is evidence that prices increase even when hospitals merge with other hospitals in different  
20 geographic markets. One analysis found that prices at hospitals acquired by out-of-market systems  
21 increased by about 17 percent more than unacquired, stand-alone hospitals. One reason for rising  
22 prices following mergers is that larger hospital systems can influence the dynamics of negotiations  
23 with insurers and shift volume to higher cost facilities. For example, hospital systems with  
24 significant bargaining power may require that insurers include all hospitals in their system in a  
25 provider network. This can lead to higher cost hospitals being in a provider network when there are  
26 lower cost hospitals nearby. In one recent antitrust case in California, the Sutter Health system was  
27 accused of violating antitrust laws by using its market power to illegally drive up prices. In the  
28 settlement, Sutter Health agreed to stop requiring that all of its hospitals be included in an insurer’s  
29 network and also agreed to pay additional damages.<sup>17</sup>

30  
31 Vertical integration between hospitals and physicians can also raise prices or spending. A study  
32 analyzing highly concentrated markets in California found that an increase in the share of  
33 physicians in practices owned by a hospital was associated with a 12 percent increase in premiums  
34 for private plans sold in the state’s Affordable Care Act Marketplace. Additionally, a study  
35 conducted to examine Medicare beneficiaries’ pattern of health care utilization found that “patients  
36 are more likely to choose a high-cost, low-quality hospital when their physician is owned by that  
37 hospital.” In May 2022, *Health Affairs* published a study on the price effects of vertical integration  
38 and joint contracting in Massachusetts. This study found that vertical integration and joint  
39 contracting led to price increases from 2013 to 2017, from 2.1 percent to 12.0 percent for primary  
40 care physicians and from 0.7 percent to 6.0 percent for specialists, with the greatest increases seen  
41 in large health systems.<sup>18</sup>

42  
43 Studies examining the impact of consolidation on quality of care have produced mixed results.  
44 Some studies have shown that quality does not improve, or even gets worse, after vertical  
45 integration and others have shown modest improvements. One study of 15 integrated delivery  
46 networks found no evidence that hospitals in these systems provide better clinical quality or safety  
47 scores than competitors. Another study found that larger hospital-based provider groups had higher  
48 per beneficiary Medicare spending and higher readmission rates than smaller groups. However, one  
49 other study found that vertical integration had a limited positive effect on a small subset of quality  
50 measures.<sup>19</sup> Regarding horizontal consolidation, studies have shown that quality may decrease in  
51 highly concentrated markets. One study found that risk-adjusted one-year mortality for heart

1 attacks in Medicare patients was 4.4 percent higher in more highly concentrated hospital markets  
 2 compared to less concentrated markets. A study published in 2020 followed hospitals for three  
 3 years after a merger and compared outcome measures with a control group of hospitals that had no  
 4 change in ownership. The analysis found that scores for 30-day readmissions and mortality rates  
 5 among patients discharged from a hospital did not improve in the hospitals that merged, when  
 6 compared to the control group. Given the differences in these results, it is imperative for these  
 7 systems to continue to collect data and monitor potential impacts of consolidation on the quality of  
 8 care. In sum, although previous research generally finds that horizontal and vertical integration  
 9 among providers is associated with higher health care prices, the net effect of such integration on  
 10 quality is yet unknown.

11  
 12 **AMA POLICY AND ADVOCACY**

13  
 14 The Council reviewed relevant AMA policy and highlights Policy H-215.960, established by  
 15 Council on Medical Service Report 7-A-19: (a) health care entity mergers should be examined  
 16 individually, taking into account case-specific variables of market power and patient needs; (b) the  
 17 AMA strongly supports and encourages competition in all health care markets; (c) the AMA  
 18 supports rigorous review and scrutiny of proposed mergers to determine their effects on patients  
 19 and providers; (d) antitrust relief for physicians remains a top AMA priority; and (e) close  
 20 monitoring of health care markets is a key aspect of AMA antitrust activity.

21  
 22 The AMA has long been a strong advocate for competitive health care markets and antitrust relief  
 23 for physicians and maintains that health care markets should be sufficiently competitive to allow  
 24 physicians to have adequate choices and practice options. AMA efforts to obtain antitrust relief for  
 25 physicians, maximize their practice options, and protect patient-physician relationships include  
 26 legislative advocacy, advocacy at the FTC and DOJ, and the creation of practical physician  
 27 resources. Furthermore, the AMA has pursued alternative solutions that promote competition and  
 28 choice, including: eliminating state certificate of need laws; repealing the ban on physician-owned  
 29 hospitals; reducing the administrative burden to enable physicians to compete with hospitals; and  
 30 achieving meaningful price transparency (Policy H-215.960).

31  
 32 In addition, the AMA strongly advocates that Congress repeal limits to the whole hospital  
 33 exception of the Stark physician self-referral law, which essentially bans physician ownership of  
 34 hospitals and places restrictions on expansions of already existing physician-led hospitals.  
 35 Repealing this ban would allow new entrants into hospital markets, thereby increasing competition.  
 36 The AMA firmly believes that physician-owned hospitals should be allowed to compete equally  
 37 with other hospitals, and that the federal ban restricts competition and choice (Policy D-215.995).

38  
 39 In the event of a hospital or health system merger, acquisition, consolidation or affiliation, the  
 40 AMA believes a joint committee with merging medical staffs should be established to resolve at  
 41 least the following issues: (a) medical staff representation on the board of directors; (b) clinical  
 42 services to be offered by the institutions; (c) process for approving and amending medical staff  
 43 bylaws; (d) physicians are encouraged and expected to work with others to deliver effective,  
 44 efficient, and appropriate care; (e) a mechanism is provided for the open and transparent sharing of  
 45 clinical and business information by all parties to improve care; and (f) a clinical information  
 46 system infrastructure exists that allows capture and reporting of key clinical quality and efficient  
 47 performance data for all participants and accountability across the system to those measures  
 48 (Policy H-215.969).

1 DISCUSSION

2  
3 While it is recognized that most hospital markets are highly concentrated and do not function as  
4 well as they could, or should, it is also recognized that hospital markets are local, and states play a  
5 significant role in regulating them. States have their own antitrust laws, and state attorneys general  
6 and other regulators have better access to the local market-level data needed to oversee and  
7 challenge proposed mergers in their states. States can take on mergers themselves or join federal  
8 antitrust efforts.

9  
10 Consistent with Policy D-215.984, the Council will continue to monitor trends in health system  
11 consolidation and the impact on physicians and their patients, using additional data when available.  
12 As previously noted in CMS Report 7-A-19, the Council remains concerned regarding the potential  
13 negative consequences for physicians and patients in highly concentrated hospital markets (such as  
14 increased prices, reduced choice, and fewer physician practice options). In addition to reviewing  
15 the current literature, the Council received input from AMA antitrust experts during the  
16 development of this report, and notes that AMA staff are readily available to assist and advise  
17 AMA members and state medical associations with questions or concerns about physician-hospital  
18 relations or hospital consolidation. Nonetheless, the Council believes it is not possible to actively  
19 oppose all future hospital mergers. Attempting to address hospital mergers in the same manner the  
20 AMA has addressed major health insurance mergers would require enormous resources and may  
21 alienate AMA members who work for hospitals and health systems.

22  
23 While previous studies suggest that hospital and hospital-physician consolidation is associated with  
24 higher health care prices, the impact on quality of care is still unknown. The economic pressures  
25 facing physicians were exacerbated by the COVID-19 pandemic and could result in continued  
26 mergers—both horizontal and vertical. Struggling private practices may find it beneficial to join  
27 with other private practices to form a larger practice (horizontal integration) or be acquired by a  
28 hospital or health system (vertical integration).

29  
30 CONCLUSION

31  
32 Hospital and hospital-physician mergers are shown to increase health care prices and spending.  
33 Nonetheless, the impact of hospital and hospital-physician mergers on the quality of health care  
34 and patient outcomes is limited and inconclusive at this time. The AMA has robust policy and  
35 guidelines on hospital and hospital-physician mergers and acquisitions. In accordance with Policy  
36 D-215.984, the Council will continue to review and report back to the House of Delegates as any  
37 new data become available, especially with respect to the impact of these mergers on health care  
38 prices and quality of care. The Council’s review could include monitoring relevant FTC-DOJ  
39 mergers to determine trends and better understand the impact of these mergers on hospitals, health  
40 systems, and physician groups.

41  
42 This report represents the first in a series on health system consolidation and related topics.  
43 Potential future report topics may include physician satisfaction and burnout associated with  
44 mergers, acquisitions, and consolidation; anti-trust issues; hurdles physicians face when starting a  
45 private practice either within a hospital employment or non-employed setting before and after a  
46 hospital merger; quality of care; and impacts on patient outcomes and mortality.

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<sup>3</sup> *Ibid.*

<sup>4</sup> Schwartz, K. What We Know About Provider Consolidation. Kaiser Family Foundation. September 2, 2020. Available at: <https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/>

<sup>5</sup> Kane, C. 2020 Policy Research Perspectives: Recent Changes in Physician Practice Arrangements: Private Practice Dropped to Less Than 50 Percent of Physicians in 2020. AMA: Physician Practice Benchmark Survey. American Medical Association. 2021.

<sup>6</sup> *Ibid.*

<sup>7</sup> Curto, V. "Price Effects of Vertical Integration and Joint Contracting Between Physicians and Hospitals in Massachusetts." *Health Affairs*. May 2022. Available at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00727>

<sup>8</sup> Schwartz, *Supra* note 4.

<sup>9</sup> Schwartz, *Supra* note 4.

<sup>10</sup> Federal Trade Commission. Cases and Proceedings. St. Luke's Health System, Ltd, and Saltzer Medical Group, P.A. FTC Matter/File Number: 121 0069. Available at: <https://www.ftc.gov/legal-library/browse/cases-proceedings/121-0069-st-lukes-health-system-ltd-saltzer-medical-group-pa>

<sup>11</sup> Saint Alphonsus Med. Center-Nampa Inc. v. St. Luke's Health Sys., Ltd. Case No. 14-35173. United States Court of Appeals, Ninth Circuit. February 10, 2015.

<sup>12</sup> The Health Care Services Acquisition Report. Twenty-Seventh Edition. Irving Levin Associates. 2021.

<sup>13</sup> *Ibid.*

<sup>14</sup> *Ibid.*

<sup>15</sup> *Ibid.*

<sup>16</sup> Schwartz, *Supra* note 4.

<sup>17</sup> Schwartz, *Supra* note 4.

<sup>18</sup> Curto, *Supra* note 7.

<sup>19</sup> Schwartz, *Supra* note 4.

## APPENDIX A

### Glossary of Terms

Antitrust – The regulation of the concentration of economic power, particularly in regard to monopolies and other anticompetitive practices. Antitrust laws exist as both federal and state statutes.

Department of Justice (DOJ) – A federal executive department of the United States government. Specific Antitrust Division housed within the Department whose mission is to promote economic competition through enforcing and providing guidance on antitrust laws and principles. The DOJ Antitrust Division works closely with the Federal Trade Commission (FTC) to review potential mergers and acquisitions.

Federal Trade Commission (FTC) – An independent agency of the United States government whose principal mission is the enforcement of civil U.S. antitrust law and the promotion of consumer protection. These laws promote vigorous competition and protect consumers from anticompetitive mergers and business practices. The FTC shares jurisdiction over federal civil antitrust enforcement with the DOJ Antitrust Division.

Herfindahl-Hirschman Index (HHI) – A commonly accepted measure of market concentration calculated by squaring the market share of each firm competing in the market and then summing the resulting numbers. HHI calculations of 10,000 indicate a monopoly.

Horizontal Integration – A business strategy in which one company acquires or merges with another that operates at the same level in an industry. An example in health care would be two hospitals merging or two physician practices merging.

Integration vs. Consolidation – Closely related, but not synonymous. Consolidation typically refers to mergers and acquisitions. Consolidation does not necessarily imply integration. Integration means firms are truly integrating their operations, for the purpose of aligning and creating efficiency.

Metropolitan Statistical Area (MSA) – A core area containing a substantial population nucleus, together with adjacent communities having a high degree of economic and social integration with that core. MSAs are determined with the U.S. Census and are one way to define geographic markets when calculating the HHI. Particularly large MSAs (i.e., New York City, Chicago, Los Angeles, etc.) are further broken down into submarkets.

Vertical Integration – The combination in one company of two or more stages of production normally operated by separate companies. An example in health care: hospitals can buy physician groups or health systems can form drug companies.