

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
- 606* Patient-Centered Health Equity Strategic Plan and Sustainable Funding
- 607* Accountability for Election Rules Violations

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

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

32 In remarks at the 2022 Annual Meeting, Dr. Harmon declared that “Gun violence is a plague on our
33 nation. It is a public health crisis, and much of it is preventable.” Also at the Annual Meeting, then
34 AMA Board Chair Bobby Mukkamala, MD, addressed the HOD to reaffirm that the Board is fully
35 committed to continuing to work on preventing firearm violence as a top AMA advocacy priority.
36 With over 45,000 firearm-related deaths in 2020 and a continuing string of mass shootings, the
37 Board recognizes this public health crisis needs heightened efforts and new strategies. According to
the Gun Violence Archive—an independent, non-profit data collection and research group that

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.

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
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-145.983](#)
45 • [Firearm safety counseling with patients, Policy H-145.976](#)
46 • [Trigger locks and gun cabinets to improve firearm safety, Policy H-145.978](#)
47 • [Data on firearm deaths and injuries, Policy H-145.984](#)
48 • [Prevention of unintentional shooting deaths among children, Policy H-145.979](#)
49 • [Ban on handguns and automatic repeating weapons, Policy H-145.985](#)
50 • [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

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 ~~polices, 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

2

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

5

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

12

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

16

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

24

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

28

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

35

36 Except for consolidating the two policies into a single policy, other changes to the policy since
37 2003 did not address the portion on fiscal notes. The policy as it appears in the Appendix has been
38 in place since 2018.

39

40 CURRENT PRACTICE WITH FISCAL NOTES

41

42 Fiscal notes are based on a gross estimate of the AMA staff time that would be required to
43 implement the resolution or report as written along with other cost centers such as survey expenses
44 and consultant fees or foregone revenue. A fiscal note is printed on every resolution and action
45 report (i.e., informational reports are excluded), provided the information is available when the
46 document is officially released in the handbook, addendum, or tote.* Fiscal notes can only rarely be

* 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

* 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 polices, 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.¹ 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.² 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.)

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

² 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.³ 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.

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

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.⁴ 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 Your Board believes a process that would allow the House of Delegates to focus on key concerns
 23 of patients and our profession may merit a test. That decision, however, rests solely with the
 24 House. Your Board is not empowered to set out House procedures, and this report should be
 25 considered a vehicle to determine whether the House of Delegates wishes to implement a trial of a
 26 standing resolution committee for future meetings. Should the House favor a test, your Board will
 27 come back with a detailed proposal at the June 2023 House of Delegates Meeting (June 10-14,
 28 2023) recommending both the parameters for a resolution committee and the necessary bylaws
 29 changes.

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

37 The nature of the virtual format of the special meetings limited the volume of business that could
 38 be considered. The limit was imposed, however, not primarily based on volume but on the
 39 collective evaluation of a proposal's urgency or priority. In fact, the special meetings were called
 40 by the Board to only handle urgent and priority business. For in-person meetings, the House has

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

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

6

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

9 2. increase the representation of “employed physicians” (a term that would need to be
10 defined) in the HOD by allocating additional representation to the Organized Medical Staff
11 Section; and

12 3. increase representation of employed physicians in AMA leadership by adding OMSS
13 representatives (who would be employed physicians) to the Board of Trustees and to each
14 AMA council and committee.

15

16 Testimony on Resolution 615 reflected concern with the proposed representation scheme.
17 Nevertheless, it was clear that the HOD seeks, in the words of the reference committee, “a
18 workable plan for supporting employed physicians.” This report examines how the voice of
19 employed physicians might best be heard within the organization.

21 BACKGROUND

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

26

27 • “strive to become the lead association for physicians who maintain employment or
28 contractual relationships with hospitals, health systems, and other entities;”

29 • “provide...assistance, such as information and advice, but not legal opinions or
30 representation, as appropriate, to employed physicians, physicians in independent practice,
31 and independent physician contractors in matters pertaining to their relationships with
32 hospitals, health systems, and other entities...” and

33 • “work through the Organized Medical Staff Section and other sections and special groups
34 as appropriate to represent and address the unique needs of physicians who maintain
35 employment or contractual relationships with hospitals, health systems, and other entities.”

* 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.¹
29 As of May 2022, there are just under 1.1 million active primary care and specialist physicians
30 working in the US,² 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,³ 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.⁴

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

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

17
18 The SPS identified the following priority areas of concern as focal points of the last five years:
19 healthy aging, transitioning to retirement/end-of-career practice patterns, physician re-entry,
20 grassroots advocacy, and the *JAMA* Career Center. The Council asked the Section what actions
21 have been taken on these issues, as well as the results of those activities. On the issue of healthy
22 aging, the SPS Governing Council (GC) has offered educational programs at AMA HOD meetings
23 on “how to keep your brain fit” and mindfulness workshops to help foster resiliency for senior
24 physicians, as well as developing a guide of best health practices in senior independent living
25 communities for publication on the AMA website. In 2018, the SPS assembled topics for a
26 members-only, web-based toolkit, “How to Successfully Transition out of Medicine and into
27 Retirement,” which included resources for transitioning to retirement as one leaves medical
28 practice. The SPS presented educational programs on alternate licensure tracks for reentering
29 physicians and created the State Licensure and Liability Laws grid for physicians, a state-by-state
30 reference guide of liability laws for senior physician volunteers.

31
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

45 Communications are sent approximately once per month for physicians who have an email address
46 in the AIMS database and have opted in (~48K physicians in 2020, up from ~42K physicians in
47 2018). Over the same period, both the open rate (28.3% in 2020, up from 23.5% in 2018) and click
48 through rate (1.3% in 2020, up from 0.6% in 2018) of those communications have increased as
49 well and the Section noted that the growth in engagement exceeds both AMA and industry
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 CLRDP DISCUSSION
23 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

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
- 22 • American Express card (for AMA business use)
- 23 • Combination fax/printer/scanner (reimbursable up to \$250)
- 24 • An annual membership to the airline club of choice offered each year during the Board
25 member’s tenure
- 26 • Personalized AMA stationery, business cards, and biographical data for official use

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 $\frac{1}{2}$ 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

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

15

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

23

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

33

34 Recommendation 39: The Speaker in consultation with the Election Committee will consider a
35 more defined process for complaint reporting, validation, resolution, and potential penalties.
36 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 Also of note was Recommendation 41 calling for a review of the modified election processes after
11 an interval of two years (after A-23).

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

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

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

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

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

34 In their review, the Board noted that while the body of the EC Report provided detailed
35 information regarding complaint reporting, validation, and resolution for possible campaign
36 violations, these details were not specified in the formal recommendations adopted by the House.
37 The EC Report detailed that when a complaint was received, the Speaker would consult with the
38 committee chair to form a subcommittee of three members to investigate the allegation. The
39 subcommittee of the EC would be selected to avoid conflicts (e.g., being part of the same
40 delegation as the alleged violator). Using necessary discretion, the subcommittee would investigate
41 the complaint and when necessary, the Office of General Counsel or the HOD Office would assist.
42 The subcommittee would report to the full EC the results of their investigation, with the final
43 determination to be made by the full committee with any potentially conflicted members recused.
44 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 9
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

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 Whereas, The Louisiana House of Delegates found the document to contain divisive and
6 inflammatory language, terminology and racially characterizing statements that stand in polar
7 opposition to our Louisiana State Medical Society Policies and to AMA Policies H-65.965,
8 H-65.953, H-140.900, and the AMA Code of Medical Ethics; and

9
10 Whereas, The Louisiana House of Delegates directed the Louisiana AMA Delegation to submit
11 a resolution to the AMA HOD; therefore be it

12
13 RESOLVED, That our American Medical Association withdraw its Organizational Strategic Plan
14 to Embed Racial Justice and Advance Health Equity (Equity Strategic Plan) and rewrite the
15 recommendations for correcting its past support for racially discriminating behavior with removal
16 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
(I-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

- 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:

4 AMA policy on lodging and accommodations includes the following:

6 1. Our AMA supports choosing hotels for its meetings, conferences, and conventions
7 based on size, service, location, cost, and similar factors.

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.

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.

21 4. It is the policy of our AMA not to ~~held 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.

29 5. Our AMA staff will work with facilities where AMA meetings are held to designate
30 an area for breastfeeding and breast pumping.

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.

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.

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 606
(I-22)

Introduced by: Oklahoma, South Carolina, Mississippi

Subject: Patient-Centered Health Equity Strategic Plan and Sustainable Funding

Referred to: Reference Committee F

1 Whereas, AMA policy H-180.944, "Plan for Continued Progress Toward Health Equity" states:
2 Health equity, defined as optimal health for all, is a goal toward which our AMA will work by
3 advocating for health care access, research, and data collection; promoting equity in care;
4 increasing health workforce diversity; influencing determinants of health; and voicing and
5 modeling commitment to health equity; and

6
7 Whereas, AMA policy D-180.981, "Plan for Continued Progress Toward Health Equity," states:
8 1. Our AMA will develop an organizational unit, e.g., a Center or its equivalent, to facilitate,
9 coordinate, initiate, and track AMA health equity activities; and 2. The Board will provide an
10 annual report to the House of Delegates regarding AMA's health equity activities and
11 achievements; and

12
13 Whereas, AMA policy H-180.944 is focused on better healthcare for all and is patient centered;
14 and

15
16 Whereas, Our AMA HOD established policy H-65.952, "Racism as a Public Health Threat," and
17 H-350.974, "Racism and Ethnic Disparities in Health Care"; and

18
19 Whereas, In April of 2019, the AMA launched the AMA Center for Health Equity with the hiring
20 of its first Chief Health Equity Officer (1); and

21
22 Whereas, On May 11, 2021, our AMA senior staff released the "Organizational Strategic Plan to
23 Embed Racial Justice and Advance Health Equity" (2) (Strategic Plan) to the press prior to
24 releasing the document to our HOD; and

25
26 Whereas, The "Strategic Plan" is a 65-page document with an additional 21 pages of charts and
27 additional information; and

28
29 Whereas, The "strategic plan" serves as a three-year roadmap to plant the initial seeds for
30 action and accountability to embed racial justice and advance health equity for years to come
31 (1); and

32
33 Whereas, The release date of the "Strategic Plan" on May 11, 2021 was one day before the "on
34 time" resolution deadline date of May 12, 2021 for the AMA June 2021 special-called meeting,
35 therefore making submission of an "on-time" resolution to address this plan practically
36 impossible; and

37
38 Whereas, Review of the AMA Board of Trustee minutes from 9/2018 to 8/2021, there are
39 references to health equity throughout, in a variety of contexts; most were directly relevant to
40 the development of the health equity strategic plan (3); and

1 Whereas, Other than a mention at the April 2021 meeting that a report would be coming soon,
2 no specific reference can be found that the Board took any kind of official action related to the
3 "Strategic Plan" (3); and
4
5 Whereas, Bylaws of the American Medical Association (January 2022) state
6 "Board of Trustees shall: (5.3.2). Serve as the principal planning agent for the AMA;
7 and (5.3.2.1) Planning focuses on the AMA's goals and objectives and involves decision-
8 making over allocation of resources and strategy development. Planning is a collaborative
9 process involving all of the AMA's Councils, Sections, and other appropriate AMA components;"
10 (4) and
11
12 Whereas, Our AMA cannot achieve our goal of optimal health for all without collaborative
13 organizations with like goals and proper funding for enhancements to community health centers
14 including their infrastructures; and
15
16 Whereas, The Health Resources and Services Administration mission is to improve health
17 outcomes and achieve health equity through access to quality services, a skilled health
18 workforce, and innovative, high-value programs; (5) and
19
20 Whereas, In April 2022 Health Resources and Services Administration announced the
21 availability of nearly \$90 million in one-time American Rescue Plan funding to support new data-
22 driven efforts at health centers to identify and reduce health disparities;(6) and
23
24 Whereas, Our AMA House of Delegates recognizes the Board of Trustees is responsible for the
25 development and oversight of any organizational strategic plan for any of our AMA pillars;
26 therefore be it
27
28 RESOLVED, Our American Medical Association HOD reaffirm policy H-180.944, "Plan for
29 Continued Progress Toward Health Equity," and aggressively advocate for Health Equity as
30 defined as optimal health for all which should be the goal toward which our AMA will work by
31 advocating for health care access, promoting equity in care, increasing health workforce
32 diversity, influencing determinants of health, and voicing and modeling commitment to health
33 equity (Reaffirm HOD Policy); and be it further
34
35 RESOLVED, That our AMA Center for Health Equity's future strategic plan should include
36 advocacy planning and be presented to the AMA HOD for consideration with the opportunity for
37 it to be more widely understood, strengthened, and supported by the HOD (Directive to Take
38 Action); and be it further
39
40 RESOLVED, As the AMA Center for Health Equity develops its next strategic plan, it shall
41 actively engage our AMA Board of Trustees in the strategic planning process, and ensure a
42 more patient-centered strategic plan for health equity advocacy that is consistent with the intent
43 of AMA policies, including H-180.944, " Plan for Continued Progress Toward Health Equity,"
44 and D-180.981, "Plan for Continued Progress Toward Health Equity," and report the strategic
45 plan to the HOD at the 2024 Annual Meeting prior to publicly releasing the plan to the press
46 (Directive to Take Action); and be it further
47
48 RESOLVED, That our AMA, in a collaboration with interested stakeholders, actively advocate
49 for sustainable funding from Congress to increase health equity efforts of identifying and
50 reducing health disparities including but not limited to funding of the Health Resources and
51 Services Administration through U.S. Department of Health and Human Services and our AMA
52 Health Equity Center. (Directive to Take Action)

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

Received: 10/13/22

References

- (1) <https://www.ama-assn.org/about/leadership/ama-s-strategic-plan-embed-racial-justice-and-advance-health-equity>
- (2) <https://www.ama-assn.org/about/leadership/ama-s-strategic-plan-embed-racial-justice-and-advance-health-equity>
- (3) <https://www.ama-assn.org/about/board-trustees/board-trustees-actions-official-record>
- (4) <https://www.ama-assn.org/system/files/ama-constitution-and-bylaws.pdf>
- (5) <https://www.hrsa.gov/about/index.html>
- (6) <https://www.hhs.gov/about/news/2022/04/21/hhs-announces-90-million-support-new-data-driven-approaches-health-centers-identify-reduce-health-disparities.html>

RELEVANT AMA POLICY

Plan for Continued Progress Toward Health Equity H-180.944

Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

Citation: BOT Rep. 33, A-18; Reaffirmed: CMS Rep. 5, I-21

Plan for Continued Progress Toward Health Equity D-180.981

1. Our AMA will develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities.
2. The Board will provide an annual report to the House of Delegates regarding AMAs health equity activities and achievements.

Citation: BOT Rep. 33, A-18

Racism as a Public Health Threat H-65.952

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 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.
4. 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.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Citation: Res. 5, I-20; Reaffirmed: Res. 013, A-22; Modified: Speakers Rep., A-22

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.

Citation: 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

Plan for Continued Progress Toward Health Equity D-180.981

1. Our AMA will develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities.

2. The Board will provide an annual report to the House of Delegates regarding AMAs health equity activities and achievements.

Citation: BOT Rep. 33, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 607
(I-22)

Introduced by: Texas

Subject: Accountability for Election Rules Violations

Referred to: Reference Committee F

1 Whereas, Our American Medical Association has a strong code of ethics; and

2 Whereas, Our AMA requires honesty and good citizenship of all its physician members; and

3 Whereas, Our AMA has election rules adjudicated by an Election Committee; and

4 Whereas, Accountability for violations of such rules is ill-defined; and

5 Whereas, The Election Committee's current structure has not been effective in discouraging
6 violations of the election rules; and

7 Whereas, The current penalty for a serious elections rules violation is limited to an
8 announcement of such violation to the House of Delegates; therefore be it

9 RESOLVED, That our American Medical Association empower the Election Committee to
10 develop a list of appropriate penalties for candidates and caucus/delegation/section leadership
11 who violate election rules (Directive to Take Action); and be it further

12 RESOLVED, That the Election Committee define potential election rule violations as minor
13 (oversight or misinterpretation of rules), moderate (more serious and more likely to affect the
14 outcome of an election), and severe (intentional violation with high likelihood of affecting the
15 outcome of an election) and assign appropriate penalties or actions to remedy the situation
16 and/or report the violation to the House of Delegates (Directive to Take Action); and be it further

17 RESOLVED, That any candidate who is deemed to have violated the vote trading election rule
18 be disqualified from the current race as well as any future races at the AMA for a period not less
19 than 2 years, upon the recommendation of the Election Committee and approval of the full
20 House of Delegates (Directive to Take Action); and be it further

21 RESOLVED, That any caucus/delegation/section leadership that is found to have engaged in
22 vote trading shall not be allowed to sponsor any candidates for a period not less than 2 years
23 (Directive to Take Action); and be it further

24 RESOLVED, That anyone who is deemed by the Election Committee to have knowingly and
25 egregiously violated the vote trading rule be referred to the Council on Ethical and Judicial
26 Affairs for potential ethics violations. (Directive to Take Action)

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

Received: 10/13/22