REPORTS OF THE BOARD OF TRUSTEES

The following reports were presented by Willie Underwood, MD, MPH, Chair:

1. EMPLOYED PHYSCIANS

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

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy D-405.969

At the 2022 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Board of Trustees Report 09, Employed Physicians, which recommended:

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

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

Testimony suggested that the proposed definition of "employed physician" required further development, and Report 09 ultimately was referred to the Board for that purpose.

Subsequently, at the 2023 Annual Meeting, the HOD adopted the following definition of employed physician via Resolution 017, rendering moot the first recommendation of referred Report 09:

> "An employed physician is any physician who derives compensation, financial or otherwise, from a contractual relationship with a practice, hospital, or other funding entity and has no direct controlling interest in the entity."

Additionally, since the 2022 Interim Meeting, the Organized Medical Staff Section-convened Employed Physician Caucus has continued to meet both in conjunction with and between AMA meetings, lending the group's expertise to the HOD – for example, by contributing to the development of Resolution 017-A-23. The Board of Trustees looks forward to reporting more fully on the evolution of representation of employed physicians within our AMA at the 2024 Annual Meeting.

RECOMMENDATION

The Board of Trustees recommends that the following recommendation be adopted in lieu of the recommendations of BOT Report 09-I-22 and that the remainder of this report be filed:

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

2. OPPOSING THE USE OF VULNERABLE INCARCERATED PEOPLE IN RESPONSE TO PUBLIC HEALTH EMERGENCIES (RESOLUTION 901-I-22)

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy H-430.976

INTRODUCTION

At the 2022 Interim Meeting of the American Medical Association (AMA) House of Delegates, Resolution 901-I-22, "Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies," was referred. This resolution called on the AMA to oppose the use of forced or coercive labor practices for incarcerated populations, support that any labor performed by incarcerated individuals or other captive populations should include adequate workplace safety and fairness standards similar to those outside of carceral institutions, and support their reintegration into the workforce after incarceration.

BACKGROUND

The U.S. incarcerates over 1.2 million people in state and federal correctional facilities, and two out of three of these individuals who are incarcerated are also workers.[1] In most instances, the jobs of individuals who are incarcerated have looked similar to those of millions of people working on the outside. These jobs include working as cooks, dishwashers, janitors, groundskeepers, barbers, painters, and plumbers.[1] They manufacture products like office furniture, mattresses, license plates, dentures, glasses, traffic signs, athletic equipment, and uniforms.[1] They also cultivate and harvest crops, work as welders and carpenters, and work in meat and poultry processing plants.[1]

The incarcerated workforce provides vital public services such as repairing roads, fighting wildfires, or clearing debris after hurricanes.[1] This was especially evident during the COVID-19 pandemic where many individuals who were incarcerated were tasked with manufacturing masks, medical gowns, face shields, and other personal protective equipment that they were then prohibited from using to protect themselves.[2,3] Individuals who were incarcerated also worked in morgues, transported dead bodies, dug mass graves, and built coffins. They washed soiled hospital laundry, disinfected supplies, and cleaned medical units.[1,3]

HISTORY BEHIND INCARCERATED LABOR

Incarcerated labor has a long history in the United States and is rooted in racial oppression. The origins of incarcerated labor programs can be traced to the end of the Civil War and the passage of the 13th Amendment of the Constitution in 1865.[4] The 13th Amendment outlawed slavery and involuntary servitude, "except as a punishment for crime whereof the party shall have been duly convicted.[5]" What followed was a rise in practices designed to incarcerate and exploit Black people and recently freed enslaved people.[6] One such practice was convict leasing. The system of convict leasing allowed correctional facilities to hire out or "lease" individuals who are incarcerated as
laborers to private parties, such as railways, mines, or plantations.[6] Individuals who are incarcerated were not paid in this arrangement.[7]

The Convict Leasing System in the North and South

In the North, incarcerated people were often contracted out to private individuals and entities to perform labor in industrial factories.[8] Incarcerated laborers were often forced to work 14 to 16 hours a day and were brutally punished for many inhumane reasons.[8] These severe punishments allowed Northern states to produce in one year alone what, in today's dollars, amounts to over $30 billion worth of prison-made goods.[8] By the late 1800s, over 75 percent of the North's incarcerated population worked in these factories. This economic exploitation fell largely upon impoverished, immigrant, and African American communities who made up the majority of the incarcerated population in the North.[8]

In the South, conditions for people who were incarcerated were just as brutal, with workers who were incarcerated forced to labor for up to 17 hours each day, building factories, laying railroads, and mining coal.[8,9] Under the convict leasing system, private employers could bid on and "lease" individuals who are incarcerated for days, months, or

years to work on plantations and at coal mines, turpentine farms, sawmills, phosphate pits, railways, and brickyards.[10] These private employers had unregulated control over unpaid, predominantly Black workers and subjected them to brutal punishments such as whipping and branding and, in many cases, worked people who were incarcerated to death.[11] For example, in Mississippi, not a single leased convict lived long enough to serve a 10-year sentence.[11]

Black Codes

Since the convict leasing system was so profitable, new laws known as "Black Codes" were passed which permitted sheriffs to arrest Black men on baseless charges and indirectly allowed states to expand their convict leasing programs.[12] Scholars note that these racist regulations emerged in 1865 as white-dominated Southern legislatures passed a series of laws that restricted the rights of newly freed Black citizens and allowed the state to maintain control over them.[6] The codes also limited Black people's ability to quit a job by criminalizing and imprisoning those who left a job for which they had a contract with the employer, which was often a requirement for employment.[13] Under the Black Codes and later the Jim Crow laws, the incarcerated population expanded, providing a large pool of unprotected and unpaid laborers for individuals or companies that wanted to profit off nonexistent labor costs.[13,14,15]

Shift From Convict Leasing System to Chain Gangs

By the 1890s, 35 states succumbed to rising union pressure to scale back incarcerated labor programs to reduce competition in the labor market. The result of this concession was the implementation of the "state-use system," in which the state became the only lawful purchaser of incarcerated labor and goods.[16] When Congress established the first federal correctional facilities in 1891, a similar system was adopted in which people who were incarcerated could be forced to work and produce certain commodities, provided that these workers were employed exclusively in the manufacture of such supplies for the government.[17] As state corrections systems expanded, the number of state-sponsored incarcerated labor programs expanded as well. Work crews, commonly known as chain gangs, were first established in the 1890s in Georgia and spread throughout the South as states began to phase out the convict lease system.[18] These chain gangs consisted of individuals who are incarcerated, the vast majority of whom were Black men, who were forced to engage in unpaid labor in brutal conditions outside of the correctional facility, such as road construction, ditch digging, rock breaking, highway maintenance, and farming, under the supervision of correctional officers armed with shotguns and whips.[1,18] Chain gangs became more prevalent in the early 20th century as states gradually abolished the convict leasing system. By 1923 every state except for Rhode Island had used chain gangs to build and repair roads.[1,18]

Establishment of Work-Release Programs and Restitution Centers

In 1913, Wisconsin established the first work-release program in the United States.[19] This program allowed those convicted of misdemeanors to leave jail during the day for the limited purpose of attending work.[19] Since the workers' wages were collected directly by the jail, which also profited from reduced supervisions costs, the model proved to be quite cost-effective.[1,19] Several states were quick to adopt near-identical versions of the Wisconsin program, while others sought to further reduce the costs associated with incarcerating large groups by expanding the program to allow those convicted of minor felonies to participate as well.[1,19]

A similar growth in incarcerated labor programs occurred within the federal system as well. In 1934, four years after the Federal Bureau of Prisons was first established, Congress authorized the creation of the Federal Prison Industries program.[1,19] This program allowed federal correctional facilities to employ individuals who are incarcerated for manufacturing of supplies, the construction of public works, and the maintenance and care of the institutions of the state in which they are imprisoned.[20] The initial aim of this program, like many of those discussed above, was to offset the costs of incarceration by allowing state governments to profit from incarcerated labor.[12] Like the state-use system, this program drew intense criticism from union groups who were concerned that incarcerated labor would displace "free labor.[1,12]" In response, Congress passed several pieces of legislation that outlawed the use of incarcerated labor to maintain federal highways and prohibited the interstate sale of prison-made goods but allowed certain exceptions which allowed states and the federal government to continue benefiting from incarcerated labor.[1,12,21]

In the 1970s, Congress and individual states increasingly allowed private entities and state governments to benefit from incarcerated labor.[1,12] For example, in 1972, Minnesota established America's first "restitution centers" in which low-level offenders were "paroled" out of jail only to be sent to a lower-security confinement facility where

they were required to secure employment to pay off any victim restitution which they owed, or otherwise participate in community service.[22] Similar to work release programs, these restitution centers proved incredibly cost-effective and, in the years that immediately followed, were rapidly adopted by other states.[23]

"War on Drugs" to Present Day

Scholars argue that the modern-day iteration of these same practices is the U.S. government's "War on Drugs," which has resulted in increased enforcement for low-level drug crimes and overly punitive sentencing schemes for drug offenses.[24] These practices are disproportionately enforced against communities of color and directly contribute to the drastic rise in carceral populations, which has tripled since 1980.[25] At present, approximately 55 percent of the U.S. carceral population works while serving their sentences.[26] Sometimes people who are incarcerated may "volunteer" to work for barely any payment as they have no other source of income while incarcerated.[27] In many other cases, labor is neither voluntary nor compensated and yet is still deemed acceptable under the punishment exception.[28] Certain states have codified requirements for participation in work programs and repercussions for anyone refusing to work when jobs are available.[29] In the absence of formal statutes that regulate incarcerated labor, individuals who are incarcerated who refuse work also face threats from guards that they will be placed in solitary confinement, transferred to dangerous housing units, or lose some of their good-time credits.[30]

WORKPLACE SAFETY FOR INDIVIDUALS WHO ARE INCARCERATED

Occupational Health and Safety Administration (OSHA)

OSHA sets workplace safety standards and provides education and training to ensure that standards are met.[31,32] In addition to standard-setting, OSHA has enforcement powers to receive worker complaints, conduct inspections, and issue citations to employers for safety violations. Importantly, the Occupational Safety and Health (OSH) Act's remedial positioning does not require that an injury occur before the agency is authorized to promulgate health and safety standards and issue citations.[32,33] OSHA provides no private right of action for workers to bring suit against their employers in court.[32,34] The OSH Act allows employees to file complaints with the agency when they believe that their workplace is in violation of a health or safety standard, or that working conditions present an imminent danger.[31,32] If OSHA determines that there are reasonable grounds to believe that a violation or danger exists, the agency must initiate an inspection as soon as practicable, to determine if such violation or danger exists.[31,32]

Although the OSH Act federalized workplace safety and health regulations and offers broad coverage to employees across the country, state and local government employees are statutorily exempted from coverage under the federal act.[35] This exemption for state employees reflects the federal government's desire to avoid unnecessary interference with a state's public administration, and to allow states themselves to regulate the health and safety of their employees. This is supported by provisions in OSH Act that allow states to opt out of regulation by federal OSHA by designing their own state health and safety plans, as long as the state plan is at least as effective as the federal program.[36]

OSHA's Applicability to Individuals who are Incarcerated

The standards promulgated by OSHA and the enforcement mechanisms available under OSH Act only cover workers who are classified as "employees."[36] The term "employee" is defined by the Act as follows: an employee is "an employee of an employer who is employed in a business of his employer which affects commerce."[37] This definition, similar to definitions of employee in many other federal statutes, gives little guidance as to whom the statute is intended to cover. The question of which workers qualify as employees and therefore, who should receive protections is a controversial and important threshold question in most areas of employment and labor law.[38]

OSHA had long interpreted its authorizing statute to exclude most incarcerated workers from its protections, primarily through agency interpretations of the term "employee."[36] In 1995, OSHA issued an agency directive interpreting OSH Act to exclude federal individuals who are incarcerated from employee status.[39] OSHA advised that although no individuals who are incarcerated are statutorily protected as "employees," workers who are incarcerated and are required to perform work similar to that outside of prisons are entitled to the applicable protections open to anyone else in similar situations, including the right to file a report of hazards with appropriate safety and health officials.[39,40] This directive suggests that the agency's jurisdiction does not extend to the large number of workers who perform "prison housework," such as cooking, serving food, and janitorial duties. Furthermore, at least one court has found that OSHA safety standards in the federal correctional facility context are advisory, rather than mandatory.[41]

OSHA has interpreted the statute's exclusion of state employers and employees from OSHA's jurisdiction to include those who are incarcerated and detained in state facilities.[42] In its interpretation letter on this matter, OSHA appears to presume that workers who are incarcerated are covered under state health and safety regulations, to the extent that said regulations exist for state employees.[43] However, since 23 states do not fill the state and local government gap in OSHA's coverage with their own health and safety plan, individuals who are incarcerated and detainees in those states are presumably also not covered by any state-issued health and safety standards.[44] Correctional officers and staff are covered under state plans, but most state agencies do not appear to directly respond to complaints by incarcerated workers.[45,46]

Accreditation and Standards for Correctional Facilities

Currently the National Commission on Correctional Health Care (NCCHC) establishes rigorous standards for health services in correctional facilities. This done by operating a voluntary accreditation program for institutions that meet those standards, offering certification for correctional health professionals, conducting educational conferences and webinars, and producing industry-specific publications and other resources. [47,48] Established by health, mental health, legal, and corrections professionals, NCCHC's standards cover the areas of patient care and treatment, governance and administration, personnel and training, safety and disease prevention, special needs and services, and medical-legal issues.[49] Some state, federal, and private correctional facilities point to accreditation by outside, private organizations like the American Correction Association (ACA) to establish that their correctional facilities comply with health and safety standards.[49] This accreditation agency publishes authoritative standards for correctional operations and conducts triennial reaccreditations of state, federal, and privately-operated correctional and detention facilities.[50] For a facility to become ACA-accredited, it must comply (at the time of accreditation) with a certain percentage of mandatory and non-mandatory standards.[51] The accreditation system relies on self-evaluation, paper audits, and on-site inspections for which the facility is given three months' notice to prepare.[52] It should be noted that there is no mechanism for those who are incarcerated to raise health and safety concerns and file complaints about non-compliance with the accreditation standards.[49,50]

PRESENT DAY LOOK AT INCARCERATED LABOR

Types of Incarcerated Work

More than 80 percent of incarcerated workers in state and federal correctional facilities who were surveyed by the Bureau of Justice Statistics reported working in jobs that served to maintain the correctional facilities where they are incarcerated.[53] Approximately 30 percent of all incarcerated workers perform general janitorial duties, nearly 20 percent work in food preparation or carry out other kitchen duties, 8.5 percent provide grounds maintenance, 6.6 percent work in maintenance or repair, 4.5 percent work in laundry, and 14.1 percent perform essential services by working in correctional hospitals or infirmaries, libraries, stockrooms, stores, and barber shops.[1,52]

State correctional facilities, constitute a second type of incarcerated labor program that accounts for about 6.5 percent of incarcerated jobs.[1.52] The number of incarcerated workers employed in state correctional facility programs has been dropping in recent years, from 91,043 in 2008 to 51,569 in 2021.[1,52] These are jobs in state-owned corporations that produce goods, services, and commodities sold to other government agencies. Many states require all state agencies, political units, and public institutions to purchase manufactured goods, including furniture, cleaning supplies, printed materials, and uniforms, from their state correctional facilities.[54] States also rely on incarcerated workers to provide a variety of services, such as data entry, repairing state-owned vehicles, and washing laundry for public hospitals and universities.[1]

A third category of incarcerated labor is public works assignments, sometimes referred to as "community work crews," for the benefit of state, municipal, and local government agencies and occasionally nonprofit organizations.[1] States and municipalities contract with state departments of corrections to use the labor of incarcerated workers for a variety of public works projects such as maintaining cemeteries, school grounds, fairgrounds, and public parks; construct buildings; clean government offices; clean up landfills and hazardous spills; undertake forestry work in state-owned forests; and treat sewage.[1] One study found that at least 41 state departments of correction have public works programs that employ incarcerated workers.[1] Through such programs, incarcerated workers also perform critical work preparing for and responding to natural disasters, including sandbagging, supporting evacuations, clearing debris, and assisting with recovery and reconstruction after hurricanes, tornadoes, mudslides, or floods.[1,55]

A fourth category of incarcerated labor is work for private industries through the Prison Industry Enhancement Certification Program (PIECP), which allows private companies to produce goods and services using incarcerated labor.[56] Some individuals who are incarcerated work directly for the private company while others are employed by the correctional facility and are contracted out to the company.[57] PIECP employs the smallest number, approximately 1 percent, of people who are incarcerated.[58] Some incarcerated workers engage in farming or ranching work for correctional facility programs or for private corporations through PIECP programs to produce livestock, crops, and other agricultural products for sale.[1,57] Some of this agricultural work occurs on penal plantations or prison farms, some of which are situated on land that was originally the site of slave plantations.[1]

Residential Reentry Centers (RRC)

The Federal Bureau of Prisons (BOP) contracts with RRC, also known as halfway houses, to provide assistance to incarcerated individuals who are nearing release.[59] Contrary to the belief that halfway houses are supportive service providers, the majority of halfway houses are an extension of the carceral experience, complete with surveillance, onerous restrictions, and intense scrutiny.[60] RRCs are meant to provide a safe, structured, supervised environment, as well as employment counseling, job placement, financial management assistance, and other programs and services.[60] RRCs are meant to help incarcerated individuals gradually rebuild their ties to the community and facilitate supervising ex-offenders' activities during this readjustment phase. RRC staff should assist incarcerated individuals in obtaining employment through a network of local employers, employment job fairs, and training classes in resume writing, interview techniques, etc.[60] Typically, incarcerated individuals are expected to be employed 40 hours/week within 15 calendar days after their arrival at the RRC.[60]

In federal RRCs, staff are expected to supervise and monitor individuals in their facilities, maintaining close data-sharing relationships with law enforcement.[61] Disciplinary procedure for violating rules can result in the loss of good conduct time credits, or being sent back to prison or jail, sometimes without a hearing. Most states do not release comprehensive policy on their contracted halfway houses.[61] Lack of publicly available data makes it difficult to hold facilities accountable. Basic information like how many facilities there are and what conditions are like is difficult for several reasons:

- No standard, transparent policies. There are few states that publicly release policies related to contracted halfway houses. In states like Minnesota, at least, there appear to be very loose guidelines for the maintenance of adequate conditions within these facilities.[61]
- Privatization. The majority of halfway houses in the United States are run by private entities, both nonprofit and for-profit. For example, the for-profit GEO Group recently acquired Community Education Centers, which operates 30 percent of all halfway houses nationwide.[62] Despite their large share of the industry, they release no publicly available data on their halfway house populations. The case is similar for other organizations that operate halfway houses.
- Poor federal data collection. The Bureau of Justice Statistics does periodically publish some basic data about halfway houses, but only in one collection (the Census of Adult State and Federal Correctional Facilities), which isn’t used for any of the agency’s regular reports about correctional facilities or populations.[63]
- Lack of oversight. The most comprehensive reporting on conditions in halfway houses are audits by oversight agencies from the federal government or state corrections departments. Since 2013, only 8 audits of federal RRCs have been released by the Office of the Inspector General.[64]

Benefits of Incarcerated Labor

One of the main advantages of using the incarcerated workforce is that it can decrease costs for companies.[65] By using individuals who are incarcerated for work, companies can save money on wages and benefits. Additionally, incarcerated labor can help reduce recidivism rates by providing individuals who are incarcerated with job skills and experience.[1,58] This can increase their chances of finding employment once they are released from correctional facilities. Another benefit is that it can help reduce overcrowding in correctional facilities.[58] When individuals who are incarcerated are engaged in work, they are less likely to engage in disruptive behavior, which can lead to disciplinary action and extended sentences.[1,58] This can ultimately lead to a reduction in the number of individuals who are incarcerated in correctional facilities. Further, companies that use incarcerated labor can contribute to the rehabilitation of individuals who are incarcerated. By providing them with meaningful work and skills training, companies can help individuals who are incarcerated develop a sense of purpose and self-worth. This can lead to improved mental health and a reduced likelihood of reoffending.[1,58]

Today, incarcerated labor is an integral part in the lives of individuals who are incarcerated and the economy. Incarcerated labor contributed to large productions of PPE during the COVID-19 pandemic.[2] In 2020 alone, a report revealed that over 4,100 corporations profited from the use of incarcerated labor.[66] According to the National Correctional Industries Association, the value of saleable goods and services produced by incarcerated workers in prison industries programs nationwide totaled $2.09 billion in 2021.[1,67]

Harms of Incarcerated Labor

Despite some of the advantages of using incarcerated labor, there are also many drawbacks. One of the main concerns is that incarcerated labor may be exploitative.[1,58] Individuals who are incarcerated are often paid low wages and do not have the same protections as other workers. For example, individuals who are incarcerated are only paid $0.23–$1.15 per hour, and portions of these wages are often garnished to cover court fees or other incarceration-related expenses.[68] In comparison, the federal minimum wage is currently $7.25 per hour, and many states impose higher minimum-wage requirements.[69] Using incarcerated labor may also perpetuate the cycle of poverty and incarceration.[1,58] Individuals who are incarcerated who work for low wages may struggle to support themselves and their families after they are released from correctional facilities, leading them to turn to crime again.[1] Forced labor can also displace educational benefits like GED programs, college programs, and skills training. Further, the use of incarcerated labor can also lead to human rights abuses. In some cases, individuals who are incarcerated have been forced to work in dangerous or unhealthy conditions, without proper safety equipment or training.[1]

As noted above, individuals who are incarcerated sometimes work in dangerous industrial settings or other hazardous conditions that would be closely regulated by federal workplace health and safety regulations, if they were not incarcerated. Sixty-four percent of incarcerated workers surveyed in a study stated that they felt concerned about their safety while working.[1] The study also noted that incarcerated workers with minimal experience or training are assigned work in unsafe conditions and without protective gear that would be standard in workplaces outside correctional facilities.[1] As a result, incarcerated workers have been burned with chemicals, maimed, or killed on the job. Although lack of data related to workplace conditions and injuries in correctional facilities makes it difficult to know the full extent of injuries and deaths, injury logs generated by the California Prison Industry Authority show that incarcerated workers reported more than 600 injuries over a four-year period, including body parts strained, crushed, lacerated, or amputated.[70] Further, incarcerated workers report receiving inadequate training on how to handle hazardous chemicals, operate dangerous equipment with cutting blades, clean biohazardous materials like excrement and blood, and use dangerous kitchen equipment.[1]

Workers who are incarcerated are employed at dangerous meat, poultry, and egg processing plants, where lack of adequate training or safety procedures has led to dozens of documented injuries and at least one death of a worker who was incarcerated.[1] Workers who are incarcerated have also been severely injured—even paralyzed and killed—by falling trees and tree limbs while cutting down trees on community work crews and in forestry and firefighting jobs.[71] In California, where research has shown that workers who are incarcerated were more likely to be injured than professional firefighters, at least four incarcerated firefighters have been killed while fighting wildfires, and more than 1,000 required hospital care during a five-year period.[72] Further, workers who are incarcerated endure brutal temperatures with inadequate water or breaks, while working outdoors and inside facilities without air conditioning. Incarcerated firefighters have been sickened and killed by heat exposure during routine training exercises in California.[73]

Race and Gender Discrimination Play a Role in Job Assignments

Studies have found that correctional facilities allocate job assignments along racial lines, even when they have contrary policies in place.[74] Desirable jobs, such as more highly paid work in the call center or the fleet garage where police vehicles are serviced, were more often allocated to white incarcerated people. This can result from biased decisions made by correctional officers as well as systems that rely on peer referral for consideration. A 2016 study found that Black men have significantly higher odds of being assigned to maintenance and other facility services work than white men—41.2 percent of Black men and 35.3 percent of white men were assigned such jobs, which are typically paid the lowest wage, if at all.[75]

Discrimination also occurs along gender lines. A study noted that white male incarcerated workers are disproportionately more likely to be assigned to higher-paying, skilled, vocational labor assignments than their minority and female counterparts.[76] Numerous women incarcerated at the South Idaho Correctional Institute reported to the ACLU of Idaho that there is a lack of training opportunities as compared to men.[1] For example, men have an opportunity to obtain their commercial driver's license. That opportunity, however, is not available to incarcerated women. Further it was noted that the white incarcerated individuals get the plumbing, electrician, and

carpentry jobs; and the Black and Latino incarcerated individuals get the jobs like kitchen, yard gang, laundry, clothing, but none of the jobs that can train incarcerated individuals to get a good job once released.[1] Discrimination is even more prominent in incarcerated pregnant individuals who already have limited rights.[77] Further, pregnant incarcerated individuals oftentimes have to work to support their families but lack workplace protections.[78] Work inside correctional facilities provide limited medical care to incarcerated individuals and therefore their reproductive health and pregnancy needs are generally not being appropriately addressed.[79]

Reentry is another critical point at which women are too often left behind. Almost 2.5 million women and girls are released from prisons and jails every year, but few post-release programs are available to them — partly because so many women are confined to jails, which are not meant to be used for long-term incarceration.[79] Additionally, many women with criminal records face barriers to employment in female-dominated occupations, such as nursing and elder care.[78] Compounding issues, formerly incarcerated women — especially women of color — are also more likely to be unemployed and/or homeless than formerly incarcerated men, making reentry and compliance with probation or parole even more difficult.[78]

SHOULD OSHA COVER INDIVIDUALS WHO ARE INCARCERATED?

The statutory purpose of OSH Act—to protect working individuals—is a broad mandate. Despite the absence of a statutory exemption for individuals who are incarcerated, OSHA and its state counterparts have interpreted the Act to not cover most incarcerated correctional facility workers.[35-37,67] Even for the small number of incarcerated workers covered by federal OSHA standards, the enforcement mechanism is limited by restrictions on surprise inspections and a lack of protection from reprisals for submitting complaints.[35-37,67] This significant gap in coverage under the OSH Act leaves some of the most vulnerable workers—often working in dangerous settings with little agency—at high risk for workplace accidents, illness, and death. Scholars argue that safe and healthful working conditions should not hinge on whether that labor is voluntary or on where the labor is performed.[80] It is also important to note that there is no other effective mechanism for incarcerated workers to raise concerns about dangerous workplace conditions and hold correctional facility administrations accountable. The NCCHC and ACA accreditation standards that some states accept as a substitute for state health and safety inspections do not provide a mechanism for individuals who are incarcerated to raise complaints. Any grievances filed with the correctional facility must go through layers of bureaucracy and can result in unlawful retaliation against the complainant by staff.[81] Individuals who are incarcerated are excluded from most state workers' compensation statutes, and incarcerated worker injuries are often not found to reach the level of a constitutional violation.[82] Finally, sovereign immunity and other doctrinal hurdles preclude most tort claims against correctional facility administrators.[83]

Given this concerning gap in coverage, some note that OSHA's authorizing statute should be interpreted more broadly, to cover all incarcerated laborers, including those that work in institutional "housework" work assignments.[67] The regulatory interpretation exempting individuals who are incarcerated in state facilities should be reconsidered given states' failure to fill this large gap in coverage.[1,67] OSHA standards should be considered mandatory in the carceral context, with additional standards specific to incarcerated work. Importantly, a mechanism should be designed so incarcerated workers can file complaints directly with an outside agency and an anti-retaliation provision should be introduced to protect workers from internal prison discipline for filing complaints.[67]

This expansion in coverage could be achieved in part through administrative action as OSHA could issue new federal directives and interpretations that cover housework and make clear the mandatory nature of the regulations. States that already operate state OSHA plans could incorporate detain5ees and individuals who are incarcerated explicitly into their regulations.[67] Both federal and state agencies should devise grievance mechanisms to make it easy for incarcerated workers to file complaints and requests for inspections directly with an outside body, without the correctional facilities' oversight. In addition, members of Congress have repeatedly introduced the Protecting America's Workers Act which would expand OSHA coverage to state and municipal employees; this bill could be amended to incorporate protections for workers incarcerated in state and local correctional facilities.[84]

EXISTING AMA POLICY

AMA policy D-430.992 "Reducing the Burden of Incarceration on Public Health" support efforts to reduce the negative health impacts of incarceration, through implementation and incentivization of adequate funding and resources towards indigent defense systems; implementation of practices that promote access to stable employment and laws that ensure employment non-discrimination for workers with previous non-felony criminal records; and housing support for formerly incarcerated people, including programs that facilitate access to immediate housing after release from carceral settings. This policy also calls on the AMA to partner with public health organizations

and other interested parties to urge Congress, the Department of Justice, the Department of Health and Human Services, and state officials and agencies to minimize the negative health effects of incarceration by supporting programs that facilitate employment at a living wage, and safe, affordable housing opportunities for formerly incarcerated individuals, as well as research into alternatives to incarceration.

CONCLUSION

The roots of modern-day labor programs can be traced to the end of the Civil War and the passage of the 13th Amendment that abolished slavery "except as a punishment for crime."[5] States in the North and the South turned to incarcerated labor as a means of partially replacing chattel slavery and the free labor force slavery provided. As state corrections systems expanded, so too did the number of state-sponsored incarcerated labor programs.[7] The exception clause in the 13th Amendment disproportionately encouraged the criminalization and effective re-enslavement of Black people during the Jim Crow era, and the impacts of this systemic racism persist to this day in the disproportionate incarceration of Black and brown community members.[1,5,8] Under today's system of mass incarceration, nearly 2 million people are held in prisons and jails across the United States.[85] Almost all U.S. correctional facilities have work programs that employ incarcerated workers: Nearly 99 percent of public adult correctional facilities and nearly 90 percent of private adult correctional facilities have such programs.[86]

The current lack of remedies for incarcerated workers facing unsafe conditions or suffering from work-related injuries disincentivizes correctional facilities from investing resources into maintaining safe working conditions.[1,67] Expanding coverage under OSHA to include all workers inside correctional and detention facilities would allow incarcerated workers to file grievances with outside agencies, request inspections, and utilize the administrative appeals and mandamus procedures under the Act.[67] In addition, an increased OSHA presence in correctional facilities could assist individuals who are incarcerated in seeking damages or other judicial remedies for egregious health and safety violations. This expansion of coverage would not only provide access to important independent enforcement mechanisms but would also signal to correctional facility administrators that the government takes prisoner health and safety seriously.[67] This signaling, and the increased risk of fines and litigation, could improve correctional facilities' general accountability for the health and safety of those they incarcerate, affirming the inherent dignity, value, and humanity of workers who are incarcerated.

The use of incarcerated labor for business purposes raises many ethical concerns. Many people argue that using individuals who are incarcerated for work is a form of exploitation and violates their human rights.[1,67,87] Additionally, the fact that individuals who are incarcerated are not entitled to the same protections as other workers raises questions about the fairness of using incarcerated labor for profit. However, proponents of incarcerated labor argue that it provides individuals who are incarcerated with valuable job skills and work experience that can help them successfully reintegrate into society upon release.[58] They also argue that it can be a cost-effective way for businesses to produce goods and services. Additionally, alternatives to using incarcerated labor should be explored to provide individuals who are incarcerated with a path to economic self-sufficiency that does not rely on their incarceration. One potential alternative to using incarcerated labor is to invest in education and job training programs for individuals who are incarcerated.[1,58] By providing individuals who are incarcerated with the skills and knowledge they need to succeed in the workforce, they can be better equipped to find employment upon release and avoid reincarceration. This approach not only benefits the individuals who are incarcerated themselves, but also the broader community by reducing recidivism rates and promoting economic growth.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 901-I-22, and the remainder of this report be filed.

1. Our AMA acknowledges that systemic racism is a root of incarcerated labor policies and practices.
2. Our AMA supports:
   (a) Efforts to ensure that all work done by individuals who are incarcerated in correctional facilities is fully voluntary.
   (b) Eliminating policies that require forced labor or impose adverse consequences on incarcerated workers who are unable to carry out their assigned jobs due to illness, injury, disability, or other physical or mental limitations.
   (c) Eliminating policies that negatively impact good time, other reductions of sentence, parole eligibility, or otherwise extend a person's incarceration for refusal to work when they are unable to carry out their assigned jobs due to illness, injury, disability, or other physical or mental limitations.

(d) The authority of correctional health care professionals to determine when an individual who is incarcerated is unable to carry out assigned work duties.

3. Our AMA encourages:
   (a) Congress and state legislatures to clarify the meaning of "employee" to explicitly include incarcerated workers within that definition to ensure they are afforded the same workplace health and safety protections as other workers.
   (b) Congress to enact protections for incarcerated workers considering their vulnerabilities as a captive labor force, including anti-retaliation protections for workers who are incarcerated who report unsafe working conditions to relevant authorities.
   (c) Congress to amend the Occupational Safety and Health Act to include correctional institutions operated by state and local governments as employers under the law.
   (d) The U.S. Department of Labor to issue a regulation granting the Occupational Safety and Health Administration jurisdiction over the labor conditions of all workers incarcerated in federal, state, and local correctional facilities.
4. Our AMA encourages:
   (a) Comprehensive safety training that includes mandatory safety standards, injury and illness prevention, job-specific training on identified hazards, and proper use of personal protective equipment and safety equipment for incarcerated workers.
   (b) That safety training is delivered by competent professionals who treat incarcerated workers with respect for their dignity and rights.
   (c) That all incarcerated workers receive adequate personal protective equipment and safety equipment to minimize risks and exposure to hazards that cause workplace injuries and illnesses.
   (d) Correctional facilities to ensure that complaints regarding unsafe conditions and abusive staff treatment are processed and addressed by correctional administrators in a timely fashion.
5. Our AMA acknowledges that investing in valuable work and education programs designed to enhance incarcerated individuals' prospects of securing employment and becoming self-sufficient upon release is essential for successful integration into society.
6. Our AMA strongly supports programs for individuals who are incarcerated that provides opportunities for advancement, certifications of completed training, certifications of work performance achievements, and employment-based recommendation letters from supervisors.

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3. UPDATE ON CLIMATE CHANE AND HEALTH – AMA ACTIVITIES

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: REFERRED

At the 2023 American Medical Association (AMA) Annual Meeting, Board of Trustees Report 17, "AMA Public Health Strategy," was adopted as amended by the House of Delegates (HOD) with an additional resolve statement asking that our "AMA Board of Trustees provide a strategic plan or outline for the AMA's plan to address and combat the health effects of climate change at I-2023."

This report provides an update on the work the AMA has accomplished towards the strategy outlined in June of 2023, which includes the following priorities:

1. Educate physicians and trainees on the health effects of climate change.
2. Identify and disseminate information to physicians on decarbonizing the health care sector and reducing greenhouse gas (GHG) emissions.
3. Elevate the voices of physician leaders on the issue of climate change and health.
4. Collaborate with stakeholders to advance policies and interventions with a unified voice.

BACKGROUND

There is increasing evidence and near-universal consensus among the scientific community that human activities within the last 150 years are impacting the climate and causing increased global surface temperatures.[1,2] Even small increases in global surface temperatures can impact weather patterns, causing regional and seasonal temperature extremes, reducing snow cover and sea ice, and intensifying heavy rainfall.[3] Several events have occurred *just since* the AMA's June 2023 Annual Meeting that clearly reflect the impacts of climate change on U.S. weather systems and its effects on health. Smoke from wildfires in Canada this summer has exposed over 70 million Americans to unhealthy air quality.[4] As of late-July, a number of south and southwestern states have experienced a historic extreme heat wave, with more than three consecutive weeks of temperatures exceeding 100-degree Fahrenheit.[5,6] In mid-July, intense rainstorms hit northeastern states and caused mass, catastrophic flooding, particularly in Vermont.[7] These types of events are just a few examples of how climate change is already impacting the U.S. and highlights the importance of it as a public health issue.

DISCUSSION

Physician and Trainee Listening Sessions

In response to the policy adopted by the HOD declaring climate change a public health crisis, the AMA held listening sessions with physicians and medical students on the topic to gauge their thoughts about the health risks of climate change, the need to decarbonize the health sector, and what specific actions they would like the AMA to address. Three virtual listening sessions with physicians and medical students were held in May 2023. Participants were recruited through invitations sent to members of AMA Councils and Sections as well as sharing of that invitation with other interested physicians. A total of sixteen participants (n =16) were chosen from across the U.S. based on their availability and to ensure diversity in specialty and geography. Sessions were 60 minutes long and followed a semi-structured interview guide.

Findings. Participants in the listening sessions were first asked, "What health impacts are physicians already seeing from climate change?" Participants identified a myriad of health impacts including an increase in natural disasters (e.g., flooding, hurricanes, and wildfires), longer than normal allergy seasons, heat waves, rising sea levels and issues with poor water quality due to higher temperatures (e.g., toxic algae blooms), as well as an increasing range and potential for vector-borne and zoonotic diseases. While many of the above listed health impacts are direct effects of climate change, the participants also highlighted indirect impacts in that climate change has the potential to exacerbate already existing health conditions and that it can act as a "multiplier effect." For example, poor air quality caused by wildfires in Canada this summer can exacerbate illness for those with pre-existing asthma or cardiovascular disease. Additionally, participants highlighted that there are important equity and environmental justice concerns and that impacts are experienced differently depending on whether it is an urban versus rural population. The quotes provided below reflect their responses.

"In Florida, one of our big things is heat. On those hot days people come in in their early 20s who are healthy and fit, but they have kidney injury due to dehydration or heart failure."

"We get algae blooms and people otherwise healthy, as well as those later in life, have severe respiratory issues."

"My patients are severely affected by wildfires, well beyond asthma. It keeps people from going outdoors which impacts their exercise and it can also impact their income which both impacts their health."

"The heat is a huge issue in the cities. Everything is more intense. The radiation of asphalt and cement along with the heat events especially in disinvested neighborhoods cause ER visits to rise dramatically."

Participants in the listening sessions were also asked, "What steps do you believe the US health care system should be taking to decarbonize itself?" Responses were largely focused on the challenges in decarbonizing the health care system, namely a lack of motivation or interest from hospital/system administration to take steps toward decarbonization, partially due to the financial investment it would require. Despite these challenges, participants acknowledged the need to work within their own systems and support the work that is currently happening (e.g., sustainability efforts), and recommended that hospital systems utilize the newly passed Inflation Reduction Act, which provides financial supports for climate change adaptation and resilience efforts, to advocate for change. However, it was recognized that the problem is complex; solutions must be multi-faceted and address larger policy issues outside of health care.

"In my medical community physicians are supportive but the administration is only concerned about fiscal goals. My CEO wants me to 'get back in my lane'."

"We're making progress but it's not to the level we need to be. The goals are there; the action isn't."

"As physicians, we are aware of all the health threats but what can one doctor do?"
Participants also discussed the need to do more communication about climate change and health, both internally (i.e., to other physicians, staff, and health care administration) and externally (i.e., to patients). One participant said it would be helpful to have a screening tool for patients to help capture how patients are vulnerable to climate change harms, which could help start the conversation and inform potential referrals.

The last question participants were asked was for recommendations in terms of what the AMA can be doing on this topic. In general, recommendations from participants could be grouped as follows:

- Convene a consortium of other health care organizations that are concentrating on climate change.
- Provide education and be a repository for all education/information about climate change, including the creation of CMEs on climate change.
- Be an advocate for climate change reform, especially around issues that affect marginalized communities.

Other specific recommendations included the identification and convening of "climate champions" from every state medical society and other topic area specific societies, creating a climate change caucus at annual meetings, and helping craft different messages based on different audiences, with a particular focus on different political audiences.

"Health is the human face of climate change. Patient health is the physicians' lane and the AMA's lane is public health. They have got to be involved."

"The AMA could be a central repository for climate change info. It would be wonderful if all of the data and talks and resources could be centrally linked at the AMA so there is one place to go."

"They should offer more on this topic at national and subnational meetings and encourage state chapters to have this within their annual meetings."

"Advocacy is so important, especially for the populations that are most affected. It's disproportionally affecting the marginalized communities which is where the AMA can come in with the advocacy."

Key Takeaways. Physicians in the listening sessions are already seeing climate change impacts in their communities and among their patients. The participants spoke passionately on this topic and felt strongly that more needs to be done, and soon, to avoid worse case scenarios presented by climate change. In terms of health care decarbonization efforts, participants spoke of many challenges, but the primary ones are administrative and financial. While there are a few hospitals leading the way in this regard, most health care systems do not see this as a priority considering other current issues. Lastly, it was clear from the listening sessions that physicians want to see the AMA more actively involved as a convener, advocate, and educational hub for climate change and health. However, their comments also reflect a lack of general awareness of the AMA's current work in this area, particularly the AMA's involvement with several consortiums and partner groups (see section below for more information) and available resources. For example, AMA has developed a resource to encourage physicians to transition to greener practices that is available on the AMA website.[8] This presents an opportunity for the AMA to improve and strengthen their communications and marketing on this topic.

AMA Actions to Advance Priority Areas

In June of 2023, the AMA hired a new staff member with subject matter expertise in environmental health and climate change. As such, the AMA is better positioned to be more actively engaged around climate change and health moving forward.

1. *Educate physicians and trainees on the health effects of climate change.*

    - The AMA has made climate change education available via the Ed Hub™ from a variety of sources including the AMA Journal of Ethics (JOE), the Journal of the American Medical Association (JAMA), and the American Public Health Association (APHA).

    - AMA staff are in the initial planning stages for developing a CME module for physicians and trainees on climate change, which we anticipate will be available in 2024.

    - AMA staff participated in a plenary panel session entitled, "Climate – Impact on Health and Health Care" at AcademyHealth's 2023 Annual Research Meeting, which took place on June 27, 2023, in Seattle, WA. The session examined how the health care system contributes to climate change, what research is needed to reduce health threats from climate change across the lifespan and explored opportunities for the U.S. health system to do its part in alleviating the effects.

2. *Identify and disseminate information to physicians on decarbonizing the health care sector and reducing GHG emissions.*

    - AMA staff are working to develop and disseminate tools and resources focused on decarbonizing the health care sector, with a focus on smaller practices. This includes reviewing existing resources available to prevent duplication of efforts. (See also NAM Action Collaborative on Decarbonizing the Health Sector)

3. *Elevate the voices of physician leaders on the issue of climate change and health.*

    - AMA's Chief Health & Science Officer joined the August 24, 2023, PermanenteDocs Chat podcast on heat waves and health, with a focus on how physicians can adjust to prepare to care for heat-related conditions brought on by climate change.

4. *Collaborate with stakeholders to advance policies and interventions with a unified voice.*

The AMA continues to engage in the following consortiums and partnerships to advance policies and interventions on climate change and health. As other working groups interested in this topic form, the AMA will consider partnering with them and, in the very least, share relevant information and resources as they become available.

Medical Society Consortium on Climate and Health. The AMA continues to engage in the Medical Society Consortium on Climate and Health (Consortium), which brings together associations representing over 600,000 clinical practitioners to weigh in to help ensure that the health risks of climate change and the health benefits of climate solutions, especially clean energy, are clearly understood.

National Academy of Medicine Action Collaborative on Decarbonizing the U.S. Health Sector. The AMA is a member of the Steering Committee and co-lead of the Health Care Delivery Workgroup. The Climate Collaborative is a public-private partnership of leaders from across the health system committed to addressing the sector's environmental impact while strengthening its sustainability and resilience. Recent accomplishments of the health care delivery workgroup include:

- Holding an executive session at the American Hospital Association Annual Membership Meeting on *Pathways to Health System Sustainability and Decarbonization,* featuring four health system CEO panelists who are further along in their decarbonization journey.
- Publication of a short list of key actions to reduce greenhouse gas emissions by U.S. hospitals and health systems.[9]
- Publication of a C-suite feature story in *Modern Healthcare* from four health system CEOs that highlights their case for decarbonization.[10]

Healthy Air Partners. The AMA is a collaborator in the American Lung Association's Healthy Air Partners campaign, which is a coalition of 40 national public health, medical, nursing and health care organizations engaged in healthy air advocacy efforts. The Coalition is united in its calling for strong federal laws and policies to slash air pollution and address climate change, recognizing climate change can affect air quality, and certain air pollutants can affect climate change. So far in 2023, the AMA has joined partners on several letters, including:

- A letter to the EPA urging them to quickly strengthen and finalize the Standards of Performance for New, Reconstructed, and Modified Sources and Emissions Guidelines for Existing Sources: Oil and Natural Gas Sector.
- A letter to EPA on their proposed ruling regarding Pollutant Emissions Standards for Model Years 2027 and Later Light- Duty and Medium-Duty Vehicles, urging them to pass the most stringent emission standards possible with existing technologies.
- A letter to EPA on their proposed ruling regarding National Emission Standards for Hazardous Air Pollutants: Coal- and Oil-Fired Electric Utility Steam Generating Units Review of the Residual Risk and Technology Review.

American Public Health Association (APHA) Advisory Board on Climate, Health, and Equity. The APHA Center on Climate, Health, and Equity leads public health efforts to inspire action on climate and health, advance policy and galvanize the field to address climate change.[11] APHA recently had an open application for their 2023-2025 Climate, Health and Equity Advisory Board. AMA staff applied to serve on this advisory board and will receive confirmation in fall 2023 whether their application was accepted.

CONCLUSION

Recognizing the public health crisis that climate change presents, the AMA will continue to engage on this topic through advocacy, education, dissemination of resources, and collaboration with partner organizations.

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4. UPDATE ON FIREARM INJURY PREVENTION TASK FORCE

Informational report; no reference committee hearing.

HOD ACTION: FILED

At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates, Board of Trustees Report 17, "AMA Public Health Strategy," provided an update on the status of the AMA's Firearm Injury Prevention task force. An additional resolve was added to that report asking "that our AMA Board of Trustees provide an update on the efforts and initiatives of the AMA's gun violence task force at I-2023."

BACKGROUND

In June we reported on Phase I of the gun violence task force, which consisted of convening those Federation members who have been most highly engaged on the issue of firearm injury prevention for many years. In February of 2023, representatives from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Physicians, American College of Surgeons, American Psychiatric Association met with members of the AMA Board and staff. AMA Board Chair Sandra Adamson Fryhofer, MD, Chair of the first phase of this Task Force, led the meeting. The goal was to better understand work already underway to address this issue, what has worked well, and the unique role an AMA convened task force could play. Gun violence advocacy organizations (Brady, Giffords, and the Johns Hopkins Center for Gun Violence Solutions) were also invited to share their perspectives on the role of physicians and organized medicine in firearm injury prevention. The advocacy groups strongly encouraged organized medicine to pick one or two things to focus on and to speak with a unified voice.

DISCUSSION

In June of 2023, the AMA Board of Trustees approved the task force charge, member organizations, and budget for the task force.

Firearm Injury Prevention Task Force Charge: Advise the AMA Board of Trustees on the role of organized medicine in firearm injury prevention. Further, the Task Force will inform the development of tools and resources for physicians and trainees on firearm injury prevention to increase counseling of high-risk patients and awareness of available interventions. This includes the implementation of directives adopted by the House of Delegates, including the development of a toolkit on extreme risk protection orders (ERPO).

Proposed Task Force member organizations:

American Academy of Child and Adolescent Psychiatry
American Academy of Pediatrics
American Academy of Family Physicians
American Academy of Physical Medicine and Rehabilitation
American College of Emergency Physicians
American College of Obstetricians and Gynecologists
American College of Physician
American College of Preventive Medicine
American College of Surgeons
American Geriatrics Society
American Pediatric Surgical Association
American Psychiatric Association
National Medical Association
Society of Critical Care Medicine

Ex Officio Members:
The Health Alliance for Violence Intervention (HAVI)

Federal Liaisons:
Centers for Disease Control and Prevention (to inform on data, latest research)
Department of Veterans Affairs (to inform on efforts in normalizing firearm counseling by clinicians and suicide prevention)

The call for nominations was sent out to medical specialty societies in July of 2023. At the time this report was prepared (August 2023), nominations have been received from six medical specialty societies. Once nominations are complete the first meeting of the task force will be scheduled. It is anticipated that the task force will meet four times per year to accomplish their work. The task force has been approved for a term of two years with the possibility of extension pending Board review and approval.

5. AMA PUBLIC HEALTH STRATEGY: THE MENTAL HEALTH CRISIS

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: RECOMMENDATION ADOPTED
REMAINDER OF REPORT FILED
See Policy D-440.912

INTRODUCTION

At the 2023 Annual Meeting of the House of Delegates (HOD), the policy, "Public Health Strategy", was adopted. The second directive of the policy directs the American Medical Association (AMA) to provide a status update of its initiatives to address the ongoing mental health crisis. The following informational Board Report provides this update for the HOD at the 2023 Interim Meeting.

BACKGROUND:

The United States is in the midst of a decades-long mental health crisis exacerbated by the COVID-19 pandemic.[1] The number of American adults reporting symptoms of anxiety and/or depressive disorder grew from one in ten in 2019 to four in ten by early 2021.[2,3] Deaths due to drug overdose are four times higher than in 1999.[2] The prevalence and severity of mental health conditions among children and teens have also increased sharply with the U.S. surgeon general urging action to address the mental health crisis among young people including increased suicidal behaviors.[4] Research shows a high incidence of co-occurring mental illness and substance use disorder, perceived stigma with both conditions, and the importance of privacy to those seeking care.[5,6,7,8,9]

Mental health is also a major concern for physicians and medical students. A recent survey showed that nearly a quarter of physicians report clinical depression and are more likely to have suicidal ideation compared to those in other professions.[10] For most physicians, seeking treatment for mental health sparks legitimate fear of resultant loss of licensure, loss of income and/or other meaningful career setbacks as a result of ongoing stigma. More than 40 percent of physicians do not seek help for depression (or burnout) for fear of disclosure to a state licensing board, leaving many to suffer in silence or worse.[11] The AMA is deeply committed to combating the ongoing mental health crisis and continues to strategically lead and support numerous initiatives to promote the mental wellbeing of physicians, their care teams and the patients they serve.

AMA POLICY

The AMA has numerous policies aimed at addressing mental health issues among the patient population, physicians and other health care professionals.

The AMA developed principles on mental health. They state:

a. Tremendous strides have already been made in improving the care and treatment of patients with psychiatric illness, but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community and the nation. Any program designed to combat psychiatric illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive.
b. The AMA recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the mental health field on two levels, as an individual of science and as a citizen. The physician has much to gain from a knowledge of modern psychiatric principles and techniques and much to contribute to the prevention, handling and management of emotional disturbances. Furthermore, as a natural community leader, the physician is in an excellent position to work for and guide effective mental health programs.
c. The AMA will be more active in encouraging physicians to become leaders in community planning for mental health.
d. The AMA has a deep interest in fostering a general attitude within the profession and among the lay public more conducive to solving the many problems existing in the mental health field (Policy H-345.999, “Statement of Principles on Mental Health”).

Additionally, the AMA supports working with all interested national medical organizations, national mental health organizations, and appropriate federal government entities to convene a federally-sponsored blue ribbon panel and develop a widely disseminated report on mental health treatment availability and suicide prevention to:

a. improve suicide prevention efforts, through support, payment and insurance coverage for mental and behavioral health and suicide prevention services including but not limited to the National Suicide Prevention Lifeline;
b. increase access to affordable and effective mental health care through expanding and diversifying the mental and behavioral health workforce;
c. expand research into the disparities in youth suicide prevention;
d. address inequities in suicide risk and rate through education, policies and development of suicide prevention programs that are culturally and linguistically appropriate;
e. develop and support resources and programs that foster and strengthen healthy mental health development; and
f. develop best practices for minimizing emergency department delays in obtaining appropriate mental health care for patients who are in mental health crisis.

Our AMA also supports physician acquisition of emergency mental health response skills by promoting education courses for physicians, fellows, residents, and medical students including but not limited to mental health first aid training (Policy D-345.972, “Mental Health Crisis”).

The AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:

a. reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public;
b. improving public awareness of effective treatment for mental illness;
c. ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural

areas and those serving children and adolescents;
d. tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity;
e. facilitating entry into treatment by first-line contacts recognizing mental illness and making proper referrals and/or to addressing problems effectively themselves; and
f. reducing financial barriers to treatment (Policy H-345.981, “Access to Mental Health Services”).

Further, our AMA encourages: (1) medical schools, primary care residencies and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (2) all physicians providing clinical care to acquire the same knowledge and skills; and (3) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes.

Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.

The AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses and to increase patient access to quality care for depression and other mental illnesses.

Our AMA: (1) will advocate for the incorporation of integrated services for general medical care, mental health care and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings; (2) encourages graduate medical education programs in primary care, psychiatry and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model such as the collaborative care model; and (3) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.

Our AMA recognizes the impact of violence and social determinants on women’s mental health (Policy H-345.984, “Awareness, Diagnosis and Treatment of Depression and Other Mental Illnesses”).

Moreover, the AMA supports:
a. maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers and other state-supported psychiatric services;
b. state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment to avoid repeated psychiatric hospitalizations and interactions with the law primarily as a result of untreated mental conditions;
c. increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness; and
d. enforcement of the Mental Health Parity Act at the federal and state level.

AMA will take these resolves into consideration when developing policy on essential benefit services (Policy H-345.975, “Maintaining Mental Health Services by States”).

The AMA will also: (1) utilize their existing communications channels to educate the physician community and the public on the new 9-8-8 National Suicide Prevention Lifeline program; (2) work with the Federation and other stakeholders to advocate for adequate federal and state funding for the 9-8-8 system including the development of model legislation; and (3) collaborate with the Substance Abuse and Mental Health Services Administration, the 9-8-8 partner community and other interested stakeholders to strengthen suicide prevention and mental health crisis services that prioritize education and outreach to those populations at highest risk for suicide attempts, suicide completions and self-injurious behavior (Policy D-345.974, “Awareness Campaign for 988 National Suicide Prevention Lifeline”).

The AMA also supports (1) mental health and faith community partnerships that foster improved education and understanding regarding culturally competent, medically accepted and scientifically proven methods of care for psychiatric and substance use disorders; (2) better understanding on the part of mental health providers of the role of

faith in mental health and addiction recovery for some individuals; and (3) efforts of mental health providers to create respectful, collaborative relationships with local religious leaders to improve access to scientifically sound mental health services (Policy H-345.971, "Faith and Mental Health").

Additionally, the AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness such as the Crisis Intervention Team model programs; (3) federal funding to encourage increased community and law enforcement participation in crisis intervention training programs; (4) legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities; and (5) increased research on non-violent de-escalation tactics for law enforcement encounters with people who have mental illness and/or developmental disabilities and research of fatal encounters with law enforcement and the prevention thereof (Policy H-345.972, "Mental Health Crisis Interventions").

Also of importance, our AMA advocates for the repeal of laws that deny persons with mental illness the right to vote based on membership in a class based on illness (Policy H-65.971, "Mental Illness and the Right to Vote").

The AMA (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives (Policy H-345.977, "Improving Pediatric Mental Health Screening").

Moreover, the AMA:

a. recognizes youth and young adult suicide as a serious health concern in the U.S.;
b. encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter youth or young adult patients, addressing effective suicide prevention including screening tools, methods to identify risk factors and acuity, safety planning and appropriate follow-up care including treatment and linkages to appropriate counseling resources;
c. supports collaboration with federal agencies, relevant state and specialty medical societies, schools, public health agencies, community organizations and other stakeholders to enhance awareness of the increase in youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources and improve care for youth and young adults at risk of suicide;
d. encourages efforts to provide youth and young adults better and more equitable access to treatment and care for depression, substance use disorder and other disorders that contribute to suicide risk;
e. encourages continued research to better understand suicide risk and effective prevention efforts in youth and young adults, especially in higher risk sub-populations such as Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations and among youth and young adults with disabilities;
f. supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in youth and young adults;
g. supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools;
h. will publicly call attention to the escalating crisis in children and adolescent mental health in this country in the wake of the COVID-19 pandemic;
i. will advocate at the state and national level for policies to prioritize children's mental, emotional and behavioral health;
j. will advocate for a comprehensive system of care including prevention, management and crisis care to address mental and behavioral health needs for infants, children and adolescents; and
k. will advocate for a comprehensive approach to the child and adolescent mental and behavioral health crisis when such initiatives and opportunities are consistent with AMA policy (Policy H-60.937, "Youth and Young Adult Suicide in the United States").

The AMA also advocates for (1) increased research funding to evaluate the validity, efficacy and implementation challenges of existing mental health screening tools for refugee and migrant populations and, if necessary, create brief, accessible, clinically-validated, culturally-sensitive and patient centered mental health screening tools for refugee and migrant populations; (2) increased funding for more research on evidence-based mental health services to refugees and migrant populations and the sex and gender factors that could increase the risk for mental disorders in refugee women and girls who experience sexual violence; and (3) increased mental health training support and service delivery funding to increase the number of trained mental health providers to carry out mental health screenings and treatment, as well as encourage culturally responsive mental health counseling (Policy D-345.982, "Increasing Mental Health Screenings by Refugee Resettlement Agencies and Improving Mental Health Outcomes for Refugee Women").

Our AMA supports (1) improvements in current mental health services for women during pregnancy and postpartum; (2) advocacy for inclusive insurance coverage of mental health services during gestation and extension of postpartum mental health services coverage to one year postpartum; and (3) appropriate organizations working to improve awareness and education among patients, families and providers of the risks of mental illness during gestation and postpartum; and will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis and substance use disorder through research, public awareness and support programs (Policy H-420.953, "Improving Mental Health Services for Pregnancy and Postpartum Mothers").

Further, our AMA is in support of adequate attention and funds being directed towards culturally and linguistically competent mental health direct services for the diverse, multi-ethnic communities at greatest risk, and encourages greater cultural and linguistic-competent outreach to ethnic communities including partnerships with ethnic community organizations, health care advocates and respected media outlets (Policy H-345.974, "Culturally, Linguistically Competent Mental Health Care and Outreach for At-Risk Communities").
The AMA also supports: (1) strategies that emphasize de-stigmatization and enable timely and affordable access to mental health services for undergraduate and graduate students in order to improve the provision of care and increase its use by those in need; (2) colleges and universities in emphasizing to undergraduate and graduate students and parents the importance, availability and efficacy of mental health resources; and (3) collaborations of university mental health specialists and local public or private practices and/or health centers in order to provide a larger pool of resources, such that any student is able to access care in a timely and affordable manner (Policy H-345.970, "Improving Mental Health Services for Undergraduate and Graduate Students").

Our AMA advocates for:

a. physicians, medical students and all members of the health care team (i) to maintain self-care, (ii) receive support from their institutions in their self-care efforts and (iii) in order to maintain the confidentiality of care, have access to affordable health care including mental and physical health care, outside of their place of work or education;
b. employers support access to mental and physical health care including but not limited to providing access to out-of-network in person and/or via telemedicine, thereby reducing stigma, eliminating discrimination and removing other barriers to treatment; and
c. for best practices to ensure physicians, medical students and all members of the health care teams have access to appropriate behavioral, mental, primary and specialty health care and addiction services (Policy D-405.978, "Access to Confidential Health Care Services for Physicians and Trainees").

Our AMA also supports requirements of all health insurance plans to implement a compliance program to demonstrate compliance with state and federal mental health parity laws (Policy H-185.916, "Expanding Parity Protections and Coverage of Mental Health and Substance Use Disorder Care").

Lastly, the AMA advocates that funding levels for public sector mental health and substance use disorder services not be decreased in the face of governmental budgetary pressures, especially because private sector payment systems are not in place to provide accessibility and affordability for mental health and substance use disorder services to our citizens (Policy H-345.980, "Advocating for Reform in Payment of Mental Health and Substance Use Disorder Services").

DISCUSSION

Federal and State Advocacy

Congressional
In 2021, the AMA successfully advocated for passage of the "Dr. Lorna Breen Health Care Provider Protection Act." The Act dedicated resources to support the mental health needs of physicians including funding for the National Suicide Prevention Lifeline. The AMA also successfully advocated for the addition of new Medicare-supported GME positions, at least 100 of which were reserved for psychiatric specialty residency positions, in the 2021 Consolidated Appropriations Act. This was the first increase of its kind in nearly 25 years. The AMA also supported additional funding for grants to establish or expand programs to grow and diversify the maternal mental health/substance use disorder treatment workforce and the Substance Abuse and Mental Health Services Administration (SAMHSA) Minority Fellowship Program.

In 2022, the AMA worked with pertinent national medical specialty societies to advocate for a number of measures to be included in a comprehensive mental health package as part of the SAMHSA reauthorization process. AMA submitted comments to House Ways and Means Committee, House Energy and Commerce Committee, Senate HELP Committee and Senate Finance Committee as part of this work. Congress enacted significant new investments and policy changes to address the ongoing mental health crisis as part of H.R. 2471, Omnibus Appropriations for Fiscal Year 2022. AMA-supported measures that were in the final law included:

1. Funding for SAMHSA at $6.5 billion, a $530 million increase including $2 billion directed to mental health programs, an increase of $288 million over fiscal year (FY) 2021. This included $102 million in additional resources for the implementation of the 9-8-8 hotline number, $42 million set aside to help communities improve related crisis care response and services and a $10 million new pilot program to help communities create or enhance mobile crisis response teams consisting of mental health responders and avoiding unnecessary police response.
2. $17 million to promote and train culturally competent care via the SAMHSA Minority Fellowship Program.
3. $24 million for the Loan Repayment Program for Substance Use Disorder Treatment Workforce to provide as much as $250,000 in loan repayments to psychiatrists and other substance use disorder clinicians who agree to work full-time in a health professional shortage area or county with abnormally high overdose rates for up to six years.
4. An increase of $5 million for the Employee Benefits Security Administration, which is responsible for enforcing compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) for the 2.2 million employer-sponsored health plans regulated under the Federal Employee Retirement Income Security Act. Importantly, the package specifically directed the utilization of additional resources to fully fund the hiring and training of additional health investigators to focus exclusively on MHPAEA compliance.
5. New policy eliminating the parity opt-out for non-federal governmental health plans and providing funding for state insurance departments to enforce and ensure compliance with the mental health parity law.
6. New policy extending the current public health emergency Medicare telehealth flexibilities and delays the implementation of the in-person requirement for telehealth services for mental health until December 31, 2024.
7. Grants and technical assistance to primary care practices to implement the evidence-based Collaborative Care Model into their practices for early intervention and prevention of mental health and substance use disorders.
8. 200 new Medicare-supported graduate medical education slots in FY 2026 psychiatry and psychiatry subspecialties.

In 2023, the AMA endorsed the Parity Enforcement Act of 2023 (H.R.3752) to provide the Secretary of the Department of Labor authority to impose civil monetary penalties on federally regulated group health plans for violations of the federal mental health and substance use disorder parity law. Additionally, the AMA signed onto a letter in support of the Children's Hospitals Graduate Medical Education program asking for the provision of $738 million in FY 2024 funding for the program which is critical because of the ongoing youth mental health crisis. The AMA has also endorsed the Resident Physician Shortage Reduction Act of 2023 (H.R. 2389) to add 14,000 Medicare-supported residency slots over seven years to address the physician workforce shortage including psychiatry and psychiatry subspecialties.

Legislative
In the past two years, the AMA Advocacy Resource Center (ARC) has advocated for and supported new laws in multiple states including Arizona, Delaware, Georgia, Illinois, Kentucky, Mississippi and Virginia. These laws help protect physicians who seek care for mental health conditions. Provisions range from providing "safe-haven" protections that shield records from disclosure to provisions requiring state licensing boards to remove stigmatizing questions from medical licensure applications.[12]

Regulatory
The ARC has worked closely with the Dr. Lorna Breen Heroes' Foundation and Federation of State Medical Boards (FSMB) to encourage all medical boards to remove stigmatizing, inappropriate questions that seek disclosure of past diagnosis of a mental illness or substance use disorder. In the past year, ARC efforts with the Foundation and FSMB have resulted in three state medical boards revising their questions and the ARC is working with eight additional state medical boards on proposed revisions.[13]

Private Sector
The ARC also is working directly with chief medical, wellness and compliance officers at more than 20 regional and multistate health systems to revise their credentialing applications to remove stigmatizing questions about past diagnosis or treatment of mental illness and substance use disorders. The efforts of the AMA and Dr. Lorna Breen Heroes' Foundation have led to nearly ten systems confirming and/or revising changes to be consistent with AMA policy and the Foundation's recommendations. Several additional health systems have approached the Foundation and AMA for technical assistance in revising their applications.

National
In partnership with the Dr. Lorna Breen Heroes' Foundation and the FSMB, the AMA has presented its wellness-focused advocacy efforts at multiple medical society and national organization meetings including the FSMB, American Academy of Family Physicians and the Federation of State Physician Health Programs. Additional efforts have focused on urging public support for wellness-focused initiatives in collaboration with the American Heart Association, Accreditation Council of Graduate Medical Education, National Committee of Quality Assurance, National Association Medical Staff Services and others.

Mental Health and Substance Use Disorder Parity
The AMA continues to urge state departments of insurance to meaningfully enforce state mental health and substance use disorder parity laws. AMA advocacy continues with the National Association of Insurance Commissioners to ensure that payers provide timely and accurate information as part of regular compliance reviews with parity laws. Notably, AMA efforts to increase regulators' focus on enforcement have resulted in strong, parity-focused network adequacy regulations in Colorado and enforcement actions in Illinois that highlighted payers' discriminatory actions with respect to medications for people with a mental illness or substance use disorder. The AMA continues to play an important role in urging regulators at the National Association of Insurance Commissioners to enforce state mental health and substance use disorder parity laws in partnership with the American Psychiatric Association and The Kennedy Forum. The AMA also is urging states to use opioid litigation settlement funds to increase resources for state departments of insurance to enforce parity laws.

Statements
AMA Immediate Past President, Dr. Jack Resneck Jr., released a statement to physicians and their care teams, health systems and policy makers calling for the expansion of the mental health workforce, acceleration of behavioral health integration (BHI) adoption within primary care, improvement and expansion of quality, timely patient access to equitable care through BHI and the advancement, support and increased patient access to quality telepsychiatry.[14]

Dr. Resneck also produced a statement that addressed the threat posed to physician wellbeing and the patient-physician relationship by physician burnout. He called for expanded access to mental and behavioral health resources for physicians, the streamlining of prior authorization, a major source of administrative burden, and the improvement of patient trust and health literacy to confront another significant burden experienced by physicians-misinformation and disinformation.[15]

Acceleration of Behavioral Health Integration (BHI)

In 2020, the AMA partnered with the RAND Corporation to publish a study in the Annals of Internal Medicine summarizing the key motivators, facilitators and barriers to BHI from those physician practices with firsthand experience.[16] That same year, the AMA partnered with seven other Federation members, the American Academy of

Child and Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Osteopathic Association and American Psychiatric Association, to create the BHI Collaborative which equips physicians and their practices with the necessary knowledge to overcome obstacles and sustain integrated care for their patients and families.[17] Additional research was conducted when the AMA partnered with Manatt Health to publish a report on the opportunities and limitations of incorporating technology to advance and enhance BHI adoption.[18]

Leadership from the BHI Collaborative published a call to action in Health Affairs calling on payers and policy makers to join forces with physicians to ensure primary care physicians and their care teams have the necessary support to provide equitable, whole-person care for their patients and families. It identified numerous practical solutions that health plans, employers and state/federal policy makers can pursue to effectively support the widespread, sustainable adoption of BHI by physician practices.[19] The AMA will be partnering with the Hawaii Medical Association, the University of Hawaii and the Physicians Foundation on a research pilot to examine the potential benefits of empowering rural-based primary care physicians and medical students to effectively implement and sustain digitally-enabled BHI in their practices.

In 2023, the Collaborative expanded beyond its initial primary care focus to include Federation members from specialties that provide longitudinal care to patients with chronic illnesses that are significantly impacted by comorbid mental health conditions. These members included the American Academy of Neurology, American College of Cardiology, American Gastroenterological Association and Association for Clinical Oncology.

The BHI Collaborative has yielded numerous free and open-source resources for physicians and others interested in integrated care. This includes the BHI Compendium, which provides an implementation framework to help guide practices through key steps and considerations of delivering effective and sustainable integrated behavioral health care, as well as educational and training opportunities through its Overcoming Obstacles series. This series provides actionable insights and real-world best practices including operational topics such as billing and coding, condition-specific topics such as suicidal ideation and patient population-specific topics such as pediatric and obstetric/gynecological care.[20,21] The Collaborative also offers, through its pilot BHI Immersion Program, free enhanced technical assistance on how to effectively implement BHI to a diverse cohort of 24 health care organizations from across the country.[22]
The AMA also developed six additional strategic behavioral health guides that provide physician practices with practical strategies, actionable steps and evidence-based resources on specific areas of integrated care. Topics included guidance on pharmacological treatment, substance use/misuse disorder screening and treatment, suicide prevention and key CPT billing codes.[23]

Other Tools and Resources

To address the mental wellness and health of physicians, the AMA STEPS Forward® program has produced several resources including a playbook, toolkits (15), educational modules (15), webinars (5), podcasts (11) and practice success stories (32).[24] The topics of these resources include preventing physician suicide, stress first aid, physician peer support programs and Project ECHO.[25,26,27,28]

The AMA has also developed the Organizational Biopsy®, an assessment tool and set of services designed to support organizations in holistically measuring and acting to improve organizational wellbeing. The tool is shared with over 200 health systems and provides health systems with a comprehensive assessment across four domains: organizational culture, practice efficiency, self-care and retention.[29] The assessment includes a "Barriers to Mental Health" question to enhance leadership's understanding of barriers that may be preventing their physicians from accessing mental health services and support. Following an assessment, organizations receive an executive summary of their key findings and access to the Organizational Biopsy data through an online reporting platform that includes national comparison data. Building on this work, the Joy in Medicine team will present an abstract at the 2023 American Conference on Physician Health that examines the relationship between certain demographic groups and responses to the "Barriers to Mental Health" question. The abstract will also review the relationship between burnout and how people respond to the "Barriers to Mental Health" question.

The AMA Debunking Regulatory Myths series, which helps physicians and their care teams understand medical regulatory requirements to reduce guesswork and administrative burdens, covered the topic of licensing and credentialing bodies' inquiry into physician mental health.[30,31] The resource clarified that it is neither a Joint Commission, nor FSMB, requirement that licensing and credentialing organizations ask probing questions about clinicians' past mental health, addiction or substance use history on licensure and credentialing applications.[31]

The AMA's Accelerating Change in Medical Education Consortium published a book titled, *Educator Well-Being in Academic Medicine*, that was written and edited by experts from across the country who have studied, planned and implemented educator wellbeing programs in undergraduate and graduate medical education. The book provides concrete, systems-based solutions to better support the educational mission and educator wellbeing.[32]

The AMA Ed Hub™ online learning platform provides physicians and other medical professionals with education from the AMA and other trusted sources on a variety of topics of which include mental health. One such resource is the "Mental Health and Anxiety Disorders" CME course which features modules from trusted education providers such as the AMA Journal of Ethics™, AMA STEPS Forward, JAMA Network™, Stanford Medicine and The Fenway Institute.[33] It also has a dedicated "Psychiatry and Behavioral Health" topic page on the latest in psychiatry including recent guidelines and advances in management of specific conditions such as anxiety, depression and bipolar disease.[34]

Additionally, the JAMA Network includes JAMA Psychiatry- an international peer-reviewed journal for clinicians, scholars and researchers in the fields of psychiatry, mental health, behavioral science and allied fields. It has a journal impact factor of 25.8- among the highest of all psychiatry journals. The journal aims to inform and stimulate discussion around the nature, causes, treatment and public health importance of mental illness, as well as promote equity and justice for those impacted.[35] Readers can also listen to podcasts where editors and authors discuss articles published in the journal.[36]

Reports, Conferences and Programs

Council on Medical Education Reports
The Council on Medical Education has developed several reports focused on the mental wellbeing of physicians and medical students. Topics included confidential access to mental health services for medical students and physicians, mental health disclosures on physician licensing applications and medical student, resident and physician suicide.[37,38,39]

AMA Substance Use and Pain Task Force Reports
In 2015, the AMA convened more than 25 national, state, specialty and other health care organizations to develop guidance for physicians to help combat and end the opioid epidemic, as well as address the needs of patients with pain. Such organizations included the American Academy of Addiction Psychiatry, American Academy of Pain Medicine, American Academy of Family Physicians and American Society of Addiction Medicine.[40,41] In 2019, the AMA Pain Care Task Force released a report that detailed efforts necessary to help patients with pain. Such recommendations included (1) support access to comprehensive, affordable and compassionate treatment, (2) put an end to stigma and (3) encourage safe storage and disposal of prescription medication.[40,41,42] In 2021, the 25 health care organizations and the AMA Pain Care Task Force united to form the AMA Substance Use and Pain Task Force. The collective group released a report in 2022 to better address the opioid epidemic, this time paying close attention to health inequities such as those surrounding race, gender and sexual orientation. These recommendations targeted physicians, policymakers and other relevant stakeholders and suggested they work to (1) improve data collection, (2) remove barriers to treatment, (3) support individualized patient care, (4) support public health and harm reduction strategies and (5) strengthen multi-sector collaboration[40,41,43].

AMA-Sponsored Conferences
The AMA hosts two biannual scientific conferences- the American Conference on Physician Health, co-sponsored with Mayo Clinic and Stanford Medicine, and the International Conference on Physician Health™, co-sponsored with the British Medical Association and the Canadian Medical Association. These events promote scientific research and discourse on health system infrastructure and actionable steps organizations can take to improve physician wellbeing and publicly demonstrate the AMA's commitment to physician wellbeing and reducing burnout.[44,45]

Joy in Medicine™ Health System Recognition Program
The Joy in Medicine™ Health System Recognition Program is designed to guide organizations interested in, committed to, or currently engaged in improving physician satisfaction and reducing burnout.[46] The program is based on three levels of organizational achievement in prioritizing and investing in physician wellbeing. Each level, Bronze, Silver and Gold, is composed of six demonstrated competencies- assessment, commitment, efficiency of practice environment, leadership, teamwork and support. The 2024 iteration of the program will require health systems to review current credentialing applications and change all language that is invasive or stigmatizing around mental health and substance use disorders to qualify for the minimum level of recognition. The program also

continues to have an ongoing relationship with the ALL IN campaign and the Dr. Lorna Breen Heroes' Foundation to advocate for updating credentialing and licensing applications.

Health Equity and Whole-Person Care

The AMA Center for Health Equity (CHE) produced two *Prioritizing Equity* spotlight videos focused on mental health and trauma-informed approaches concerning the COVID-19 pandemic. Additionally, CHE Vice President of Equitable Health Systems and appointed member of the American Psychiatric Association's Mental Health Services Conference Scientific Program Committee, Dr. Karthik Sivashanker, presented at Association's conference as a plenary speaker in 2022. There, he spoke about the role of the Association and the profession more broadly in addressing historical injustices and present inequities at the intersection of mental health and racism.[47]

CONCLUSION

The AMA has made substantial efforts to address the ongoing mental health crisis and continues to effectively promote the mental health and wellbeing of physicians, their care teams and the patients they serve. The AMA's efforts have included the adoption of a variety of policies, advocacy, partnerships with professional organizations, development and dissemination of tools, education and resources, research, conferences and a program for health systems to promote physician wellness.

RECOMMENDATIONS

The Board of Trustees recommends that the second directive of BOT Report 17 be rescinded as having been accomplished by this report. (Rescind HOD Policy)

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6. UNIVERSAL GOOD SAMARITAN STATUE

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy H-130.937

At the 2022 Interim Meeting, the House of Delegates referred Resolution 214-I-22, sponsored by the Georgia Delegation. Resolution 214-I-22 asks the American Medical Association (AMA) to: 1) help protect patients in need of emergency care and protect physicians and other responders by advocating for a national "universal" Good Samaritan Statute; and 2) advocate for the unification of the disparate statutes by creation of a national standard via either federal legislation or through policy directed by the Department of Health and Human Services to specify terms that would protect rescuers from legal repercussion as long as the act by the rescuer meets the specified universal minimal standard of conduct and the good faith requirement, regardless of the event location; thus, effectively eliminating variations in the state statutes to facilitate the intent of the Good Samaritan statutes removing barriers that could impede the prompt rendering of emergency care.

The Reference Committee heard mixed testimony concerning Resolution 214, which noted that more needs to be done to support strong protections of physicians responding as Good Samaritans, regardless of location within the United States and regardless of the type of medical emergency they are called upon to address. Testimony highlighted that our AMA already has policy that promotes shielding physician Good Samaritans from liability while rendering treatment in response to emergencies, the opioid overdose epidemic, and in-flight medical emergencies. However, testimony also stated that our AMA should not create policy that would preempt existing state laws that are more protective than that of a national minimum standard. For these reasons, the House of Delegates (HOD) referred Resolution 214 for a report to be considered at the 2023 Interim Meeting.

BACKGROUND

Origin of Good Samaritan Laws

All 50 states and the District of Columbia have a Good Samaritan law, in addition to federal laws for specific circumstances.[1] However, the protection that Good Samaritan laws provide is not unlimited and varies from state to state,[2] including who is protected (e.g., physicians, emergency medical technicians, and other first responders) from liability and under what circumstances (e.g., rendering voluntary care). In general, these laws do not protect medical personnel from liability if acting in the course of their usual profession.[3]

Good Samaritan laws provide liability protection against claims of "ordinary negligence." Ordinary negligence is the failure to act as a reasonably prudent person; that is, the failure to exercise such care as a reasonably acting person would ordinarily apply under the same or similar circumstances.[4] These laws typically do not protect against "gross negligence" or willful actions. Gross negligence is a conscious and voluntary disregard of the need to use reasonable care that is likely to cause foreseeable grave injury or harm to persons, property, or both.[5]

Applicability of Good Samaritan Laws to Physicians

Good Samaritan laws apply to physicians (and other health care professionals) only when certain conditions are met:

(1) There must exist no duty to treat (for this reason, Good Samaritan protection does not typically apply to on-call physicians). Any physician with a pre-existing relationship with the patient will generally not be considered a Good Samaritan.
(2) The physician or other health care provider providing aid cannot receive compensation for their care.[6]

AMA POLICY

The AMA has several policies that have guided AMA advocacy in support of Good Samaritan protections for physicians, including responding to the COVID-19 public health emergency and the opioid overdose epidemic.[7]

AMA policy supports Good Samaritan protections for medical professionals responding to emergencies as "bystander physicians" (Policy H-130.937, Delivery of Health Care by Good Samaritans), and to medical

professionals during in-flight medical emergencies (Policy H-45.997, In-Flight Emergency Care). In addition, AMA policy supports protections for callers or witnesses seeking medical help for overdose victims (Policy H-45.997, 911 Good Samaritan Laws). Thus, while the AMA has strong policy supporting the protection of physicians acting as a Good Samaritan in certain circumstances, and has advocated that Good Samaritan protections be extended to health care professionals when volunteering during a federally declared disaster,[8] such policy does not directly ask for the alignment and harmonization of disparate state laws into a universal minimum standard of conduct.

AMA policy also reflects the concern that a federal or universal effort could undermine state liability laws—see H-130.937, Delivery of Health Care by Good Samaritans, which states that, "…3. Where there is no conflict with state or local jurisdiction protocol, policy, or regulation on this topic, the AMA supports the following basic [Good Samaritan] guidelines to apply in those instances where a bystander physician happens upon the scene of an emergency and desires to assist and render medical assistance." Also, AMA policy on national and federal medical liability reform and protections is conditioned on not preempting effective or stronger state liability protection laws—see H-435.978, Federal Medical Liability Reform, which states that, "… (3) [AMA support] for any federal initiative incorporating provisions of this type [of liability reform] would be expressly conditional. Under no circumstances would support for federal preemptive legislation be extended or maintained if it would undermine effective tort reform provisions already in place in the states or the ability of the states in the future to enact tort reform tailored to local needs."

DISCUSSION

The AMA has strong policy in support of general Good Samaritan liability protections, primarily at the state level, as well as strong policy in support of medical liability reform. AMA policy in support of federal legislation, such as the Good Samaritan Health Professionals Act, is limited in scope or applies to limited circumstances. In particular, the AMA has well established policy to ensure that any federal liability law does not preempt effective state laws. In addition to the policies mentioned above, this limitation is reflected in policies H-435.967, Report of the Special Task Force and the Advisory Panel on Professional Liability, and H-435.964, Federal Preemption of State Professional Liability Laws. These policies reflect the concerns raised during past HOD deliberations on liability protections that there is the potential for unintended consequences in creating federal standards, which may jeopardize more protective state laws, and that advocating for federal standards or the unification of disparate state laws may not be uniformly supported by all state and specialty Federation members.

As noted above, AMA policy on Good Samaritans is limited to certain circumstances that are federal in nature—aviation (Policy H-45.997, In-Flight Emergency Care) and national emergencies, such as the overdose epidemic (Policy D-95.977, 911 Good Samaritan Laws). The AMA strongly supports the Good Samaritan Health Professionals Act (see footnote 8), which protects health care professionals from liability exposure when volunteering during a federally declared disaster and would help to ensure that needed medical volunteers are not turned away due to confusion and uncertainty about the application of Good Samaritan laws. However, the bill includes provisions to ensure that it would not preempt stronger state laws ("This section preempts the laws of a State or any political subdivision of a State to the extent that such laws are inconsistent with this section, unless such laws provide greater protection from liability."[9])

The Board agrees with the intent of the Resolution to help protect patients in need of emergency care by protecting physicians and other first responders with a Good Samaritan statute. The Board also agrees with the general concept of encouraging the development of effective Good Samaritan protection standards. The Board is concerned, however, that advocating for a federal standard or the unification of state Good Samaritan protections into a federal standard may jeopardize more protective state laws and may not be uniformly supported by all state and specialty Federation members. A more impactful approach would be to review current federal and state Good Samaritan laws and develop a set of principles on the most effective protections that would encourage physicians to render emergency care (as well as remove any barriers that impede the prompt rendering of emergency care). This approach would demonstrate what uniform standards would look like and could be used to assist states with less protective statutes to seek more protective legislation based on the principles as well as provide guidance on where federal laws could apply in the absence of a state law. Therefore, in lieu of adopting Resolution 214-I-22, the Board recommends that AMA Policy H-130.937, Delivery of Health Care by Good Samaritans, be amended by a new clause that directs the AMA to develop model principles on Good Samaritan protections for physicians under state and federal laws that would encourage the prompt rendering of emergency care.

Policy H-130.937, Delivery of Health Care by Good Samaritans
1. Our AMA will work with state medical societies to educate physicians about the Good Samaritan laws in their states and the extent of liability immunity for physicians when they act as Good Samaritans.
2. Our AMA encourages state medical societies in states without "Good Samaritan laws," which protect qualified medical personnel, to develop and support such legislation.
3. Where there is no conflict with state or local jurisdiction protocol, policy, or regulation on this topic, the AMA supports the following basic guidelines to apply in those instances where a bystander physician happens upon the scene of an emergency and desires to assist and render medical assistance. For the purpose of this policy, "bystander physicians" shall refer to those physicians rendering assistance voluntarily, in the absence of pre-existing patient-physician relationships, to those in need of medical assistance, in a service area in which the physician would not ordinarily respond to requests for emergency assistance. (a) Bystander physicians should recognize that prehospital EMS systems operate under the authority and direction of a licensed EMS physician, who has both ultimate medical and legal responsibility for the system. (b) A reasonable policy should be established whereby a bystander physician may assist in an emergency situation, while working within area-wide EMS protocols. Since EMS providers (non-physicians) are responsible for the patient, bystander physicians should work collaboratively, and not attempt to wrest control of the situation from EMS providers. (c) It is the obligation of the bystander physician to provide reasonable self-identification. (d) Where voice communication with the medical oversight facility is available, and the EMS provider and the bystander physician are collaborating to provide care on the scene, both should interact with the local medical oversight authority, where practicable. (e) Where voice communication is not available, the bystander physician may sign appropriate documentation indicating that he/she will take responsibility for the patient(s), including provision of care during transportation to a medical facility. Medical oversight systems lacking voice communications capability should consider the addition of such communication linkages to further strengthen their potential in this area. (f) The bystander physician should avoid involvement in resuscitative measures that exceed his or her level of training or experience. (g) Except in extraordinary circumstances or where requested by the EMS providers, the bystander physician should refrain from providing medical oversight of EMS that results in deviation from existing EMS protocols and standing orders.
4. Our AMA urges the International Civil Aviation Organization to make explicit recommendations to its member countries for the enactment of regulations providing "Good Samaritan" relief for those rendering emergency medical assistance aboard air carriers and in the immediate vicinity of air carrier operations.

RECOMMENDATION

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 214-I-22 and that the remainder of the report be filed.

That Policy H-130.937, Delivery of Health Care by Good Samaritans be amended by addition:

5. Our AMA will develop model principles on Good Samaritan protections for physicians under state and federal laws that would encourage the prompt rendering of emergency care.

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3 See footnote 1, *supra.*
4 *Ibid*
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6 *Ibid*
7 *See,* (1) Statement of the American Medical Association to the Committee on Energy & Commerce Subcommittee on Oversight and Investigations, United States House of Representatives, Re: "Combatting the Opioid Abuse Epidemic: Professional and Academic Perspectives," Presented by Patrice A. Harris, MD, MA, Secretary, Board of Trustees April 23, 2015, available at: https://searchlf.ama-

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9 H.R. 2819, Good Samaritan Health Professionals Act of 2023, §224A.(c)(1).

7. OBTAINING PROFESSIONAL RECOGNITION FOR MEDICAL SERVICE PROFESSIONALS

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy TBD

At the 2022 Interim Meeting, the House of Delegates (HOD) referred Resolution 232-I-22, sponsored by the Organized Medical Staff Section. Resolution 232-I-22 asks the American Medical Association (AMA) to collaborate with leadership of the National Association of Medical Staff Services' Advocacy and Government Relations teams to advocate to the U.S. Bureau of Labor Statistics (BLS) for obtaining a unique standard occupational classification code during the next revision for medical service professionals to maintain robust medical credentialing for patient safety.

Testimony regarding this resolution was generally positive, recognizing the support that medical service professionals (MSPs) provide to medical staff by performing core functions such as credentialing. It was noted that the work that MSPs perform helps make the credentialing process more efficient and less administratively burdensome for physicians. Testimony further indicated that MSPs have previously been denied a standard occupation classification by the BLS but are unsure of the reason for this denial. Moreover, testimony expressed concerns that the resolution raised several questions that required further information and consideration before determining what, if any, advocacy strategy might be most effective in order to support MSPs and to achieve the goals of Resolution 232. This report focuses on the role of MSPs, their pursuit of a Standard Occupational Classification from the BLS, and the propriety of AMA support for these efforts.

BACKGROUND

A Standard Occupational Classification (SOC) is a system used to categorize and classify occupations within an economy. It is a standardized numerical code that groups similar jobs together based on the tasks, duties, and responsibilities performed by workers in those occupations. The SOC system is typically used by government agencies, labor market analysts, and researchers to collect and analyze occupational data for various purposes, such as workforce analysis, labor market information, and statistical reporting. The SOC system helps provide consistency and comparability when discussing and analyzing different occupations across various industries and sectors. It helps ensure that similar jobs are grouped together and that there is a common language for describing and classifying occupations, which is particularly important for statistical and policy-related purposes. The BLS is responsible for maintaining the SOC system and revises the SOC Manual approximately every 10 years. During the revision period, entities can petition to obtain a unique classification code for a profession. The revision process takes approximately four years. The BLS last revised its SOC Manual in 2018. It is likely that the BLS will announce the next revision process within the next few years.

Currently, there is no unique SOC for MSPs. The BLS instead categorizes MSPs as human resources professionals. The National Association Medical Staff Services (NAMSS)—which is a membership organization that includes medical staff and credentialing services professionals from medical group practices, hospitals, managed care organizations, and credentials verification organizations—petitioned the BLS to obtain a unique SOC for MSPs during the last revision period, but their petition was denied. NAMSS intends to submit a revised petition to the BLS and is seeking stakeholder support.

DISCUSSION

If there is a growing demand for a specific occupation, such as MSPs, it is possible that the BLS may consider creating a specific SOC to better capture and categorize the role of MSPs. The decision to establish a new SOC code or include an occupation within an existing code ultimately depends on various factors, including the demand for data, industry recognition, and the BLS' assessment of the occupation's uniqueness and significance in the labor market.

As mentioned above, BLS does not currently have an SOC for MSPs as a distinct category. Instead, BLS provides SOC codes for various specific occupations within the health care industry. Some of the occupations that may encompass roles related to MSPs include medical records and human information technicians, medical secretaries and administrative assistants, medical transcriptionists, and billing and posting clerks. MSPs, however, perform

more specialized duties. For example, the Centers for Medicare & Medicaid Services (CMS) requirements to onboard medical staff members are distinct from other hospital employees because of the direct effects on patient safety. CMS sets rigorous standards for medical staff that MSPs oversee to minimize patient and hospital risks. Credentialing and privileging physicians and other clinicians require MSPs' unique skillset to ensure compliance with policies and procedures that are not required of human resources personnel. The following chart (provided by NAMSS) lists some of the differences between MSPs and human resources personnel.

MSPs	HR Personnel
Supports Medical Staff Services Office Members	**Supports Hospital Employees**
• Exclusively serves the Medical Staff, a self-governing body separate from HR. • Does not participate in hiring processes. • Focuses on practitioners, who are often contracted, not employed. • Enrolls practitioners in payer networks, provides documentation to treat patients, and tracks approvals for claims reimbursement. • Provides Medical Staff leadership support (e.g., meeting, financial, election, committee, credentialing-software management). • Manages development of bylaws, process and procedures, federal/state/organizational rules and regulations, privileging forms, peer review, and fair hearings/appeals. *Responsibilities*: Primary-source verification, credentialing, privileging, provider enrollment, continuous practitioner monitoring, reappointment, committee management, CME coordination, accreditation/regulatory compliance, Medical Staff governance, and National Provider Data Bank reports.	• Posts and fills open employee positions. • Oversees payroll, I-9 verification, tax information, employment rules, compensation, and benefits. • Manages private personnel information and employee-related issues. Enforces federal and state employment laws. • Focuses on organizational employee policies. • Counsels employees. • Ensures facility safety, security, and compliance. • Implements and facilitates employee professional-growth programs. *Responsibilities*: Staffing, employee support, employee policies, compensation/benefits, retention, safety/security, training/development, legal and worker protection.
Credentials and Privileges	**Recruits, Hires, Onboards**
• Credentials and privileges practitioners that HR hires. • Obtains and primary-source verifies practitioner education, training, affiliation history, malpractice claims, peer references, certifications, licensure, DEA registration, federal/state sanctions.	• Develops and oversees employed-staff structure, posts job descriptions, recruits, matches candidates with positions, develops benefits packages, onboards employees. • Reviews self-reported applicant data. • Does not assess clinical competencies.
Continuously Evaluates Performance	**Oversees Staffing and Working Conditions**
• Continuously monitors medical staff. • Uses understanding of medical procedures to match qualifications with privileges. • Reappoints practitioners every 2-3 years through vigorous recredentialing process.	• Focuses on staffing, interpersonal relations, and workplace conditions. • Oversees growth and retention initiatives. • Does not review Medical Staff members quality performance.

Medical Staff Compliance Experts	Employment Law Experts
• Experts in bylaws, policies, and procedures, regulatory standards related to practitioners. • Ensures compliance with, and awareness of, accrediting-body standards; federal and state regulatory standards.	• Abides by labor laws, regulations relating to employment, and HR-specific accreditation regulations. • Reports and maintains federal employment information.
Credentials	**Credentials**
• Certified Provider Credentialing Specialist (CPCS) • Certified Professional Medical Services Management (CPMSM)	• Certified in Healthcare Human Resources (CHHR) • Certified Professional in Healthcare Risk Management (CPHRM)

AMA POLICY

AMA policy supports the compilation of accurate data on all components of physician practice costs and the changes in such costs over time, as the basis for informed and effective advocacy (Policy H-400.966, Medicare Payment Schedule Conversion Factor). The same policy supports the AMA working aggressively with CMS, BLS, and other appropriate federal agencies to improve the accuracy of such indices of market activity as the Medicare Economic Index and the medical component of the Consumer Price Index.

AMA policy also supports workforce planning efforts, done by the AMA or others, that utilize data on all aspects of the health care system, including projected demographics of the number and roles of other health professionals in providing care (Policy H-200.955, Revisions to AMA Policy on the Physician Workforce). The same policy supports the integral involvement of the medical profession in any workforce planning efforts sponsored by federal or state governments, or by the private sector.

CONCLUSION

Based on the discussion above, the Board believes that the duties performed by MSPs are more unique than what can be captured under SOCs for human resources. Also, AMA policy generally aligns with NAMSS' initiative to obtain a SOC for MSPs during the next revision of the BLS SOC Manual. While the Board recommends support for a SOC for MSPs, the AMA's active advocacy resources and efforts should remain focused on the AMA Recovery Plan for America's Physicians. Therefore, the Board recommends that an Alternate Resolution 232-I-22 be adopted that would establish policy in support of an SOC for MSPs in lieu of an active collaboration with the leadership of NAMSS.

RECOMMENDATION

The Board of Trustees recommends that Alternate Resolution 232-I-22 be adopted to read as follows, and the remainder of the report be filed:

> RESOLVED, That our American Medical Association support a unique standard occupational classification from the U.S. Bureau of Labor Statistics for medical services professionals.

8. AMA EFFORTS ON MEDICARE PAYMENT REFORM

Informational report; no reference committee hearing

HOUSE ACTION: FILED

BACKGROUND

At the 2023 American Medical Association (AMA) Annual Meeting of the House of Delegates (HOD), the HOD adopted Alternate Resolution 214 (we will add policy number when it becomes available in Policy Finder) and amended Policy D-390.922, "Physician Payment Reform and Equity." They call for the Board of Trustees (the Board) to report back to the HOD at each Annual and Interim meeting highlighting the progress of our AMA in achieving Medicare payment reform until predictable, sustainable, fair physician payment is achieved. The Board has prepared the following report to provide an update on AMA activities for the year to date.

AMA ACTIVITIES ON MEDICARE PHYSICIAN PAYMENT REFORM

The AMA's Medicare physician payment reform efforts were initiated early in 2022, following the development of a set of principles outlining the "Characteristics of a Rational Medicare Payment System" that was endorsed by 124 state medical societies and national medical specialty organizations. These principles identified strategies and goals to: (1) ensure financial stability and predictability for physician practices; (2) promote value-based care; and (3) safeguard access to high quality care.

Subsequently, the AMA worked with Federation organizations to identify four general strategies to reform the Medicare payment system, including:

- Automatic annual payment updates based on the Medicare Economic Index (MEI);
- Updated policies governing when and how budget neutrality adjustments are made;
- Simplified and clinically relevant policies under the Merit-based Incentive Payment System (MIPS); and
- Greater opportunities for physician practices wanting to transition to advanced alternative payment models (APMs).

At the heart of the AMA's unwavering commitment to reforming the Medicare physician payment system lie four central pillars that underscore our strategic approach: legislative advocacy, regulatory advocacy, federation engagement, and grassroots, media, and outreach initiatives. Grounded in principles endorsed by a unified medical community, our legislative efforts drive the advancement of policies that foster payment stability and promote value-based care. We actively champion reform through regulatory channels, tirelessly engaging with crucial agencies such as Centers for Medicare & Medicaid Services (CMS) and the White House to address impending challenges and ensure fair payment policies. Our federation engagement fosters unity and consensus within the broader medical community, pooling resources and strategies to amplify our collective voice. Lastly, our grassroots, media, and outreach efforts bridge the gap between policymakers and the public, ensuring our mission is well-understood and supported from all quarters. Together, these pillars fortify our endeavors to achieve a more rational Medicare physician payment system that truly benefits all.

Legislative Advocacy

Legislation (H.R. 2474) was introduced on April 3, reflecting AMA drafted language, that would automatically update the Medicare physician payment schedule each year by Medicare's annual estimate of practice cost inflation, the MEI.

Legislative language was drafted to revise budget neutrality policies and procedures by: (1) raising the $20 million projected spending threshold that triggers the need for a budget neutrality adjustment to $100 million, updated by inflation every five years; (2) clarifying which payment policy changes may require a budget neutrality adjustment; (3) requiring CMS to use actual claims data to readjust payment updates if utilization assumptions used to calculate a budget neutrality adjustment were incorrect. Potential sponsors for the legislation are being sought.

Legislative language is being finalized that would: (1) simplify MIPS reporting and improve its clinical relevance; (2) reduce the potential severity of penalties (currently as much as -nine percent) for those scoring poorly under MIPS; (3) provide support to smaller practices that tend to score lower under the program; and (4) provide timely

and meaningful performance feedback to physicians and expand the use of clinical data registries.

Legislation was introduced on July 27 (H.R. 5013) that would extend incentives and ease increases in revenue thresholds that must be met to qualify for incentive payments. It also would provide additional technical support and infrastructure investments for small and rural practices and those in medically underserved areas. The bill is based on legislation introduced in the last Congress that the AMA supported. In advance of the legislation being introduced the AMA, in conjunction with the Alliance for Value-based Health Care, hosted a Congressional briefing entitled, "Value-Based Care 101: Improving Patient Health and Lower Costs," on April 27 in the Capitol Visitors Center, which was widely attended by Congressional staff.

On July 28, a bipartisan group of 101 U.S. House of Representatives members sent a letter to House leadership on the need to prioritize Medicare physician payment reform, following extensive grassroots support from the AMA and members of the Federation.

In addition to regular interactions with members of Congress and their staff by Advocacy staff, the AMA sent a number of letters and statements to Capitol Hill, including the following:

- 1/23 signed on a physician/allied health professions letter to Congressional committees requesting MACRA oversight hearings;
- 2/13 signed on a coalition letter to committees on value-based care;
- 3/15 a sign on letter developed by the AMA was sent to Congress regarding the Medicare Payment Advisory Committee (MedPAC) recommendation for an inflation-based update;
- 3/20 an AMA statement was filed for the Senate Health, Education, Labor and Pensions Committee's health care workforce hearing, highlighting the impact of declining Medicare payments on the workforce;
- 4/19 a sign on letter developed by the AMA was sent to the House expressing support for H.R. 2474;
- 5/3 signed on a physician/allied health professions letter to Congress in support of H.R. 2474; and
- AMA submitted a letter for the record of hearing health by the House Energy & Commerce Oversight & Investigations Subcommittee on MACRA held on 6/22.

Regulatory Advocacy

In anticipation of a new round of budget neutrality adjustments expected in 2024 due to implementation of the G2211 code for complex office visits, the AMA meet with officials at CMS, the Department of Health and Human Services (HHS), and the White House to discuss options for reducing the severity of the adjustment—and to argue whether any adjustment is needed at all. The proposed rule on the 2024 Medicare physician fee schedule that was released on July 13 revised the utilization estimate used to calculate the budget neutrality adjustment from the 90 percent previously announced in 2021 to 38 percent, significantly reducing the project impact on payments. The 2024 proposed rule also postponed implementation of updated MEI weights, which would change the proportion of Medicare physician payments based on physician work, practice expenses, and liability insurance costs with potentially significant payment redistributions across specialties. The delay was made in response to the need for continued public comment and the AMA's national study, the Physician Practice Information (PPI) survey, to collect data on physician practice expenses. The PPI survey was launched on July 31.

The AMA also secured another hardship exemption that physicians can claim under MIPS to avoid up to -nine percent in performance penalties in 2025.

Federation Engagement

A Medicare Reform Workgroup comprising staff from national medical specialty societies and state medical associations was organized in 2022 and has continued to meet to develop consensus on medicine's reform proposals and advocacy strategies. The AMA also participates in a second coalition, organized by the American College of Radiology, which involves non-physician clinicians who bill under the Medicare fee schedule to expand our reach and minimize potential for divergent proposals and strategies.

Periodic telephone conference calls are held with staff for Federation organizations to keep them apprised of developments in Washington and to elicit their support for grassroots efforts. A combined advocacy push for cosponsorship of H.R. 2474 was launched with a physician webinar in late July, followed by distribution of talking points and advocacy support material to the Federation.

Grassroots, Media, and Outreach

The AMA has maintained a continuous drumbeat of grassroots contacts through its Physicians Grassroots Network, Patients Advocacy Network, and its Very Influential Physicians program. Op eds have been placed in various publications from AMA leaders, as well as from "grasstops" contacts in local newspapers. Digital advertisements are running, targeted specifically to publications read on Capitol Hill, and media releases have been issued to highlight significant developments (e.g., in response to release of a Medicare Trustees report expressing concerns about the adequacy of physician payment updates).

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

Message testing of arguments made in support and opposition to Medicare payment reform is nearly complete. Focus groups of U.S. voters were conducted in June, and a national poll was launched in late July. The results of this message testing will be used to refine language used in earned and paid media, as well as patient grassroots outreach.

CONCLUSION

As we forge ahead in continued partnership with the Federation to advance organized medicine's collective goals in our strategic mission to reshape the Medicare physician payment system, the AMA remains unwavering in its commitment to successfully pursuing the four pillars discussed in this report. Our steadfast dedication ensures that our members' voices are heard, and that we advocate for a system that is fair, sustainable, and reflective of the value physicians bring to patient care. There has been progress so far in 2023, and with every stride we make as we enter the fourth quarter this year and beyond, we move closer to achieving our vision of Medicare physician payment reform. Please follow Advocacy Update, join the Physicians Grassroots Network, and follow other AMA communications vehicles to stay up to date and engaged on this topic.

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

Informational report; no reference committee hearing

HOUSE ACTION: FILED

This report provides an update on the formation of the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted in accordance with Policies G-605.009 and D-5.998.

BACKGROUND

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

1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
    a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;
    b. Practice management, including developing recommendations and educational materials for addressing

reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;
d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;
e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;
f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and
g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.

Additionally, Policy D-5.998 was adopted during the 2022 Interim Meeting that added a requirement for an annual report of the Task Force. Policy D-5.998(1) instructs that:

1. Our AMA Task Force developed under HOD Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," will publish a report with annual updates with recommendations including policies, strategies, and resources for physicians who are required by medical judgment and ethical standards of care to act against state and federal laws.

DISCUSSION

On June 24, 2022, the U.S. Supreme Court issued its landmark decision in *Dobbs v. Jackson Women's Health Organization*, holding that the U.S. Constitution does not confer a constitutional right to abortion and returned the authority to regulate abortion to the states. The AMA immediately condemned the decision and undertook a multifaceted strategy, including engagement with policymakers at the state and federal levels, judicial advocacy, and more to counter the deleterious impact of the decision–work that continues to this day.

Nevertheless, the decision and subsequent implementation of state abortion bans resulted in widespread uncertainty among physicians and profoundly shifted medical practice. In response to the need to gain insights into the developing challenges resulting from the *Dobbs* decision, AMA Board of Trustees (Board) Immediate Past Chair Sandra Adamson Fryhofer, MD (then Board Chair), convened several obstetricians and gynecologists from the Board, AMA Council on Legislation, and AMA Council on Medical Service, in July 2022, to provide initial guidance and information to staff. This valuable guidance informed advocacy work, as well as the initial steps toward the formation of a task force.

In the fall of 2022, the AMA Advocacy Resource Center, the AMA's state government affairs team, surveyed state and national medical specialty organizations to identify existing resources on the topics enumerated in Policy G-605.009 and gain a better understanding of the position and capacity of stakeholders to engage on these issues. Federation members were asked the following questions:

- Please share your organization's perspective on these issues, including where they fall among your current priorities.
- What considerations need to be taken into account as these issues are addressed?
- What specific recommendations or guidance has your organization developed related to these issues?
- What specific resources or tools has your organization produced related to these issues?
- What is your organization's capacity to engage on these issues in the coming year?
- What organizations outside the Federation have you worked with and recommend engaging around these issues?

Federation members were given approximately seven weeks to respond. Responses were received from nine states and thirteen specialties. Most responding states indicated that they did plan or expect to engage in these issues in the coming year. Responses among specialties were more varied, with a few stating that they expected to be heavily engaged in these issues.

Subsequently, at the June 2023 meeting of the Board, the Board formally approved the formation of a Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted (Task Force). The Board also decided that appropriate resources would be made available for the operation of the Task Force. Notably, AMA advocacy to protect the patient-physician relationship has been ongoing even prior to adoption of this underlying policy.

Next steps

As approved by the Board, the Task Force will host a combination of both virtual and in-person meetings over the course of two years. The Board will appoint a member of the Board to serve as liaison to the Task Force, identify candidates to serve on the Task Force from the AMA Councils on Legislation, Medical Service, Medical Education, Science and Public Health, and Ethical and Judicial Affairs, and invite interested sections, state and specialty societies to identify candidates to serve on the Task Force. The Board estimates approximately 50 participants from state and specialty participants, including staff. Participation by Federation members will be at their own expense.

The Board envisions that, in accordance with Policies G-605.009 and D-5.998, the Task Force will advise the Board of new and emerging threats to the provision of evidence-based medical care and appropriate and innovative responses to protect access to care and to preserve the role of the patient-physician relationship as a central element in medical decision making. The Task Force will also recommend, and review resources identified or developed pursuant to the topics enumerated in Policies G-605.009 and D-5.998(1). The Board expects that the actions and recommendations of the Task Force will be informed by the personal experiences of Task Force members and the expertise and resources of the state and specialty medical associations they represent, as well as by insights from other relevant organizations and impacted communities, particularly those who have been historically marginalized and minoritized and who are most vulnerable when governments erect barriers to necessary care.

CONCLUSION

The Board will form the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted and continue to implement Policies G-605.009 and D-5.998.

10. MEDICAL DECISION-MAKING AUTONOMY OF THE ATTENDING PHYSICIAN

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

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy D-373.994

Resolution 009-I-22, "Medical Decision-Making Autonomy of the Attending Physician," was heard at the I-22 meeting and the House of Delegates (HOD) referred for report at the I-23 meeting. Resolution 009-I-22 (Resolution 009) contains four resolve clauses that ask our American Medical Association (AMA) advocate against administrative encroachment on physicians, particularly encroachment that interferes with the patient-physician relationship and harms patients.

BACKGROUND

Resolution 009 explains that "the majority of [American] physicians are now employed" by an entity such as a physician group, insurers, or hospital system rather than being self-employed in private practice. Additionally, recent "growth in the number of health care administrators has far outpaced growth in the number of physicians." [1] The rise of employed physicians and health care administrators—i.e., those administrative roles such as Chief Medical Officer or Chief Health Officer—has created a tension, and there is often a "disconnect" and "lack of understanding" between these professional groups. [1] This tension may be viewed as diverging goals or diverging responsibilities between physicians and administrators, i.e., the professional ethical duties physicians possess

contrasted with administrators' fiduciary obligations to their business interests.[1] For example, Chandrashekar and Jain explain that while physicians and administrators often share certain "core values", their approaches to health care fundamentally differ as "[p]hysicians are focused on delivering patient-centered care, whereas administrators are focused on managing resources. Physicians are trained to think patient by patient, whereas administrators are trained to create system-level change." [1]

This tension between physicians and administrators (this report uses the terms "administrators" and "health care administrators" interchangeably) is recognized as a significant source of encroachment on physician autonomy. The "large-scale employment of physicians" is a "sea change" that has yet to be "fully assimilated by the profession," [2] resulting in ongoing conflicts as traditional physician sovereignty over patient care is eroded as health care administrators' influence over physicians' provision of individual patient care increases. Richman and Schulman explain that "[p]hysician independence has always meant more than economic status" and has been "the foundation of a professional ethos" that contains a "devotion to patient welfare, and a broad commitment to the health of the public." [2] Hence, the key concern is that this new organizational and economic reality of medicine will undermine physician autonomy in a way that harms patients. Resolution 009 notes that there may be "questions of loyalties," where health care institutions' financial incentives may conflict with patient well-being. For example, concerns have arisen that physicians may be pressured to make decisions motivated by cost versus high quality patient care, e.g., "hospital-employed physicians may be under pressure to admit patients from the emergency department who could be treated in an observation setting or as an outpatient" or pressured to "discharg[e] Medicare patients" earlier than clinically appropriate." [3]

RESOLUTION 009-I-22 and AMA POLICY

In response to the concerns regarding the impact on physician autonomy and potential harm towards patients, Resolution 009 proffered four resolve clauses addressing the issue. Below, each of the resolve clauses are detailed and analyzed with regards to AMA policy.

First Resolve Clause

The first resolve clause advocates for AMA to recognize the primacy of the patient-physician relationship as a foundation for decision making:

> That our American Medical Association advocate that no matter what may change in regard to a physician's employment or job status, that there is a sacred relationship between an attending physician and his/her patient that leads the patient's attending physician to hold the ultimate authority in the medical decision-making that affects that patient. (Emphasis added)

The AMA *Code of Medical Ethics* supports the fundamental, or sacred, nature of the patient-physician relationship. Opinion 1.1.1, "Patient-Physician Relationships," states that the "practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering" and that the "relationship between a patient and physician is based on trust." However, the sanctity of the relationship does not —as the first resolve claims— "lead" a physician to have the "ultimate authority" in medical decision making over the patient. Such a conclusion is an absolutist view of physician autonomy, that conflicts with a collaborative ethical model that also embraces patient-autonomy. Opinion 1.1.3, "Patient Rights," explains that the "health and well-being of patients depends on a collaborative effort between patient and physician in a mutually respectful alliance." Physician autonomy is concomitant with patient autonomy, both serving the patient's best interests in the face of adverse interests that reside outside the sanctity of the patient-physician relationship.

Second Resolve Clause

The second resolve clause advocates for an ethics committee to adjudicate disputed medical decisions between physicians and administrators. It asks:

> That our AMA advocate strongly that if there is a unique circumstance that puts the attending physician's care into question by a hospital administrator of any sort such as listed above [listed in the resolution's whereas clauses; list contains examples of administrative roles: Chief Executive Officer, Chief Medical Officer, etc.] but certainly not limited to that list– physician or not- in the event of a disagreement between an administrator and the attending physician regarding a decision one would call a mere judgment call, the onus would be on the

> administrator to prove to an ethics committee why the attending physician is wrong prior to anyone having the authority to overturn or overrule the order of the physician attending the patient directly. (Emphasis added)

The second resolve clause proposes using ethics committees as arbitrators of disputes between health care administrators and physicians. First, AMA ethics policy makes clear that ethics committees are not adjudicators with the "authority to overturn or overrule" an administrator's decision. Opinion 10.7, "Ethics Committees in Healthcare Institutions," states that ethics committees "offer assistance in addressing ethical issues that arise in patient care and facilitate sound decision making that respects participants' values, concerns, and interests" and that committees "serve as advisors and educators rather than decision makers. Patients, physicians and other health care professionals, health care administrators, and other stakeholders should not be required to accept committee recommendations." (Emphasis added) Similarly, Opinion 10.7.1, "Ethics Consultations," states that committees "serve as advisors and educators rather than decision makers."

Additionally, H-285.954, "Physician Decision-Making in Health Care Systems," states that "certain professional decisions critical to high quality patient care should always be the ultimate responsibility of the physician regardless of the practice setting, whether it be a health care plan, group practice, integrated or non-integrated delivery system or hospital closed department, whether in primary care or another specialty, either unilaterally or with consultation from the plan, group, delivery system or hospital" and such decision may include "[r]ecommendations to patients for other treatment options, including non-covered care." (Emphasis added) H-285.954 further states that the AMA "encourages organizations and entities that accredit or develop and apply performance measures for health plans, groups, systems or hospital departments to consider inclusion of plan, group, system or hospital department compliance with any applicable state medical association or medical staff-developed decision-making guidelines in their evaluation criteria," which would allow for criteria that value the physician-decision making model of care. Thus, existing policy proposes a model that defers to physicians' professional judgment with respect to treatment recommendations, in conflict with the Resolution 009's request to grant an ethics committee the role of adjudicator.

Third Resolve Clause

The third resolve clause asks AMA to reaffirm that physician decision making should be upheld absent an egregious lapse in judgment or mistake:

> That our AMA reaffirm that the responsibility for the care of the individual patient lies with a prudent and responsible attending physician, and that his/her decisions should not easily be overturned unless there has been an egregious and dangerous judgment error made, and this would still call for an ethics committee consult in that instance. (Emphasis added)

As noted above, H-285.954 addresses prioritizing the physician-decision making model and how this model should be encouraged by health care organizations when developing decision making guidelines. Hence, the substance of H-285.954 substantially addresses and accomplishes the aim of the third resolve clause.

Fourth Resolve Clause

The fourth resolve clause advocates for resistance against encroachment of administrators upon physicians' medical decision making. It asks:

> That our AMA aggressively pursue any encroachment of administrators upon the medical decision making of attending physicians that is not in the best interest of patients as strongly as possible, for there is no more sacred relationship than that of a doctor and his/her patient, and as listed above, first, we do no harm. (Emphasis added)

The first part of the resolve: "That our AMA aggressively pursue any encroachment of administrators upon the medical decision making of attending physicians" is sound. The concept aligns well with H-285.954. Also, placing checks and balances on administrator encroachment is truly what lies at the heart of Resolution 009's goals of promoting physician autonomy and patient well-being. However, the resolve's claim that "there is no more sacred relationship of a doctor and his/her patient" is unsupported puffery. The importance and therapeutic nature of the relationship is well-established in both ethics literature and the *Code* (e.g., Opinion 1.1.1 and 1.1.3), but the claim that the patient-physician relationship is most sacred of *all* relationships, should not be codified as AMA policy.

Broad Themes of Concerns

Additionally, emergent from Resolution 009's resolves are three themes of concern regarding physician autonomy: (1) the primacy and sanctity of the patient-physician relationship; (2) deference to physician decision making, (e.g. ethics committees used to resolve disputes and reluctance to overturn physician judgment that is made in the best interest of the patient, and respect for a physician's due process) and (3) the well-being and best interests of patients prioritized over the business or financial interests promoted by administrators.

Broadly, the key concerns and issues raised by Resolution 009 are reflected by voluminous current AMA policy—both House and ethics policy—in numerous contexts, underscoring the AMA's enveloping commitment to valuing and addressing these concerns.

Primacy of the Patient-Physician Relationship

- H-285.910 – "The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community"
- H-225.950 – "AMA Principles for Physician Employment"
- H-165.837 – "Protecting the Patient-Physician Relationship"
- Opinion 1.1.1 – "Patient-Physician Relationships"
- Opinion 1.1.3 – "Patient Rights"
- Opinion 10.1 – "Ethics Guidance for Physicians in Nonclinical Roles"
- Opinion 11.2.1 – "Professionalism in Health Care Systems"
- Opinion 11.2.6 – "Mergers of Secular and Religiously Affiliated Health Care Institutions"

Deference to Physician Decision-Making

- D-125.997 – "Interference in the Practice of Medicine"
- D-285.959 – "Prevent Medicare Advantage Plans from Limiting Care"
- D-285.954 – "Physician Decision-Making in Health Care System"
- H-285.931 – "The Critical Role of Physicians in Health Plans and Integrated Delivery Systems"
- H-225.957 – "Principles for Strengthening the Physician-Hospital Relationship"
- H-285.910 – "The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community"
- H-285.954 – "Physician Decision-Making in Health Care Systems"
- H-225.942 – "Physician and Medical Staff Member Bill of Rights"
- H-225.947 – "Physician Employment Trends and Principles"
- H-225.950 – "AMA Principles for Physician Employment"
- H-285.959 – "Prevent Medicare Advantage Plans from Limiting Care"
- H-285.920 – "Criterial for Level of Care Status"
- H-285.983 – "Organized Medical Staffs in Medical Delivery Systems"
- H-235.980 – "Hospital Medical Staff Self-Governance"
- Opinion 10.2 – "Physician Employment by a Nonphysician Supervisee"
- Opinion 9.4.1 – "Peer Review & Due Process"

Well-Being and Best Interests of Patients

- H-285.910 – "The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community"
- H-285.931 – "The Critical Role of Physicians in Health Plans and Integrated Delivery Systems"
- H-225.957 – "Principles for Strengthening the Physician-Hospital Relationship"
- H-285.910 – "The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community"
- H-285.954 – "Physician Decision-Making in Health Care Systems"
- H-225.942 – "Physician and Medical Staff Member Bill of Rights"
- H-225.947 – "Physician Employment Trends and Principles"
- H-225.950 – "AMA Principles for Physician Employment"

- H-285.998 – "Managed Care"
- H-285.951 – "Financial Incentives Utilized in the Management of Medical Care"
- H-320.953 – "Definitions of 'Screening' and 'Medical Necessity'"
- Opinion 1.1.1 – "Patient-Physician Relationships"
- Opinion 1.1.6 – "Quality"
- Opinion 10.1.1 – " Ethical Obligations of Medical Directors"
- Opinion 10.2 – "Physician Employment by a Nonphysician Supervisee"
- Opinion 10.7 – "Ethics Committees in Health Care Institutions"
- Opinion 10.7.1 – "Ethics Consultations"
- Opinion 11.2.1 – "Professionalism in Health Care Systems"
- Opinion 11.2.6 – "Mergers of Secular and Religiously Affiliated Health Care Institutions"
- Opinion 11.2.2 – "Conflicts of Interest in Patient Care"
- Opinion 11.2.3 – "Contract to Deliver Health Care Services"

CONCLUSION

Resolution 009 recognizes concerns about physician autonomy in consideration of practice changes involving the newfound realities of employed physicians and health care administrators. However, the AMA currently has policy that already addresses those concerns.

- Existing policy recognizes the primacy of patient-physician relationships and the physician's responsibility and authority to exercise professional judgment in making recommendations for care, as requested by the first and third resolve clauses.

- Moreover, existing policy recognizes that the primary role of ethics committees is to serve consultative and educational functions and to foster ethically sound decision making within the context of patient-physician relationships, in keeping with consensus in the ethics community. The second resolve clause of Resolution 009 conflicts with this established consensus in the field and AMA policy.

- The fourth resolve clause should be adopted in part. The first part of the clause regarding the encroachment of administrators should be adopted as a new directive to take action, while the second part of the resolve regarding the supremacy of the patient-physician relationship should not be adopted.

RECOMMENDATION

In light of the foregoing, your Board of Trustees recommends that the:

1. First, second, and third resolve clauses of Resolution 009, "Medical Decision-Making Autonomy of the Attending Physician" not be adopted; and

2. Fourth resolve clause of Resolution 009 be adopted with amendment as follows:
That our AMA ~~aggressively pursue~~ continue to strongly oppose any encroachment of administrators upon the medical decision making of attending physicians that is not in the best interest of patients ~~as strongly as possible, for there is no more sacred relationship than that of a doctor and his/her patient, and as listed above, first, we do no harm~~.

REFERENCES

1. Chandrasheker P, Jain SH. Understanding and Fixing the Growing Divide Between Physicians and Healthcare Administrators. *Medical Practice Management.* 2019; March/April:264-268.
2. Richman BD, Shulman KA. Restoring Physician Authority in an Era of Hospital Dominance. *JAMA.* 2022;328(24):2400-2401.
3. Crosson FJ. Physician Professionalism in Employed Practice. *JAMA.* 2015;313(18):1817-1818.

BOARD OF TRUSTEES REPORT 11 WAS WITHDRAWN

12. AMERICAN MEDICAL ASSOCIATION MEETING VENUES AND ACCESSIBILITY

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: REFERRED

At the 2022 Annual Meeting, Resolution 610 was introduced by the Senior Physicians Section. The House of Delegates adopted three resolves, which were incorporated into Policy G-630.140, "Lodging, Meeting Venues, and Social Functions," as sections [6] through [8], respectively. G-630.140[8] was rescinded through approval of Board of Trustees Report 18-A-23.

A fourth resolve of Resolution 610-A-22 was referred and asked that "our AMA investigate ways of allowing meaningful participation in all meetings of the AMA by members who are limited in their ability to physically attend meetings."

At the 2022 Interim Meeting, Resolution 602, introduced by the Southeast Delegation and the American College of Radiology, was referred. Resolution 602-I-22 asked that Policy G-630.140, "Lodging, Meeting Venues, and Social Functions," be amended by addition and deletion to read as follows:

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 regulation or ~~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.

This report responds to the referred resolve of Resolution 610-A-22, and to Resolution 602-I-22 (Note: the text of Policy G-630.140 included in Resolution 602-I-22 above includes Section [8] of the policy, since that section was not rescinded until the 2023 Annual Meeting).

RESOLUTION 602-I-22

Policy G-630.140, especially bullets [3] and [4], constrain options for AMA meeting venues. When Section 4 was added to the policy, the AMA Office of General Counsel determined that the most expedient way to comply with the policy would be for the AMA to follow the list (hereafter the "California list") compiled by the State of California Attorney General's office to comply with its state law AB 1887.

The California Legislature determined that "California must take action to avoid supporting or financing discrimination against lesbian, gay, bisexual, and transgender people." To that end, AB 1887 prohibits a state agency, department, board, or commission from requiring any state employees, officers, or members to travel to a state that has enacted a law that: (1) has the effect of voiding or repealing existing state or local protections against discrimination on the basis of sexual orientation, gender identity, or gender expression; (2) authorizes or requires discrimination against same-sex couples or their families or on the basis of sexual orientation, gender identity, or gender expression; or (3) creates an exemption to antidiscrimination laws in order to permit discrimination against same-sex couples or their families or on the basis of sexual orientation, gender identity, or gender expression. The law also prohibits California from approving a request for state-funded or state-sponsored travel to such a state.

There are, as of the time of this report's drafting, 24 states on the California list (though it will likely consist of 26 states shortly, as the California Attorney General has announced that Missouri and Nebraska will be added). At the time the AMA decided to follow the California list, many other organizations were using the list as a guide to meeting venues and organization-funded travel. However, this list's utility has diminished over the years, as it has had unintended consequences, including for academics, researchers, and others in the DEI and LGBTQ+ communities. Even the City of San Francisco has decided to no longer use it for travel by its employees. The State of California is also considering repeal of AB1887.

While Policy G-630.140 supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors, there are already very few venues that can accommodate the House (and its many associated ancillary meetings of the sections, caucuses, etc.) meeting without requiring multiple hotels and a convention center. Additionally, the size of the House is increasing. There are now over 700 delegate slots, with a corresponding number of alternate delegates, though not all credential or attend the meetings. This number further limits the venues that are options for our Annual and Interim Meetings.

Adhering to the California list diminishes the number of venues capable of hosting the Annual and Interim Meetings even further, given that more than half the nation is deemed ineligible. It also has had the effect of making it so some Medical Student Section regions cannot have a meeting within their own region.

RESOLUTION 610-A-22, RESOLVE 2

As noted above, Board of Trustees Report 18-A-23 responded to the following adopted resolve of Resolution 610-A-22: That our AMA 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. BOT Report 18-A-23 covered in detail accessibility options already in place for meeting attendees with disabilities. This report thus only will discuss the referred resolve asking that our AMA investigate ways of allowing meaningful participation in all meetings of the AMA by members who are limited in their ability to physically attend meetings.

In trying to be responsive to all participants' needs, the AMA has provided for accommodations to be made for all in attendance who have the need for assistance. Recognizing that there are those for whom an onsite accommodation may not be enough, options for virtual participation have been made available when possible. Specifically, House meetings include Online Member Forums allowing for members to comment on the items of business before the House. In addition, members and others are invited and encouraged to view sessions through live streaming of all House sessions and reference committee hearings. However, AMA meetings are not only about the content that is delivered but about the interaction with others on-site, the availability of mentorship, and in the case of the National Advocacy Conference, the opportunity to advocate for AMA priorities by visiting with Members of Congress and their staff.

While some would suggest a hybrid model is the best option for those who are unable to attend in-person, a hybrid meeting is not a viable solution for the Annual and Interim Meetings in particular. The cost of the meetings would likely double, as the AMA would be hosting two meetings: the virtual and the in-person. Without strict registration, credentialing, and attendance protocols there would be no way to know how many people would be attending in

person and how many virtually, presenting issues with credentialing and voting.

A hybrid model would create conundrums in contracting and financing the meeting. There would likely be either not enough hotel rooms or too many that go unused, which could cause the AMA to incur a penalty for attrition. In addition, if only a few participate virtually, it would not be worth the expense to offer that option.

A hybrid would also result in significant issues with completing the business in a timely fashion. As experienced with the virtual special meetings, business had to be strictly limited, and the time devoted to committee hearings and House sessions still exceeded that of in-person meetings.

Thus, while meaningful participation is a laudable goal, it is not deemed to be practical for Annual and Interim Meetings at this time. The Board of Trustees and Speakers will continue to monitor future means for enhancing participation options for those who cannot attend in person.

DISCUSSION

While myriad factors are considered when determining future meeting sites for AMA House of Delegates meetings, the primary consideration is alignment of AMA policy and availability of acceptable venues. Acceptable venues include those which meet the needs of all meeting attendees to participate with any necessary accommodations.

Due to current policy and size constraints the AMA is limited to approximately four properties in the continental United States: Hyatt Regency Chicago in Illinois, Gaylord Chula Vista in California, Gaylord Rockies in Denver, Colorado, and Gaylord National in Maryland as options for the Annual and Interim Meetings of the HOD. These properties are compliant with the Americans with Disabilities Act and allow for in-person participation of all members of the HOD. There are properties that could accommodate the meetings in other states, but due to discriminatory or smoking policy those are eliminated from the list of possibilities.

While state laws are a factor, other determinations should be allowed in the consideration of future meeting venues. For example, several of the properties that can hold the AMA meeting in one venue are excluded due to state laws (e.g., Florida and Texas). The parent companies of the properties may have a strong policy that prohibits the exclusions that are not provided in the state law and would therefore make the property's own policies compliant with AMA policy. Disney, for example, is generally regarded as a nondiscriminatory employer and venue, and Orlando's Swan and Dolphin is a Disney property. Nonetheless, because of recently adopted legislation, the entire state of Florida is disallowed.

CONCLUSION

The Association has been boxed into the proverbial corner by well-meaning policies, but whether the AMA's policies on meeting locations are having their intended effect merits consideration. No state is likely to change its policies to secure an AMA meeting, as our meetings are relatively small and carry minimal economic value. In truth, the policies are likely of no impact outside the four walls of the AMA. Changing current policy to allow locations (states, cities) would expand options for future meetings. Selection of venues will of course be sensitive to state laws and any risks that attendees would face, but not limited by state laws. It is of utmost importance to emphasize the significance of prioritizing the safety of our participants as a central element of this policy. It is also important to address the criminalization of medicine aspect, particularly in relation to reproductive health care laws following the *Dobbs* decision. This includes a thorough examination of the potential impact of these laws on medical professionals and patients, as well as the potential implications for attendees' safety and access to comprehensive healthcare services.

In summary, however, the Board does not believe it is prudent for the AMA to be hamstrung by policies that overly constrain its abilities to contract for and hold meetings and recommends amendments to Policy G-630.140 to allow the AMA greater latitude in venue selection while retaining strong anti-discrimination policy. The Board also notes that amendment of G-630.140[3], as suggested by Resolution 602-I-22, is a reasonable change to the venue selection policy with regard to smoking.

RECOMMENDATION

The Board of Trustees therefore recommends that Policy G-630.140, "Lodging, Meeting Venues, and Social Functions," be amended by addition and deletion as follows in lieu of Resolution 610-A-22, Resolve 2, and

Resolution 602-I-22, and the remainder of this report be filed:

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 regulation or 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 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 will not hold meetings organized by or primarily sponsored by our AMA at venues that have 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.

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

7. 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.

8. 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.

9. Our AMA will utilize security experts to assess the safety risk for our attendees and guests at all venues.

13. HOUSE OF DELEGATES (HOD) MODERNIZATION

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy G-600.013

At the June 2022 Annual Meeting, Resolution 622, "HOD Modernization," was considered and referred.

BACKGROUND

Resolution 622-A-22, in part, called on our American Medical Association (AMA) to convene a task force "…to determine how future in-person meetings may be updated to improve the efficiency and effectiveness of the HOD, while making efforts to maintain the central tenets of our House, including equity, democracy, protecting minority voices, and recognizing the importance of in-person deliberations." The need for a task force was deliberated with the decision that there were already multiple activities and task forces planned or in progress and that creating yet another task force at this time would not assist in creating efficiencies as desired. This report serves to provide updates on current task forces and modernization activities in the House of Delegates.

One of the major undertakings that continues is the review and implementation of reforms of the HOD elections process. Resolution 603-A-19 called on our AMA to create a Speaker-appointed task force for the purpose of recommending improvements to the HOD election process. At the June 2021 Special Meeting of the AMA, Speakers' Report 2, "Report of the Election Task Force," was submitted with forty-one recommendations. Recommendation 41 of that report was adopted which called for a review to be conducted by the Speaker after an interval of two years with a report back to the HOD. After the adjournment of the 2023 Annual Meeting (and the end of the two-year assessment period) the Speaker appointed the Election Task Force 2 (ETF2) with broad representation from the House of Delegates. An in-person meeting is scheduled for Saturday, August 25, 2023, with subsequent virtual meetings to be scheduled as required. A report of the ETF2 to the HOD is planned at I-23 to provide an update on its activities and provide recommendations if ready to do so.

Another major initiative just getting underway is establishing a Resolution Modernization Task Force (RMTF). Resolution 604, "Speakers' Task Force to Review and Modernize the Resolution Process," was adopted at the 2023 Annual Meeting. The first resolved of Resolution 604 reads:

> That our American Medical Association form a Speakers' Task Force on the Resolution Process to review the entire process of handling resolutions for our AMA House of Delegates, including but not limited to definitions of on time resolutions, emergency resolutions, and late resolutions, deadlines for submission of resolutions by all sections, processing and review of reference committee reports, and use of virtual meetings so that all on time resolutions can be submitted by the same deadline

The resolution also calls for a report back to the HOD by the 2024 Annual Meeting. Immediately following the 2023 Annual Meeting, the Speaker appointed the Resolution Modernization Task Force (RMTF) with broad representation from the House of Delegates. An in-person meeting is scheduled for Sunday, August 26, 2023, with subsequent meetings to follow as needed to review all processes related to resolutions and provide recommendations to the HOD for consideration. Also included as a part of the RMTF activities, there will be a review of the Online Member Forums. Resolution 606-N-21, "Increasing the Effectiveness of Online Reference Committee Testimony," calls for the AMA to conduct a two-year trial during which reference committees will produce a reference committee document based on the written online testimony prior to the in-person reference committee hearings. I-23 will mark the end of the two-year trial period. Your Board believes that the RMTF is the most appropriate body to conduct this review and provide recommendations in their report due at A-24.

For I-23, changes were made to expedite the processing of business items including adjusting the on-time resolution submission deadlines where allowable within our rules and creating a template for correct resolution formatting. These changes will allow for posting of the handbook as one item without an addendum and will also allow for posting of all items to the Online Member Forums for member comments. This will in turn allow for a more robust discussion by the reference committees for their preliminary document production. More substantial changes are expected following the completion of the RMTF process, but members can be assured that any improvements that can be put into place for the HOD to run more efficiently and effectively will be considered and implemented if possible.

In addition to the aforementioned task forces looking at specific areas to improve efficiencies within the HOD itself, your Board along with AMA management are open to and are looking at ways to improve efficiencies internally in support of HOD functions. Board of Trustees Report 20-A-23 adopted policy stating, "that our AMA continues to invest in critical information technology and other appropriate infrastructure that allows for the tracking of past resolutions, existing policy, and supporting materials," and that work is ongoing. The HOD website is under review, upgrades and improvements to the online member forums and AMA Policy Finder are in the queue to begin work in late 2023/early 2024. Online submission forms for volunteer applications and other information gathering needs are being explored with planned implementation in the near future.

CONCLUSION

The Board concludes that the ETF2 and RMTF should continue their work in examining and improving current processes within the HOD and provide recommendations for consideration by the HOD when appropriate. Additionally, the Board and AMA management will continue to investigate opportunities to support processes and solutions that optimize efficiencies where possible, provide a satisfactory experience for all HOD members and enable constituencies to feel engaged and informed.

RECOMMENDATION

In light of these considerations, your Board of Trustees recommends that:

1. Resolution 622-A-22 not be adopted.
2. Board of Trustees Report 20-A-23 be reaffirmed.

14. FUNDING FOR PHYSICIANS TO PROVIDE SAFE STORAGE DEVICES TO PATIENTS WITH UNSECURED FIREARMS IN THE HOME

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy H-145.965

At the 2022 Interim Meeting, the House of Delegates (HOD) referred the third resolve clause of Resolution 923, "Physician Education and Intervention to Improve Patient Firearm Safety," to the Board of Trustees for a report back to the HOD. The third resolve of Resolution 923 asked "that our American Medical Association (AMA) and all interested medical societies advocate for policies that support the provision of funding for physicians to provide affordable rapid-access safe storage devices to patients with firearms in the home." The reference committee heard mixed testimony on whether to adopt this clause, with concerns raised about the approach outlined to achieve the sponsor's intended goals. Some speakers sought referral due to the complexity, cost, and concerns that, while well-intentioned, the implementation could lead to increased physician liability. Therefore, the reference committee recommended that the third resolve be referred to the Board for decision. However, following further debate on the HOD floor, the HOD voted instead to refer the third resolve clause to the Board for report back at the 2023 Interim Meeting. This report responds to this action.

BACKGROUND

Addressing firearm violence is a longtime priority for the AMA. In the 1980s the AMA recognized firearms as a serious threat to the public's health as the weapons are one of the main causes of intentional and unintentional injuries and deaths. At the 2016 Annual Meeting, following the Pulse nightclub shooting, policy was adopted declaring that "gun violence represents a public health crisis which requires a comprehensive public health response and solution." Since that time firearm injuries and deaths have increased and disparities have widened. The majority of AMA policy focuses on firearm safety and on preventing firearm injuries and deaths, including physician education, patient counseling about unsecured firearms in homes, and safe storage solutions.

On the advocacy front, the AMA continues to push lawmakers to adopt common-sense steps, broadly supported by the American public, to prevent avoidable deaths and injuries caused by firearm violence, including closing background check loopholes and urging Congress to earmark appropriations to the Centers for Disease Control and Prevention and the National Institutes of Health specifically for firearm violence research efforts. The AMA has also worked with the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM), a physician-led, non-profit organization that aims to counter the past lack of federal funding for firearm violence research by sponsoring firearm violence research with privately raised funds.

In 2018, the AMA created a continuing medical education module to help physicians learn how to identify and counsel patients at high-risk of firearm injury and death. Case studies focus on patients at risk of suicide, victims of domestic violence, and parents of children with firearms in the home. The module is available for free on the AMA Ed Hub and is being revised to include updated data and scenarios. The updated module will be released in 2023. The module includes a handout that physicians can share with their patients on different firearm storage options, including average cost. The AMA is also developing an online tool that will be released in 2023 that contains state-specific information about legal topics related to firearms, such as laws governing physicians counseling patients about firearms, physicians' obligations to disclose confidential patient information, safe storage and child access prevention laws, laws governing the possession and transfer of firearms, and extreme risk protection orders.
Most recently, Policy D-145.992, "Further Action to Respond to the Gun Violence Public Health Crisis," adopted by the HOD at A-22, directed the AMA to "establish a task force to focus on gun violence prevention including gun-involved suicide." Following an initial meeting in February of 2023 of those Federation members who have been

most highly engaged on the issue of firearm injury prevention, the AMA Board of Trustees approved the charter and membership of the task force in June of 2023. In addition, the AMA is actively participating in a coalition led by the American Academy of Pediatrics focused on maintaining and increasing federal funding for firearm violence research and looks forward to additional information regarding participating in a new coalition, the Healthcare Coalition for Firearm Injury Prevention, formed by the American College of Surgeons.

DISCUSSION

As firearm violence continues to be a public health crisis in the country with an increase in mass shootings and the unrelenting daily incidents of deaths and injuries from suicides, homicides, and accidental shootings, many physicians are frustrated at the ongoing death and violence and have urged the AMA and Congress to do more to prevent firearm-related injuries and deaths. This is especially so with respect to children: in 2020 and 2021, firearms were involved in the deaths of more children ages 1-19 than any other type of injury or illness, surpassing deaths due to motor vehicles, which had long been the number one factor in child deaths.

The Board understands and shares this frustration and agrees that firearm injury prevention continues to be of vital importance. We also recognize, however, that this a difficult and multi-faceted problem without a single solution. As stated above and summarized in more detail in recent reports BOT Rep. 2-I-22, "Further Action to Respond to the Gun Violence Public Health Crisis," and BOT Rep. 17-A-23, "AMA Public Health Strategy," the AMA has extensive existing policy covering prevention, safety, education, and research on firearm violence prevention, including safe storage of firearms in the home. Moreover, there are numerous national, state, and local organizations, many of which the AMA works with, including Brady, Giffords, the Johns Hopkins Center for Gun Violence Solutions, and Moms Demand Action, which focus on trying to prevent and reduce firearm violence. The AMA has met with the Ad Council and Brady around their End Family Fire campaign, which is a movement to promote responsible firearm ownership and encourage safe firearm storage in the home. The AMA has amplified the PSAs developed by this campaign on our social media channels. In addition to these national efforts, there are numerous local efforts underway with public health departments, police departments, hospitals, and local governments that are promoting safe storage or providing free gun locks (see, e.g., Oak Park, IL, and Anne Arundel County, MD).

While it is beyond the scope of this report to provide a comprehensive survey of the different types of safe storage devices and their effectiveness, the Board notes that in the recent past, safe storage, as with other firearm safety issues, has not been extensively studied, most likely due to the lack of federal funding until the last few years for such research. Some studies have raised questions about the effectiveness of promoting safe storage or how such promotion is done. For example, a 2017 report by the U.S. Government Accountability Office (GAO), "Programs that Promote Safe Storage and Research on Their Effectiveness," identified 16 public or nonprofit programs that promote the safe storage of firearms on the national and local levels primarily involving education efforts through media campaigns and partnerships in the community:

> GAO identified 12 studies that evaluated locking device distribution or physician counseling programs from GAO's literature review, as well as from discussions with researchers. These studies found that free lock distribution efforts influenced behavior to store firearms more safely, but these results were largely based on self-reports. Studies evaluating physician consultation presented mixed results. Some found that counseling in pediatric primary care visits did not change parents' storage behavior, but emergency care consultation following an adolescent psychiatric crisis did prompt parents to store firearms safely.

In another study released in 2023, "Firearm Owners' Preferences for Locking Devices: Results of a National Survey," it was noted that while secure home storage of firearms may reduce suicide and injury risk and that providing locking devices may increase secure firearm storage practices, questions remain about which devices motivate secure storage. The study concluded that current prevention efforts may not be aligned with firearm owners' preferences and that more rigorous research is needed on this issue to better inform health care and community-based programs to provide free or discounted devices.

While safe storage of firearms in the home can lower the risk of injuries and deaths from firearms, and the AMA remains committed to educating physicians and counseling patients about existing initiatives and programs, the Board is concerned that there may be research gaps in existing knowledge about the most effective approaches to providing safe storage devices to patients. The Board also agrees with the issues and questions raised during Reference Committee and HOD floor debate about Resolution 923, specifically about complexity, cost, and

concerns that, while well intentioned, the implementation could lead to increased physician liability in providing any such devices. The Board notes that while the AMA supports educating patients about the importance of children wearing bicycle helmets and using car seats, as a general practice, pediatricians do not provide bike helmets and car seats but rather ask parents if they have and use helmets and car seats. Moreover, in light of the availability of safe storage devices from existing police department, hospital, and local government programs that already are providing free gun locks, the Board concludes that the AMA should encourage existing and new programs to work with physician offices, hospitals, and other health care entities to provide safe storage devices at low or no cost.

Recommendation

The Board of Trustees recommends that Alternate Resolution 923 be adopted in lieu of Resolution 923 and that the remainder of the report be filed:

> RESOLVED, That our AMA encourage health departments and local governments to partner with police departments, fire departments, and other public safety entities and organizations to make firearm safe storage devices accessible (available at low or no cost) in communities in collaboration with schools, hospitals, clinics, physician offices, and through other interested stakeholders.

15. REDEFINING AMA'S POSITION ON ACA AND HEALTH CARE REFORM

Informational report; no reference committee hearing

HOUSE ACTION: FILED

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

IMPROVING THE AFFORDABLE CARE ACT

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

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

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

Our AMA has been advocating for the following policy provisions:

Cover Uninsured Eligible for ACA's Premium Tax Credits

- Our AMA advocates for increasing the generosity of premium tax credits to improve premium affordability and incentivize tax credit eligible individuals to get covered. Currently, eligible individuals and families with incomes between 100 and 400 percent federal poverty level (FPL) (133 and 400 percent in Medicaid expansion states) are being provided with refundable and advanceable premium tax credits to purchase coverage on health insurance exchanges.
- Our AMA has been advocating for enhanced premium tax credits for young adults. In order to improve insurance take-up rates among young adults and help balance the individual health insurance market risk pool, young adults ages 19 to 30 who are eligible for advance premium tax credits could be provided with "enhanced" premium tax credits—such as an additional $50 per month—while maintaining the current premium tax credit structure that is inversely related to income, as well as the current 3:1 age rating ratio.
- Our AMA is also advocating for an expansion of the eligibility for and increasing the size of cost-sharing reductions. Currently, individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which leads to lower deductibles, out-of-pocket maximums, copayments, and other cost-sharing amounts. Extending eligibility for cost-sharing reductions beyond 250 percent FPL, and increasing the size of cost-sharing reductions, would lessen the cost-sharing burdens many individuals face, which impact their ability to access and afford the care they need.

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

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

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

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

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

- Our AMA advocates for eliminating the subsidy "cliff," thereby expanding eligibility for premium tax credits beyond 400 percent FPL.
- Our AMA has been advocating for the establishment of a permanent federal reinsurance program, and the use of Section 1332 waivers for state reinsurance programs. Reinsurance plays a role in stabilizing premiums by reducing the incentive for insurers to charge higher premiums across the board in anticipation of higher-risk people enrolling in coverage. Section 1332 waivers have also been approved to provide funding for state reinsurance programs.
- Our AMA also is advocating for lowering the threshold that determines whether an employee's premium contribution is "affordable," allowing more employees to become eligible for premium tax credits to purchase marketplace coverage.
- Our AMA strongly advocated for the Internal Revenue Service proposed regulation on April 7, 2022 that would fix the so-called "family glitch" under the ACA, whereby families of workers remain ineligible for subsidized ACA marketplace coverage even though they face unaffordable premiums for health insurance coverage offered through employers. The proposed regulation would fix the family glitch by extending eligibility for ACA financial assistance to only the family members of workers who are not offered affordable job-based family coverage. The Biden Administration finalized the proposed rule on October 13, 2022.

EXPAND MEDICAID TO COVER MORE PEOPLE

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

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

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

AMERICAN RESCUE PLAN OF 2021

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

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

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

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

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

LEGISLATIVE EXTENSION OF ARPA PROVISIONS

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

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

ACA ENROLLMENT

According to the U.S. Department of Health and Human Services (HHS), 16.3 million Americans have signed up for or were automatically re-enrolled in the 2023 individual market health insurance coverage through the marketplaces since the start of the 2022 Marketplace Open Enrollment Period on November 1, 2022, through January 15, 2023.

CONTINUOUS MEDICAID ENROLLMENT

During the PHE, the Families First Coronavirus Response Act required states to provide continuous coverage to nearly all Medicaid/CHIP enrollees as a condition of receiving a temporary federal medical assistance percentage (FMAP) increase. With disenrollments frozen, churn out of the program effectively ceased and enrollment increased nationally by 35 percent, from 70,875,069 in February 2020 to 93,876,834 in March 2023, after which the continuous enrollment requirement was lifted. Most of this growth was in the Medicaid program, which increased by 22,634,781 individuals (35.3 percent), while CHIP enrollment increased during this period by 366,984 individuals (5.4 percent). The Consolidated Appropriations Act of 2023 (CAA), which was signed into law in December 2022, established March 31, 2023 as the end date for the Medicaid continuous enrollment requirement and phased down the enhanced FMAP amount through December 2023.

The CAA established new requirements that states must meet to receive the phased-down FMAP increase and gave CMS authority to require states to submit monthly unwinding data, such as the number of people whose coverage was terminated, the number of those terminated based on eligibility criteria versus for procedural reasons, plus call center volume and wait times. The CAA also authorized several enforcement mechanisms including corrective action plans, financial penalties, and requiring states to temporarily pause terminations

The AMA continues to advocate that CMS ensure that states are maintaining Medicaid rate structures at levels that ensure sufficient physician participation, so that Medicaid patients can access appropriate, necessary care, including specialty and behavioral health services, in a timely manner and within a reasonable distance to where they live.

SGR REPEAL

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

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

INDEPENDENT PAYMENT ADVISORY BOARD REPEAL

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

CONCLUSION

Our AMA will remain engaged in efforts to improve the health care system through policies outlined in Policy D-165.938 and other directives of the HOD. Given that most of the ACA fixes that led to calls in 2013 for this report at every HOD meeting have been accomplished, our primary goal now related to health care reform is stabilization of the broken Medicare physician payment system, including the need for inflation-based positive annual updates and reform of budget neutrality rules.

16. 2023 ADVOCACY EFFORTS

Informational report; no reference committee hearing.

HOD ACTION: FILED

BACKGROUND

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

DISCUSSION OF 2023 ADVOCACY EFFORTS

In 2023, our AMA is advocating powerfully for physicians and patients on the most critical health care issues. The AMA is advancing its policy at the federal and state levels despite a highly polarized political environment. The AMA has attained major progress on some issues and incremental successes on others but is committed to pressing forward on its goals in both Washington, DC and state capitals.

With the COVID-19 Public Health Emergency (PHE) officially ending in 2023, the AMA has prioritized five main issues as part of its Recovery Plan for America's Physicians:

- Reforming Medicare physician payment;
- Fixing prior authorization;
- Promoting physician-led team-based care/fighting inappropriate scope of practice expansions;
- Improving physician wellness and reducing burnout; and
- Supporting telehealth to maintain coverage and payment.

Physicians identified these issues as vital to helping their practices recover from pandemic hardships, and the AMA is making progress in addressing them. At the same time, the AMA has been advocating on numerous other issues vital to physicians and patients including but not limited to: surprise billing; reproductive health; firearm violence; maternal health; mental health parity; the overdose epidemic; access to health care; drug pricing transparency; physician-owned hospitals; physician workforce; augmented intelligence; public health; gender-affirming care; and immigration.

So far in 2023, the AMA has sent over 150 letters to federal and state policymakers advocating for AMA positions on these issues. Many of these letters stem directly from HOD resolutions. Further, some were sign-on letters written in conjunction with the Federation of Medicine, and the AMA is grateful for the partnership. AMA grassroots efforts have been robust to date and will intensify in the second half of the year. Finally, there is a separate section later in this report detailing the options to participate in AMA advocacy efforts, and the HOD is encouraged to be engaged in all of them.

Medicare Payment Reform

Medicare payment reform is a top priority for the AMA. The AMA has been advocating for physician payment reform, but there is a heightened sense of urgency based on recent payment cuts which threaten practice viability. The HOD adopted clear and decisive policy on Medicare payment reform at the 2023 Annual Meeting, and the AMA is working hard to implement it.

To achieve the needed level of reform, the AMA and 120 Federation groups agreed on a set of Medicare payment reform principles ("Characteristics of a Rational Medicare Payment System") in 2022, and these principles form the foundation for AMA advocacy on this issue moving toward a sustainable and rational system that better supports physician practice. Also at the end of 2022, the AMA launched an advocacy campaign joined by more than 150 other organizations that helped physicians avoid the most severe Medicare payment cuts slated for 2023. While these cuts were mitigated to an extent, the remaining reduction rightfully infuriated physicians and continues to

threaten access for patients—especially those in historically marginalized and rural communities.

Based on AMA advocacy, Congress recently took an important first step toward Medicare payment reform with the introduction of H.R. 2474, a bill that would provide automatic, annual payment updates to account for practice cost inflation as reflected in the Medicare Economic Index (MEI). This is a move that the AMA has long supported because it would place physicians on equal ground with other health care providers. Federation groups have joined forces in seeking bipartisan cosponsors for this legislation, and the AMA has activated the Physicians Grassroots Network and Patient Action Network to urge physicians and patients to call their legislators to co-sponsor H.R. 2474.

In addition, the AMA has drafted and is seeking sponsors for legislation that would reform the budget neutrality policies that have been producing across-the-board payment cuts. The draft bill would:

- Require the Centers for Medicare & Medicaid Services (CMS) to review actual claims data and correct flawed utilization assumptions that cause inappropriate conversation factor cuts or increases;
- Raise the spending threshold that triggers a budget neutrality adjustment; and
- Clarify which payment and policy changes are subject to budget neutrality.

The need for action by Congress was illustrated once again with the release of the proposed rule for the 2024 Medicare physician fee schedule on July 13, which calls for a 3.4% across-the-board payment cut due to budget neutrality adjustments (1.25% was the amount remaining from the Evaluation and Management (E/M) coding and payment changes made in recent years). The majority of the rest was due to implementation of the G2211 add-on visit code intended to account for additional visit complexity.

The AMA has relaunched the FixMedicareNow.org website to help achieve the needed policy changes. In addition, advocacy materials have been made available to Federation groups at ama-assn.org/medicare-pay-reform. These materials include payment trend charts and other educational tools. The AMA also conducted public message testing with voter focus groups in June and a nationwide survey in July and August, to identify policy arguments that are most persuasive to the public. A major grassroots initiative was held during the August congressional recess.
The AMA is also undertaking a new national study, supported by 173 health care organizations, to collect representative data on physician practice expenses. The aim of the Physician Practice Information (PPI) Survey is to better understand the costs faced by today's physician practices to support physician payment advocacy. The study will serve as an opportunity to communicate accurate financial information to policymakers, including members of Congress and CMS. The AMA has contracted with Mathematica, an independent research company with extensive experience in survey methods as well as health care delivery and finance reform, to conduct the study. The Medicare physician payment schedule, maintained by CMS and used by many other payers, relies on 2006 cost information to develop practice expense relative values, the MEI, and resulting physician payments. As the U.S. economy and health care system have undergone substantial changes since that time, including inflation and the wide-spread adoption of electronic health records and other information technology systems, practice expense payments no longer accurately reflect the relative resources that are typically required to provide physician services. In the Proposed Rule for the 2024 Medicare Physician Payment Schedule, CMS announced that it will delay MEI weighting of relative value pools, recognizing the pending data from the PPI Survey. The re-weighting would have led to payment reductions for certain specialties and geographic localities in 2024.

Prior Authorization

Reducing administrative burden is a key to promoting physician wellness and alleviating physician burnout. Prior authorization is consistently identified by physicians as a major hurdle to promoting optimal and timely health care for patients. The AMA has led a campaign (#FixPriorAuth) to try to "right size" prior authorization and reduce its negative effects.

The 2022 AMA Prior Authorization Physician Survey updated previous AMA research and provides clear evidence once again that prior authorization remains a major burden on physician practices and continues to harm patients:

- 94% of respondents said that prior authorization delays access to necessary health care for patients whose treatment requires prior authorization;
- 80% of respondents reported that prior authorization can at least sometimes lead to treatment abandonment;

- 33% of respondents reported that prior authorization has led to a serious adverse event for a patient in their care; and
- 89% of respondents said that prior authorization has a negative impact on patient clinical outcomes.

The AMA pressed CMS successfully to finalize a regulation that right-sizes prior authorization in Medicare Advantage plans by ensuring continuity of care, improving the clinical validity of coverage criteria, increasing transparency of health plans' processes, and reducing care disruptions. The AMA is also strongly advocating to finalize additional CMS rulemaking that would require government health benefit plans (e.g., Medicare Advantage) to offer electronic prior authorization, publicly report program statistics, and reduce processing time. With this goal in mind, the AMA launched a grassroot-effort to secure Congressional co-signers on House and Senate *Dear Colleague* letters to CMS urging the agency to make these improvements. The AMA also worked to secure the introduction of new legislation for the 118th Congress that would bring much needed reforms to prior authorization processes in Medicare Advantage.

At the state level, the AMA continues to work closely with medical societies to provide legislative language, talking points, data, and other resources to push for important prior authorization reforms in legislatures across the U.S. The AMA supported passage of laws in seven states (Arkansas, Indiana, Louisiana, Montana, North Dakota, Rhode Island, and Washington State) that make progress on this issue with resources, model legislation, data, and coalition building. About a dozen states have adopted comprehensive prior authorization reforms—many based on the AMA model bill—and there have been more than 30 reform bills introduced in the states in the 2023 legislative sessions.

Finally, United Healthcare (UHC) announced plans to voluntarily reduce the volume of prior authorizations required under their plans. In its August 1, 2023, network bulletin, UHC announced removal of prior authorization requirements on approximately 20% of codes. This change will go into effect in two phases (September and November) and will apply across all lines of business. In addition, UHC will implement a national goldcarding program that will exempt qualifying physicians from prior authorization requirements in early 2024. On August 24, 2023, Cigna announced that, effective immediately, it removed prior authorization requirements for nearly 25% of medical procedures (600+), and that it plans to remove prior authorization requirements for nearly 500 additional services for Medicare Advantage plans later this year.

Scope of Practice

The AMA remains committed to advocating for physician-led team-based health care and opposes inappropriate scope of practice expansions that threaten patient safety. Historically, most scope legislation has occurred at the state level, but in recent years, there has been more federal activity. The AMA Scope of Practice Partnership (SOPP), a coalition of 109 national, state and specialty medical and osteopathic associations, has been instrumental in defeating scope expansion bills across the U.S. Further, the SOPP has awarded more than $3.5 million in grants to its members to fund advocacy tools and campaigns since 2007.

To date, AMA advocacy has achieved more than 85 state-level victories in partnership with the Federation to protect against inappropriate scope expansions by nonphysician health care providers in 2023, including wins in Alabama, Alaska, Arizona, Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, New York, North Dakota, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, and Washington.

At the federal level, the AMA organized sign-on letters on two separate occasions to the House Ways & Means and Energy & Commerce committees, expressing strong opposition to H.R. 2713, the "Improving Care and Access to Nurses Act," or the "I CAN Act." This legislation would endanger the quality of care that Medicare and Medicaid patients receive and is expected to be the primary advocacy focus of nonphysician practitioners in this Congress. The AMA is also leading a coalition effort to oppose the U.S. Department of Veterans Affairs' (VA) Supremacy Project, which aims to set national standards of practice for all health professionals who provide care in the VA system.

Physician Wellness

The AMA is committed in its advocacy work to promoting physician wellness and preventing physician burnout. The AMA was a major proponent of the "Dr. Lorna Breen Health Care Provider Act in 2022" and is assisting in its implementation. The AMA is also continuing to push for regulatory, legislative and other solutions to direct more

funding and resources to support the mental health needs of physicians.

In the past two years, the AMA has advocated for and supported new laws in multiple states, including Arizona, Delaware, Georgia, Illinois, Kentucky, Mississippi, South Dakota, and Virginia. These laws help protect physicians who seek care for wellness and burnout. Provisions range from providing "safe-haven" type protections to shield records from disclosure to provisions requiring state licensing boards to remove stigmatizing questions from medical licensing applications. Background on these state actions can be found in this issue brief.

The AMA has worked closely with the Dr. Lorna Breen Heroes' Foundation (DLBHF), Federation of State Medical Boards (FSMB), and Federation of State Physician Health Programs to encourage all medical boards to remove stigmatizing, inappropriate questions that seek disclosure of past diagnosis of a mental illness or substance use disorder. In the past year, these efforts have resulted in three state medical boards revising their questions, and the AMA is working with eight additional state medical boards on proposed revisions. The AMA is also working directly with more than 30 regional and multistate health systems to revise their credentialing applications to remove stigmatizing questions about past diagnosis or treatment of mental illness and substance use disorders.

Additional national advocacy efforts have begun to address the ways in which credentialing organizations can play a positive role. This includes urging the National Committee for Quality Assurance and National Association of Medical Staff Services to remove requirements that health systems might misinterpret as requiring stigmatizing questions. The AMA previously helped secure an important public statement from The Joint Commission that it supported removing such stigmatizing questions. Similarly, the AMA has urged the Accreditation Council for Graduate Medical Education to take additional steps to support trainees' health and wellness. Staff highlights that the Society for the Teachers of Family Medicine have worked closely with the AMA to urge program directors to not ask trainees questions about past mental illness or treatment.

Telehealth

The use of telehealth as a valuable tool for physicians and patients was showcased during the COVID-19 PHE. The AMA has sought to maintain coverage and payment for telehealth coming out of the pandemic. The AMA won an important victory for physicians and patients with the passage of legislation extending pandemic-related telehealth flexibilities for two more years (through 2024), ensuring that patients could continue to receive remote care regardless of where they lived. The Administration is also using this legislative authority to extend payment for audio-only telehealth services through 2024.

The AMA is actively engaged in developing legislation for passage by the end of 2024 that will make these flexibilities permanent. Toward this end, a bipartisan group of 60 senators reintroduced "the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act." This legislation will expand coverage of telehealth services through Medicare, make permanent COVID-19 telehealth flexibilities, improve health outcomes, and make it easier for patients to connect with their physicians. More specifically, the legislation would:

- Permanently remove all geographic restrictions on telehealth services and expand originating sites to include the home and, by 2025, any other site that is deemed clinically appropriate for the service;
- Permanently allow health centers and rural health clinics to provide telehealth services;
- Remove unnecessary in-person visit requirement for telemental health services; and
- Allow for the waiver of telehealth restrictions during public health emergencies.

Surprise Billing

The AMA is a strong proponent of protecting patients from unanticipated medical bills that can significantly raise out-of-pocket expenses and threaten access to quality care, which is the intent of the "No Surprises Act" (NSA). However, the federal rules implementing the NSA have gone contrary to Congress' intent. The AMA has provided extensive comments and worked with the Federation to coordinate messaging and advocacy to counter this.

One of most challenging aspects of NSA implementation has been the physician-payer dispute resolution process. AMA advocated for a fair and balanced process to determine payment to physicians for out-of-network care that included an Independent Dispute Resolution (IDR) process where an independent arbiter could consider all the relevant factors used to determine fair payment. Litigation led by the Texas Medical Association has resulted in

revised IDR guidance that better reflects the statutory language and Congressional intent; however, this result is being appealed.

There have been other implementation issues as well as plans failing to pay physicians following an IDR determination in the physician's favor; underuse of the open negotiations period by health plans; complicated and confusing eligibility determinations; a backlog of IDR claims; increased costs to access IDR; and overly restrictive batching and bundling requirements. The AMA will continue advocating for fixes to these issues.

Reproductive Health

The AMA strongly opposes government interference in the practice of medicine and strongly opposes laws that prohibit physicians from providing evidence-based medical care that is in the best interest of their patients. The AMA also supports patients' access to the full spectrum of reproductive health care options, including abortion and contraception. Specific AMA actions include speaking out forcefully against recent court actions in the 5th Circuit that would have undermined U.S. Food and Drug Administration (FDA) decision making and impacted the availability of mifepristone and potentially other drugs. The AMA recently provided expert witness testimony at an Indiana state medical board hearing on behalf of a physician who performed an abortion on an adolescent rape victim from a state with more restrictive laws on reproductive care. The AMA also applauded the executive order from the Biden Administration that explores pathways to protect access to reproductive health care services and provide guidance to physicians. Further, the AMA supported continued, unrestricted access to mifepristone through joint letters with the American College of Obstetricians and Gynecologists to the White House and the FDA.

The AMA is also working closely with state medical associations to make sense of confusing legal obligations in restrictive states, identifying strategies to mitigate harm, and advocating against new restrictive laws. In states where abortion remains legal, the AMA is collaborating with state medical associations to enact additional legal and professional protections for physicians in those states. The AMA had joined the American College of Obstetricians and Gynecologists and other leading medical organizations in submitting amicus briefs supporting legal challenges to state abortion bans and supporting federal guidance on the "Emergency Medical Treatment & Labor Act" (EMTALA). The AMA is leading and participating in additional court actions, striving to protect both physicians and their patients. Further, the AMA submitted comments encouraging the FDA to consider approval of over-the-counter oral contraceptives and applauded the FDA for issuing a recent approval of the first OTC option. Upon the direction of our HOD, an AMA Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted has been established and is being organized.

Firearm Violence

The AMA labeled firearm violence a public health crisis in 2016 and is forming a task force to address this issue per an HOD directive. The AMA continues to push lawmakers to adopt common-sense steps, broadly supported by the American public, to prevent avoidable deaths and injuries caused by firearm violence including closing background check loopholes and working to ban assault weapons, ban high-capacity magazines, and ban other weapons of war that remain all-too-available, while also addressing the root causes that have fueled mass murders and casualties. President Biden issued an executive order in March 2023 that directs the Attorney General to clarify the statutory definition of who is "engaged in the business" of selling firearms with the goal of expanding background checks. This action is based on the bipartisan legislation enacted after the tragic mass shooting in Uvalde, Texas. The AMA will also continue advocating for recent AMA policies on this issue, such as ensuring that active-shooter drills consider the mental health of children, regulating ghost guns, and advocating for warning labels on ammunition packages.

Maternal Health

The AMA is highly alarmed about the increase in maternal mortality—particularly in Black patients—and is seeking solutions to this crisis. President Biden's proposed 2024 budget included $471 million to support ongoing implementation of the Blueprint for Addressing the Maternal Health Crisis and would require all states to provide continuous Medicaid coverage for 12 months postpartum, eliminating gaps in health insurance at a critical time. To date, 45 states and Washington, DC have extended Medicaid for 12 months postpartum or are in the process of doing so. Two additional states implemented limited expansions in prior years. In addition, the U.S. Department of Health and Human Services (HHS), through the Health Services and Resources Administration (HRSA) announced the availability of as much as $468 million in funding related to maternal and child health that will support home

visiting programs, innovative efforts developed at the state level, and a research collaborative supporting Minority-Serving Institutions focused on addressing and finding community-based solutions to maternal health disparities.

The AMA will continue to advocate with the Federation to pass the "Preventing Maternal Deaths Reauthorization Act of 2023," legislation to reauthorize funding for the state-based maternal mortality review committees that requires the U.S. Centers for Disease Control and Prevention to work in consultation with HRSA to disseminate best practices relating to the prevention of maternal mortality to hospitals and other health care providers. The AMA will also continue working with the Federation to secure passage of "the Connected Maternal Online Monitoring Act" (or the "Connected MOM Act"), which would require the CMS to send a report to Congress that identifies barriers to coverage for remote physiologic devices (e.g., pulse oximeters, blood pressure cuffs, scales, blood glucose monitors) under state Medicaid programs to improve maternal and child health outcomes for pregnant and postpartum women. Additionally, the AMA will continue to press for legislation and appropriations for high priority medical conditions associated with maternal mortality and morbidity through the bipartisan Congressional Black Maternal Health Caucus and the bipartisan Congressional Maternal Health Caucus. Please read more about AMA efforts here.

The AMA also made progress in support of pregnant individuals with a substance use disorder across multiple fronts. The AMA developed new model legislation to support plans of family care for pregnant individuals and family members during the prenatal and postpartum periods. The AMA model legislation, which was developed in partnership with multiple specialty societies, helps ensure that pregnant people are not penalized for seeking treatment, including when receiving medications for opioid use disorder (MOUD). The model legislation also helps support keeping the family unit intact by ensuring that the presence of MOUD is not deemed abuse or neglect for the purposes of involving child welfare services. The AMA is actively urging all states to introduce the model bill.

On the judicial front, the AMA signed on to an amicus brief in the *State of Ohio v. Tara Hollingshead*, which concerned a pregnant person who was sentenced to a lengthy prison term for using illicit drugs during the third trimester. The AMA strongly opposes criminalizing pregnant individuals who have substance-use disorders. The AMA joined seven other Ohio and national organizations to file an amicus brief that urged the court to overturn the verdict that would have sent the woman to prison for eight to 12 years. They were joined in the brief by 31 experts on maternal, fetal and neonatal health and the effects of drug use on pregnant people, pregnancies and babies. In May, the court vacated the conviction.

Access to Health Care

The AMA continues to seek ways to ensure that patients have access to quality health care coverage. In 2023, the Administration announced those with Deferred Action for Childhood Arrivals (DACA) status will have access to government-funded health insurance programs. And in another major development, in March, the continuous enrollment provisions that froze Medicaid disenrollments during the PHE expired, requiring states to redetermine eligibility for millions of Medicaid beneficiaries. The AMA has been working closely with stakeholders to minimize coverage disruptions, and more information on the AMA's activities related to the unwinding of the continuous enrollment requirement is available in CMS Report 5-I-23. Additionally, the Administration announced that beginning January 1, 2024, Federally-facilitated Marketplaces and State-based Marketplaces will have the option to implement a new special enrollment period (SEP) for people losing Medicaid or CHIP coverage. This will allow consumers to select a plan for marketplace coverage 60 days before, or 90 days after, losing Medicaid or CHIP coverage. This SEP works to reduce gaps in coverage and allows for a more seamless transition into Marketplace coverage—particularly for those patients who received coverage through PHE expansions. The Administration is also promulgating new rules that would limit short-term plans that promise coverage but do not deliver appropriate coverage when needed. Finally, at the state level, North Carolina became the latest state to expand Medicaid.

Drug Pricing Transparency

In 2023, the AMA relaunched its TruthinRx.org website aimed at increasing drug pricing transparency among pharmaceutical companies, pharmacy benefit managers (PBMs) and health insurers. In particular, new web content raises awareness around the games PBMs play within the complex and opaque drug supply chain, while advocating for policymakers to hold PBMs accountable by passing comprehensive drug pricing transparency legislation. In less than two months since the reboot in early June, the new look site has attracted over 2,000 new users and social media promotion has yielded 1,172 engagements. The AMA's newly invigorated campaign has indeed helped contribute to a growing groundswell of nationwide concern over PBMs which has in turn helped spur activity on Capitol Hill.

On March 13, 2023, the AMA sent a letter in support of both S. 127, the "Pharmacy Benefit Manager Transparency Act" and S. 113, the "Prescription Pricing for the People Act" both bills sponsored by Senators Cantwell (D-WA) and Grassley (R-IA). Both bills shed light on PBM business practices, while also prohibiting unfair or deceptive PBM conduct that drives up costs for patients. Both bills have broad bipartisan support and have been passed out of their respective committees.

Mental Health and Substance Use Disorder Parity

The AMA continues to urge state departments of insurance to meaningfully enforce state mental health and substance use disorder parity laws. AMA advocacy continues with the National Association of Insurance Commissioners to ensure that payers provide timely and accurate information as part of regular compliance reviews with parity laws. Notably, AMA efforts to increase regulators' focus on enforcement has resulted in strong, parity-focused network adequacy regulations in Colorado and enforcement actions in Illinois that highlighted payers' discriminatory actions with respect to medications for people with a mental illness or substance use disorder.

At the federal level, the AMA issued strong support for the Administration's commitment to addressing insurers' continued failures to comply with the "Mental Health Parity and Addiction Equity Act" (MHPAEA). For more than 15 years, the combined lack of enforcement and compliance with MHPAEA has been a significant factor driving the nation's mental health crisis and substance use disorder epidemic, which have both been exacerbated by the pandemic. Insurers' egregious violations of MHPAEA contribute to growing inequities in mental health and substance use disorder care, which often falls disproportionally to historically marginalized and minoritized communities. The AMA is urging the Administration to provide the Labor Department with the necessary resources to make oversight and enforcement of MHPAEA a top priority.

Overdose Epidemic

Ending the nation's drug-related overdose and death epidemic—as well as improving care for patients with pain, mental illness, or substance use disorder—requires partnership, collaboration, and commitment to individualized patient care decision-making to implement impactful changes. At the federal level, the AMA advocated for manufacturers to submit over-the-counter (OTC) applications for naloxone and that the FDA help make naloxone available OTC—the FDA approved its first naloxone product to be available for OTC status in March. The AMA is continuing advocacy efforts to urge manufacturers to responsibly price naloxone and for insurers to continue to cover the lifesaving medication.

The AMA also opposed the new eight-hour training requirements regarding substance abuse disorder management contained in "the Medication Access and Training Expansion (MATE) Act." On June 27, the new requirements went into effect for physicians applying for or renewing their Drug Enforcement Administration (DEA) registration to prescribe controlled substances. The AMA has been working with the DEA, and the agency is trying to be flexible. There is confusion about which training counts and which courses do not. The DEA has streamlined the implementation by adding three questions to the application, and physicians are not required to submit any documentation and must only attest to one of the questions by checking a box. During the 60 days before their renewal is due, the DEA will contact physicians five times to make sure they are aware of it, and each time will tell them about the training requirement. The DEA has also been accessible, hosting webinars for medical societies.

Efforts by AMA to support decriminalization of fentanyl test strips has helped with more than 10 new state laws in 2022-2023 (Arizona, Florida, Georgia, Kansas, Kentucky, Mississippi, Montana, New Mexico, Ohio, Pennsylvania, Texas, Utah, and Wisconsin). The AMA also supported the enactment of legislation or other policies in more than a dozen states to help ensure that opioid litigation settlement funds are focused on public health efforts. The AMA has also created a specific list of actions for state medical associations to take, including specific examples of evidence-based efforts they can use in their state.

Physician-Owned Hospitals

The AMA has been advocating to Congress and before CMS that the Stark exemption for physician-owned hospitals needs to be restored as a legitimate, powerful, and competitive response to concentrated and consolidating hospital markets. The AMA expressed its support for "the Patient Access to Higher Quality Health Care Act," which is bipartisan legislation introduced in both chambers. The legislation would repeal limits to the whole hospital exception to the Stark physician self-referral law, which essentially bans physician ownership of hospitals and places restrictions on expansion of already existing physician-owned hospitals.

The AMA also responded on the regulatory front in its comments (PDF) on the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long-Term Care Hospital Prospective Payment System proposed rules. The AMA strongly opposed proposals to:

- Revoke flexibilities for physician-owned hospitals that serve greater numbers of Medicaid patients;
- Increase the agency's regulatory authority to grant or deny exceptions to expansion; and
- Expand the scope of community input.

The AMA stressed that these proposals limit the capacity of physician-owned hospitals to increase competition and choice in communities throughout the country and, more significantly, limit patients' access to high-quality care. The AMA's comments highlight the benefits of physician-owned hospitals, including their high performance on quality and efficiency, value to the community, promising role in value-based care delivery and payment models, and increased competition.

Physician Workforce

With a projected physician workforce shortage between 37,800 and 124,000 by 2034, the AMA continues to seek solutions on this issue. We have been pushing Congress to help stop the current and impending future crisis by emphasizing a multi-prong solution that is complementary to the AMA Recovery Plan for America's Physicians. The AMA is proposing:

- Additional GME slots and funding so that more physicians can be trained;
- Additional funding in support of programs created through "the Dr. Lorna Breen Health Care Provider Protection Act;" and
- More loan repayment and scholarship programs for physicians.

Augmented Intelligence

In 2023, the Administration announced new efforts to "advance the research, development, and deployment of responsible artificial intelligence." Relevant items in the announcement include:

- Updated National Artificial Intelligence (AI) Research and Development Strategic Plan (PDF), encompassing an updated roadmap for federal investment in augmented intelligence; and
- Office of Science and Technology Policy (OSTP) Request for Information (PDF), seeking stakeholder input on national priorities for mitigating AI risks, protecting rights and safety, and harnessing AI to improve lives.

The announcement came during a time of heightened interest in and concern around AI after the release of OpenAI's ChatGPT technology. The AMA is pleased to see the Administration's increased focus on the responsible and safe deployment of AI technologies, while acknowledging additional action is needed to limit risks and ensure patient safety. The AMA submitted comments urging increased focus on health care in government-wide efforts on AI and additional actions to ensure the responsible, ethical, safe and transparent deployment of health care AI. The AMA has also developed a ChatGPT primer (PDF) for physicians with questions regarding the technology and use in medical practice.

Gender-Affirming Care

The AMA strongly opposes state laws that discriminate against transgender adults and youth regarding the health care they receive. Health care decisions are properly made through shared decision-making between the patient, family and physicians, without third parties, including government officials, inserting themselves into the medical exam room or second-guessing health care decisions made in the context of the patient-physician relationship. The AMA strongly believes that clinical interventions should not be criminalized or otherwise restricted. The AMA has advocated against state restrictions on evidence-based gender-affirming care in several states including Missouri, Montana, New Hampshire, and South Dakota. The AMA will continue to work closely with state medical associations to oppose bans on evidence-based care. The AMA has filed and joined briefs in multiple federal court cases supporting evidence-based gender-affirming care. Finally, at the federal level, the AMA joined the American Academy of Pediatrics and Children's Hospital Association in issuing a letter to Attorney General Merrick Garland urging the Department of Justice to investigate the increasing threats of violence against physicians, hospitals and families of children for providing and seeking evidence-based gender-affirming care.

Climate Change

The AMA continues to work in coalition efforts to address climate change and its impact on health. We hold a board position in the Medical Society Consortium on Climate Change and Health. We also join in advocacy efforts led by the American Thoracic Society and the American Lung Association, including joining on a comment letter to the U.S. Environmental Protection Agency earlier this year on proposed regulations to strengthen limits on harmful air pollution from oil and gas sources. Board Report 3, which is being presented to the HOD at the Interim Meeting, provides a full update on AMA efforts including holding listening sessions with physicians and medical students to gauge their thoughts about the health risks of climate change, the need to decarbonize the health sector, and where they would like the AMA to focus on this issue.

Immigration

The AMA remains committed to ensuring fairness in the immigration process. The AMA sent a letter expressing support for S. 665, the "Conrad State 30 and Physician Access Reauthorization Act," which would reauthorize and make targeted improvements to the J-1 visa waiver program in a manner that helps alleviate the shortage of physicians, especially in rural and underserved areas, and promotes a more diversified workforce. The AMA also signed onto a letter raising concerns about a harmful immigration policy that was reportedly under consideration—the reinstatement of detention of immigrant families. Such family detention puts the health and safety of children and their parents at risk and, as such, the AMA urged the Administration to abandon any effort to detain families in Immigration and Customs Enforcement facilities. The AMA sent a letter urging the Administration to allow more flexibility during public health emergencies in the worksite requirements governing where international medical graduates in H-1B status may practice and as a result of this letter received a meeting with the U.S. Department of Labor. Finally, AMA wrote to the Administration (letter) offering comments on the proposed amendments to the qualifying criteria for critical federal health programs. In the proposed rule, HHS cited a 2021 survey of DACA recipients which found that 34% of respondents reported that they were not covered by health insurance, 47% attested to having experienced a delay in medical care due to their immigration status, and 67% said that they or a family member were unable to pay medical bills or expenses. Please read more about AMA efforts here.

Nutrition

The AMA also engaged on federal nutrition policy in 2023. The AMA commented on the proposed revisions to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Food Packages. Overall, the AMA supports the primary goal of revising the program to align with the current Dietary Guidelines for Americans while providing flexibility in the variety and choice of foods and beverages. This flexibility will better reflect cultural and medical needs and personal preferences while adhering to the science associated with nutritional necessities that promote growth and health in pregnant, breastfeeding, and non-breastfeeding postpartum individuals and children. The AMA also commented on the U.S. Department of Agriculture's (USDA or Department) Food and Nutrition Service (FNS) proposed revisions to the Child Nutrition Programs: Revisions to Meal Patterns Consistent with the 2020 Dietary Guidelines for Americans. Overall, the AMA applauded the Child Nutrition Program's primary goal of revising the program to align with the current Dietary Guidelines for Americans (DGA) while providing flexibility in the variety and choices offered in school meals. Finally, the AMA commented on the USDA FNS on the "WIC: Online Ordering and Transactions and Food Delivery Revisions to Meet the Needs of a Modern, Data-Driven Program" proposed rule. By removing barriers to online ordering and internet-based transactions, harmonizing the near-complete transition to electronic benefit transfer, and modernizing regulations to support food delivery and minimize burden on WIC food suppliers, FNS will modernize the WIC program and increase accessibility so that WIC can meet the evolving needs of the millions who rely on the benefit.

AMA ADVOCACY ONGOING UPDATES AND MEETINGS

The AMA offers several ways to stay up to date on our advocacy efforts, and we urge the HOD to avail themselves of all of them to stay informed and advance our grassroots efforts:

- Sign up for AMA Advocacy Update—a biweekly newsletter that provides updates on AMA legislative, regulatory, and private sector efforts. We try to make sure all HOD members are on the email list, but if you are not receiving AMA Advocacy Update, please subscribe and encourage your colleagues to do so as well. Subscribers can read stories from previous editions here.
- Join the Physicians Grassroots Network for updates on AMA calls to action on federal legislative issues. And if

you have connections with members of Congress, or are interested in developing one, the Very Influential Physician (VIP) program can help grow these relationships.
- Connect with the Physicians Grassroots Network on Facebook, Twitter, and Instagram.

The AMA also encourages HOD members to consider attending the State Advocacy Summit and National Advocacy Conference. Save the dates for the 2024 State Advocacy Summit on Jan. 11-13 in Amelia Island, Florida, and the 2024 National Advocacy Conference on Feb. 12-14 in Washington, D.C. Registration and additional information is forthcoming.

CONCLUSION

The AMA has an incredible amount of work to do on the advocacy front, and it needs continued partnership with the Federation to advance organized medicine's collective goals. There has been progress so far in 2023, but there is still substantial work to be done on the Recovery Plan topics as well as many other ones directly affecting physicians and patients.

17. SPECIALTY SOCIETY REPRESENTATION IN THE HOUE OF DELEGATES – FIVE-YEAR REVIEW

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

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

The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) required to submit information and materials for the 2023 American Medical Association (AMA) Interim Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020, "Summary of Guidelines for Admission to the House of Delegates for Specialty Societies," and AMA Bylaw 8.5, "Periodic Review Process."

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

The following organizations were reviewed for the 2023 Interim Meeting:

American Academy of Allergy, Asthma & Immunology
American Academy of Ophthalmology, Inc.
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology—Head and Neck Surgery
American Academy of Pain Medicine
American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Association of Neurological Surgeons
Society of Nuclear Medicine and Molecular Imaging

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

The materials submitted indicate that: the American Academy of Ophthalmology, Inc., American Academy of Orthopaedic Surgeons, American Academy of Otolaryngology—Head and Neck Surgery, American Academy of

Pain Medicine, American Academy of Pediatrics, American Academy of Physical Medicine and Rehabilitation, American Association of Neurological Surgeons, and Society of Nuclear Medicine and Molecular Imaging meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicate that the American Academy of Allergy, Asthma & Immunology did not meet all guidelines and is not in compliance with the five-year review requirements of specialty organizations represented in the HOD.

RECOMMENDATIONS

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

1. The American Academy of Ophthalmology, Inc., American Academy of Orthopaedic Surgeons, American Academy of Otolaryngology—Head and Neck Surgery, American Academy of Pain Medicine, American Academy of Pediatrics, American Academy of Physical Medicine and Rehabilitation, American Association of Neurological Surgeons, and Society of Nuclear Medicine and Molecular Imaging retain representation in the American Medical Association House of Delegates.

2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5 the American Academy of Allergy, Asthma & Immunology be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership.

REPORT OF THE SPEAKERS

The following reports were presented by Lisa Bohman Egbert, MD, Speaker; and John H. Armstrong, MD, Vice Speaker:

1. REPORT OF THE RESOLUTION MODERNIZATION TASK FORCE UPDATE

Informational report; no reference committee hearing.

HOD ACTION: FILED

At the Annual 2023 Meeting of the House of Delegates (HOD), resolution 604, "Speakers' Task Force to Review and Modernize the Resolution Process," was adopted and directed the speaker to establish a task force to evaluate and modernize the HOD resolution process. Subsequently, the Speaker formed the Resolution Modernization Task Force (RMTF) and solicited applicants with broad representation in the House. The following nine members were appointed to join the Speakers on the RMTF:

- David Henkes, MD, Chair, Texas
- Sarah Candler, MD
- Ronnie Dowling, MD
- Rachel Ekaireb, MD
- Michael Hanak, MD
- Susan Hubbell, MD
- Gary Pushkin, MD
- Kaylee Scarnati
- Rachel Kyllo, MD
- Lisa Bohman Egbert, MD, Speaker, Ohio
- John H. Armstrong, MD, Vice Speaker, American College of Surgeons

BACKGROUND

Members of the RMTF were sent background material related to the current resolution process in the House (Appendix A). The task force subsequently met on August 27 to assess the resolutions process, identify potential areas for improvement, and develop a list of topics to discuss at the open forum scheduled to be held at Interim 2023 at 10 am on Sunday, November 12, 2023. The task force will subsequently develop its report with recommendations to be presented at Annual 2024 as directed in resolution A-22-604.

At their initial meeting, the task force stated, "The RMTF seeks to develop efficient processes that allow for all business before the House to be equally reviewed by all delegates with the ultimate goal of the best policy being developed for our AMA." Subsequent discussion focused on identifying current "roadblocks" to achieving this goal and considering potential solutions. Following is the list of topics with brief synopsis for discussion at the I-23 open hearing as shared by the task force. This list is not intended to be exclusive and also does not imply that the task force has reached a conclusion on any specific topic.

ITEMS FOR CONSIDERATION

Unequal Time for Delegates to Evaluate Items of HOD Business

The task force identified unequal time for delegates to evaluate the individual items of House of Delegates (HOD) business as a significant barrier to creating a better process for the development of our policy. Unequal time to evaluate the business can be further divided into two broad areas: increased volume of business and variable definition of "on time" resolutions.

Topic #1 Increased Volume of Business

The volume of business has been increased at the last three in-person meetings. This may be attributed to the backlog of resolutions from the Federation that were unable to be handled during the Special Meetings, the increasing number of delegates leading to production of more resolutions, the focus on policy making within the

Sections, and the politicization of issues related to science, medicine and health. Tracking this data is challenging as all processing of resolutions at the AMA level is done "by hand." The task force encourages individual delegations to review their recent resolution production and share those numbers at the upcoming open forum.

A large volume of business inevitably leads to a large volume of policy which is challenging to manage, both from a data processing perspective (i.e., Policy Finder) and, more importantly, from AMA management and board perspectives as they are tasked with the development and implementation of our AMA strategic plan that derives from House policies.

Topic #1
Should the volume of business be limited? If so, how can this be accomplished fairly without infringing on the individual delegate's right to present business to the House? Should there be a requirement for authors to explain how resolutions correlate with our AMA strategic plan?

Topic # 2 Definition of "On-time Resolutions"

Bylaw 2.11.3.1 *Introduction of Business* sets the resolutions submission deadline as *"not later than 30 days prior to the commencement of the meeting at which it is to be considered."* It then goes on to delineate two exemptions to this rule, which are paraphrased below:

1. Resolutions from member organization's house of delegates or primary policy making body, as defined by the organization, that adjourn during the 5-week period preceding the commencement of the AMA House of Delegates meeting are allowed 7 days following the close of their meeting to submit resolutions from that meeting.
2. Resolutions presented from the business meetings of the AMA Sections held in conjunction with the HOD meeting may be presented up until the recess of the opening session of the House of Delegates.

Combined, these two exceptions account for a significant number of resolutions that are presented after the handbook has been posted. These items are not available on the Online Member Forums for review. In addition, the later the resolutions are made available, the less time for groups to meet to discuss them in advance of the reference committee hearings potentially affecting the quality of resolutions passed.

Topic #2
Should there be one firm deadline, with no exceptions, for all business presented at each meeting, with items received after that deadline treated as *late?

**Late resolutions, as defined by bylaw 2.11.3.1.3, are those received after the 30-day deadline and prior to the recess of the opening session of the House of Delegates. These resolutions are reviewed by the Committee on Rules and Credentials and can be accepted as business with a two-thirds majority vote.*
**Late resolutions are recommended for consideration by the Committee on Rules and Credentials based on two criteria: why they could not be submitted on time and the urgency of the topic and thus the need to be considered at the meeting. This would continue to apply to the currently exempted items if they became "late" by changing to one firm deadline.*

Topic #3 Avoiding Redundancy with Existing Policy

The RMTF identified the significant volume of existing policy and the potential for redundancy within that policy as another broad area that should be improved. While this is in part due to the increasing volume of business, another contributing factor is an inadequate mechanism to identify and deal with new resolutions that are not significantly different from existing policy. These issues can be further delineated as follows:

Resolution writing process

- Authors vary in their efforts and success in identifying existing AMA policy on the topics under consideration for resolutions.
- Policy Finder is not user-friendly, making searches of existing policy time-consuming and often unproductive. Updates to policy finder are ongoing but will not be completed in the short-term.
- Federation policymaking bodies are not compelled to review current AMA policy in writing resolutions for

their own organizations before forwarding them to the AMA HOD. In addition, many organizations are required to forward all resolutions, as passed, to the AMA HOD, without consideration for alternative pathways to achieving their goals.

Identifying Submitted Resolutions for Reaffirmation

- Resolutions are reviewed for possible reaffirmation of existing policy by AMA staff who are content matter experts. Corporate turnover, especially during COVID-19, has resulted in the loss of long-time staff who had considerable institutional memory of AMA policy. This leaves our newer staff more dependent on Policy Finder and its inherent shortcomings.
- The Rules and Credentials Committee reviews the list produced by staff to develop their report. Note that per bylaws this committee, like all other HOD committees, cannot officially act prior to the commencement of the meeting. Their report is released in the meeting tote ("Saturday" tote) for action at the second opening session later that day, allowing limited time for review by delegations.

Pulling items off the reaffirmation consent calendar

- Current rules allow an individual delegate to pull an item off of the consent calendar.
- While there is typically a significant number of items placed on the consent calendar, half to 2/3rds are typically pulled off and sent to reference committee hearings.
- Reference committees often ultimately recommend reaffirmation of policy in lieu of many items initially recommended for reaffirmation on the Reaffirmation Consent Calendar.
- Many authors/delegations do not consider reaffirmation a "win" with regard to their resolution, despite the fact that the sunset clock is reset and the topic is noted in the proceedings.

Alternative Pathways

- G-600.060 (5) states, *"The submission of resolutions calling for similar action to what is already existing AMA policy is discouraged. Organizations represented in the House of Delegates are responsible to search for alternative ways to obtain AMA action on established AMA policy, especially by communicating with the Executive Vice President. The EVP will submit a report to the House detailing the items of business received from organizations represented in the House which he or she considers significant or when requested to do so by the organization, and the actions taken in response to such contacts."*
- While your task force is not recommending flooding the desk of our EVP, this is an underutilized alternative to writing a redundant resolution in order to stress the importance of a specific topic already in policy.

Topic #3
Can we reduce the introduction of resolutions that are redundant to existing policy? Are there ways to improve the production of the reaffirmation consent calendar? Should items identified as potential reaffirmation be so delineated on the Online Forum? Should authors of items identified as reaffirmation be asked to explain in writing to Rules and Credentials why their item is not reaffirmation? Should there be a higher bar for removal from the reaffirmation calendar? How do we encourage the use of alternative pathways for increasing awareness of given topics? How do we reframe reaffirmation as a "win"?

Topic #4 Reference Committee Process

The task force noted several concerns with the process by which resolutions move through reference committees. These can be broadly separated into two main topics: Online Member Forums and In-person Hearings.

Online Member Forum
The Online Member Forum has been underutilized by the HOD despite successful use by many Sections and component societies. This is due in large part to the inability to have all business before the House available for comment on the Forum, which in turn is due to the large number of resolutions that arrive after the posting of the initial handbook.

Policy D-600.956 *Increasing the Effectiveness of Online Reference Committee Testimony* initiated a two-year trial of the production of a preliminary reference committee document, based on testimony in the Online Member Forum during a prescribed 14 day period, which is then intended to be used to inform the discussion at the in-person reference committee hearing. I-23 marks the conclusion of this trial. For I-23, your Speakers established an expedited deadline system to enable all items, minus the exempted items, to be included in the handbook and the

forum. No addendum was produced. Multiple communications were sent to the House to encourage more robust use of the Forum, and the reference committees were directed to enhance their preliminary documents. As of the writing of this report, the effects of these changes are unknown but are hoped to stimulate better utilization of the Online Forum and that the improved preliminary documents will expedite the in-person hearings.

Topic #4
How can the Online Forum be better utilized? Should the preliminary document be more robust? Should the preliminary document include reference committee recommendations and be used as the basis for the discussion at the in-person hearing?

Topic #5 Reference Committee Hearings

Your Speakers have heard several concerns regarding reference committee hearings at our recent in-person meetings. Despite the earlier meeting start which allowed for more time for deliberation, the volume of business before the reference committee hearings caused several to run over their allotted time. Concerns have been raised that items at the end of the agenda do not receive adequate discussion due to lack of attendance and significant restrictions on debate, in one instance down to 30 seconds. This often results in more items at the end of reference committees being extracted from the consent calendar for full House deliberation. Reference committee members and particularly the chairs spend significant time following the hearings in executive session and report review. In addition, reference committee members and staff work, often without sleep, for prolonged periods in order to complete their reports. It may be that this has become such a significant time commitment that it is a reason for your Speakers having difficulty obtaining enough volunteers for the reference committees at recent meetings.

Topic #5
How can we improve reference committee hearings to allow all items to receive adequate discussion in a timely fashion? How can we decrease the time spent on report development while maintaining the quality of the reports?

CONCLUSION

The RMTF is looking forward to hearing your comments regarding the above topics at the Open Forum to be held on Sunday, November 12 at 10 am. Note that this list is not meant to be all inclusive but rather a guide to frame the discussion. The task force is open to hearing all comments or suggestions from our House regarding improving this process.

2. EXTENDING ONLINE FORUM TRIAL THROUGH A-24

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: **RECOMMENDATION ADOPTED**
REMAINDER OF REPORT FILED
See Policy D-600.956

At the N-21 Special Meeting of the AMA House of Delegates (HOD), resolution 606, "Increasing the Effectiveness of Online Reference Committee Testimony," was adopted as amended establishing policy D-600.956 which states:

1. Our AMA will conduct a trial of two-years during which all reference committees, prior to the in-person reference committee hearing, produce a preliminary reference committee document based on the written online testimony.
2. The preliminary reference committee document will be used to inform the discussion at the in-person reference committee.
3. There be an evaluation to determine if this procedure should continue.
4. The period for online testimony will be no longer than 14 days.

This trial was implemented beginning with the 2022 Annual Meeting and is set to conclude at the 2023 Interim Meeting.

For the trial each reference committee member was asked to be available to meet on the weekend prior to the start of the meeting to develop their preliminary reference committee document. Note that these reference committee preliminary meetings would be in violation of bylaw 2.13.1.5 which states, *"reference committees shall serve only during the meeting at which they are appointed."* (This prohibition excludes members of reference committee F, who are appointed to serve two-year terms.) However, because bylaw 2.13.1.5 goes on to say, *"unless otherwise directed by the House of Delegates,"* these preliminary meetings were able to be convened during the defined two-year period as specifically directed by the HOD in policy D-600.956. Therefore, reference committee preliminary meetings, except for F, will no longer be able to be held after the conclusion of the two-year trial at I-23.

At A-22 resolution 604, "Speakers' Task Force to Review and Modernize the Resolution Process," was adopted directing the speaker to establish a task force to evaluate and modernize the HOD resolution process. The Speaker appointed the Resolution Modernization Task Force (RMTF), and the first meeting was held on August 27, 2023. The RMTF was instructed to include an evaluation of the above trial and to make further recommendations within their report which is due at A-24.

For I-23, the Speakers have redefined the deadlines for resolution submission to enable the single posting of the entire handbook (without an addendum), minus the exempted resolutions. Likewise, the entire handbook was made available for comments on the Online Forum for its 14-day window. In addition, the Speaker instructed reference committees and their staff to enhance their preliminary documents to better *"inform the discussion at the in-person reference committee"* hearings. The outcome of these changes is yet to be determined.

Given the ongoing work of the RMTF with a report due at I-24 and the enhancements to the I-23 on-time submission deadline, your Speakers recommend continuing the trial established by D-600.956 through A-24.

RECOMMENDATION:

1. That the trial established by Policy D-600.956 be continued through Annual 2024.

3. REPORT OF THE ELECTION TASK FORCE 2

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

HOD ACTION: RECOMMENDATIONS 2, 9, 10, 17, 19-22, 25, 28 & 29 ADOPTED
RECOMMENDATIONS 11, 15 & 26 ADOPTED AS FOLLOWS
RECOMMENDATIONS 1, 3-8, 12-14, 16, 18, 23 & 24 REFERRED
RECOMMENDATION 27 NOT ADOPTED
REMAINDER OF REPORT FILED
See Policy H-135.908, D-610.089 and G-610.090

Policy G-610.031, "Creation of an AMA Election Reform Committee," was adopted at A-19 and called on your speakers to appoint a task force to recommend improvements to our American Medical Association's (AMA) election process. The speakers presented a report of the Election Task Force (ETF1) at the 2021 June Special Meeting which was adopted as amended bringing about substantial reforms to the election process. The final recommendation called for the following:

After an interval of 2 years a review of our election process, including the adopted recommendations from this report, be conducted by the Speaker and, at the Speaker's discretion, the appointment of another election task force with a report back to the House.

The 2023 Annual Meeting marked the two-year point (and 2nd election cycle) of the new AMA election rules implemented for A-22. Immediately following A-23, volunteers were solicited from the House of Delegates (HOD) to participate in an Election Task Force 2 (ETF2) to review and provide recommendations to amend or further refine current election processes. Nine individuals were appointed to serve alongside your speakers. Members selected for ETF2 have considerable experience either as a member of ETF1, candidate, or campaign team member. The task force recommendations included in this report are based on their review and best judgment of the election processes during these past two election cycles. The appointees include:

- Jordan Warchol, MD, Chair*
- Mary Carpenter, MD
- Richard Evans, MD*
- Stuart Glassman, MD
- Josh Lesko, MD*
- Neva Lundy
- Vikram Patel, MD
- John Poole, MD*
- Ted Mazer, MD, Election Committee
- Lisa Bohman Egbert, MD, Speaker*
- John H. Armstrong, MD, Vice Speaker

*ETF 1 Member

Task force members were sent a packet of materials (Appendix A), for review that provided historical background and an understanding of the progression of election reforms dating back to A-19. The materials sent for review included:

- Relevant reports and resolutions
- Current bylaws and policy pertaining to AMA elections
- 2023 Election Manual

The ETF2 met on Saturday, August 26, 2023. Members reviewed the charge and goals of the task force and concurred with original Election Task Force goal as stated in the June 2021 ETF1 report: "In proposing changes to our election processes, the task force has sought to ensure that the best candidates can be selected in free and fair elections while reducing obstacles, or perceived obstacles, that dissuade qualified members from seeking elective office. At the same time, the task force seeks to enable and facilitate the ability to have an informed electorate."

The topics for discussion of the ETF2 followed the structure of the ETF1 report and included:

- Campaign Memorabilia
- Stickers, Buttons, and Pins
- Campaign Receptions
- Dinners, Suites, and Such
- Campaign Literature
- Electronic Communication
- Websites and Social Media
- Interviews
- Voting Process and Election Session
- Announcements and Nomination
- Newly Opened Positions
- The Role and Influence of Caucuses
- The Day of Elections
- Election Committee

DISCUSSION

The ETF2 agreed that most of the changes implemented through the ETF1 report were positive and overall did much to achieve the goal of a fair and equitable election process. Therefore, much of the discussion of the ETF2 centered on finalizing and consolidating election policies to provide clear guidance to candidates and member organizations. Each of the topics listed above were discussed; however, no changes were recommended to the issues of campaign memorabilia, newly opened positions, the role and influence of caucuses and the day of elections. Discussion and recommendations for changes to the remaining topics as well as a new topic are the focus of this report.

Stickers, Buttons, and Pins

Under current policy, campaign stickers, buttons and pins are disallowed. Specifically excluded from this prohibition are pins for AMPAC, the AMA Foundation, specialty societies, state and regional delegations. These pins should be small and distributed only to members of the designated group. The ETF2 noted that AMA pins should also be allowed and recommend making this addition.

Current policy also allows pins for health-related causes that do not include any candidate identifier and notes that all pins may not be worn directly on the badges to avoid obstructing the view of the speakers when in the House and to avoid interfering with the enhanced security measures. To prevent a proliferation of such pins and the temptation to wear them on the badges, the Task Force recommends that such pins may only be worn with prior approval by the speaker no later than 30 days before the Opening Session of the HOD. Depending on the number of requests or nature of the item, the speaker should have discretion in the approval, regardless of the worthiness of the cause. The approved list will be included on the Speakers' Letter.

Campaign Receptions

The 2023 Annual Meeting marked the end of the two-year trial of an AMA-hosted candidate reception. The consensus of the ETF2 was that the campaign reception has been a successful change and should be continued. The receptions at A-22 and A-23 were well attended and gave all candidates equal opportunity to be featured at a reception at no or low cost to them. Therefore, the task force recommends that this reception be made a permanent part of our AMA election process.

Dinners, Suites, and Such

The ETF2 spent a significant amount of time discussing dinners, suites, and interactions that occur during these activities. In the last two election cycles, this topic has generated multiple questions requiring speaker clarifications regarding the possibility of candidate exposure to complaints of a campaign violation. There is a balance that must be struck between allowing organic discussions that should be encouraged to enable delegates to learn about a candidate versus overt campaigning. Exchanges that result from invitations to suites and group dinners are difficult to monitor but can be easily misconstrued, particularly in the age of social media and "gotcha" moments. Candidates and organizations should be aware of the scrutiny that their participation may bring and should always conduct

themselves in a way that minimizes any appearance of impropriety. The task force does not wish to be overly prescriptive yet believes there is need for clearer parameters and therefore offers the following recommendations.

Announced candidates in a currently contested election may not be "featured" at any gathering of delegates outside of the single campaign reception they have chosen. For the purpose of AMA elections, the definition of "featured" includes being mentioned in the invitation, whether written or verbal, or publicly acknowledging or discussing a candidacy with attendees at a function. Candidacies may be discussed informally during the period for active campaigning.

The Task Force recommends that all group dinners attended by an announced candidate in a currently contested election must be "Dutch treat," meaning that each participant pays their own share of the expenses. There would no longer be a minimum number of attendees for this rule to be in effect. All individuals must cover their personal expenses, with the exception that societies and delegations may cover the expenses of their own members. Candidates may participate in meals provided by groups of which they are a member, such as delegation or caucus breakfast/lunches, when the meal has other purposes and does not include campaigning by the candidate or campaign team.

Finally, ETF2 recommends that prior to the active campaigning period, currently contested candidates may discuss their candidacy on an individual basis in private conversations after announcement to the HOD. This would exclude all other individuals such as members of their campaign teams, delegations, caucuses, and "friends" from campaigning or discussing the candidacy. Under current rules, candidates, once announced, are not allowed to openly discuss their candidacy until active campaigning has commenced. Any casual discussion can easily be construed as "campaigning" and can put a candidate in an awkward position of not knowing what can and cannot be said. The task force decided that candidates should be able to acknowledge their candidacy in private conversations with other individuals without fear of being "reported" for a campaign violation.

Campaign Literature
Electronic Communications
Website and Social Media

The Task Force noted that the decrease in the expense and amount of campaign materials produced as a result of the campaign reforms of ETF1 has been tremendously beneficial. They recommend there should be further limitations made to include all print and digital distribution of campaign literature by the candidate and campaign team. Although distribution of printed campaign materials were significantly limited by the previous reforms, the task force recommends eliminating production of all printed materials and further recommends disallowing electronic distribution of campaign material as well as any mass contact by the candidates.

The ETF2 members also considered phone calls and electronic communications from candidates and campaign teams. Receiving phone calls from or about a candidate during the course of a busy day can be disruptive for many physicians. Although no data is available about how widespread this practice is, members of the task force recommend prohibiting all mass campaign calls. The task force also recommends disallowing all mass electronic campaign communications. Although not specifically prohibiting "personal" electronic campaign communications and phone calls, the ETF2 strongly discourages them and notes that the current rule that any campaign related electronic communication must include a simple method to opt out for the recipient should remain. As noted on multiple communications from the speakers over the last two election cycles, candidates and campaign teams should consider the recipient's perception of any outreach. If the recipient considers the outreach to be from someone they do not know "well enough" to hear from other than for the campaign outreach, they may file a complaint to this effect.

In lieu of printed or emailed materials and phone calls, candidates and campaign teams should utilize the communication channels that were put in place by ETF1. These include posting an announcement card on the AMA website as well as providing a statement for the election manual, an electronic campaign "brochure" for the AMA HOD distributed campaign email, and the ability to create an AMA Candidate Web Page on the AMA website. All of these opportunities are low (or no) cost to the candidate and are equally available to all candidates, yet still provide the ability to customize materials and messaging.

Interviews

The ETF1 report noted that candidate interviews were the most important decision-making element in our AMA's election process. As such, significant changes were made by ETF1 to the candidate interview process to optimize the availability of this vital tool for all delegates. These changes also improved the previously complicated process of scheduling interviews for both candidates and interviewing groups. The ETF2 notes that these changes were well received and recommends some further clarifications and improvements as follows.

The ETF2 recommends continuing to post on the AMA website the virtual speaker interviews for contested elections. Although they were not widely viewed in A-22 or A-23, the Task Force believes that such uniform interviews provide access for all delegates. This specifically allows the relatively small number of delegates who may not be a part of an interviewing group to have access to such interviews. However, conducting these interviews is quite time intensive, and the speakers are urged to consider ways to streamline the process.

Virtual interviews were found to be a welcome addition to assess candidates and alleviate some of the time crunch during the Annual Meeting. ETF2 recommends that this option be continued in addition to the traditional in-person interviews. They also recommend formally including the Election Committee interpretation and a further clarification to the interview rules as follows: that any questioning of or presentations by announced candidates, including answers or presentations in writing, would fall under the rules for interviews. ETF2 further recommends that all members of an interviewing group be included or be given access to interviews whenever possible. Although technical capabilities and resources vary from group to group, the interview should be recorded if possible and with the candidate's consent, and made available to members of the interviewing group by posting to a website or sharing via email. This helps to facilitate each individual delegate's assessment of the candidate and enable informed decisions about candidates.

ETF2 further recommends that the HOD Office continue the process of developing and maintaining a list of all groups that wish to interview and requiring that they be on this list in order to do so. The interviewing group must specify whether they wish to interview in-person or virtually and for which contests they wish to interview by the deadlines designated by the speaker. They further recommend that the HOD Office no longer schedule interviews for officers so that all interview scheduling will go through the same process. This levels the playing field for both interviewing groups and candidates and gives all candidates equal opportunity to be interviewed. It further eliminates the unequal and often uncomfortable situation for candidates when asked to appear at informal functions or to "drop by" group meetings by disallowing it altogether.

The speakers are encouraged to craft communications that emphasize the need for openness and accessibility of interviews to all members of groups and to increase the awareness of the "rules of engagement" between interviewing groups and the candidates.

Voting Process and Election Session

The task force noted that the voting process and the creation of the Election Session has significantly streamlined our AMA elections. However, interpreting current bylaws pertaining to multiple candidates for officers and councils is confusing and thus time-consuming. The intent of these rules when written was to limit the number of run-off ballots which took significant time away from House business due to requiring a paper ballot. With the current electronic balloting process which allows for rapidly cast ballots and reporting of results, multiple run-off elections are no longer difficult and time consuming. During the recent election cycle, the rate limiting part of the process for contests with multiple candidates was quickly and correctly applying the current rules to the results. Therefore, the task force recommends amending Bylaws 3.4.2.1.3, 3.4.2.2, and 6.8.1.4 to drop the lowest vote getter on each vote, except in the case of a tie for lowest votes in which case both would be dropped. Example amended language is shown below:

> Bylaw 3.4.2.1.3
>
> If all vacancies for Trustees are not filled on the first ballot, the lowest vote getter shall be dropped and the remaining candidates shall be placed on the subsequent ballot. In the event of a tie for the lowest vote, both candidates shall be dropped. ~~and 3 or more Trustees are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the~~

~~preceding ballot, except where there is a tie. When 2 or fewer Trustees are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are Trustees yet to be elected, and must cast each vote for different nominees.~~ This procedure shall be repeated until all vacancies have been filled.

Bylaw 3.4.2.2

All other officers, except the medical student trustee and the public trustee, shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the lowest vote getter shall be dropped and the remaining candidates shall be placed on the subsequent ballot. In the event of a tie for the lowest vote, both candidates shall be dropped.~~the nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie.~~ This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

Bylaw 6.8.1.4
If all vacancies are not filled on the first ballot, the lowest vote getter shall be dropped and the remaining candidates shall be placed on the subsequent ballot. In the event of a tie for the lowest vote, both candidates shall be dropped ~~and 3 or more members of the Council are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest number of votes on the preceding ballot, except where there is a tie. When 2 or fewer members of the Council are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are members of the Council yet to be elected, and must cast each vote for a different nominee~~. This procedure shall be repeated until all vacancies have been filled.

The ETF1 report encouraged the speaker "to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced, including collecting written personal points from candidates to be shared electronically with the House after the meeting or imposing time limits on such comments." After the virtual meetings and at all subsequent elections, the speaker has collected and emailed "points" from candidates to the House. Given the time constraints at A-22, the speaker did not allow candidates to make in-person points of personal privilege; however, at A-23 points were allowed after the lunch break on Tuesday following the Election Session that morning. The task force recommends that the speaker continue to have discretion regarding in-person points, and time permitting should offer the opportunity for candidates to present abbreviated personal points at the HOD business session after lunch on the same day that the Election Session was held. In addition, written points should continue to be collected and emailed to the House with a deadline of 10 days after the conclusion of the meeting.

Announcements and Nomination

Candidates submit an electronic announcement "card" to announce their candidacy. Cards received prior to the end of the Annual Meeting the year before a candidate is planning to run in an election are posted at the end of the last business session of the HOD and then posted to the AMA election website. An Official Candidate Notification document which identifies all open and potentially open seats is then sent out to the HOD following the meeting. Announcement cards received subsequent to the meeting are posted to the AMA election website as they are received. However, the Official Candidate Notification to the House is currently sent after the Interim Meeting, after the April Board meeting, and periodically at the discretion of the speaker. The task force recommends that an updated Official Candidate Notification be sent with all regular speaker communications.

Items currently allowed on the electronic announcement cards include the candidate's name, photograph, email address, URL, the office sought and a list of endorsing societies. The task force recommends removing URL from this list. URL's on announcement cards are directed to a candidate's personal website, and with the development of the AMA Candidates' Pages, there is no longer a need for such individual websites. Therefore, the task force recommends that all candidate websites other than the AMA Candidates' Pages be disallowed.

The ETF2 identified ongoing confusion with the definitions and rules regarding nominations, announcements, and candidate applications. Therefore, the task force recommends clarifying this process. Per AMA bylaws, all nominations are made at the Opening Session of the HOD meeting at which the election is taking place, which includes the right to be nominated "from the floor" without prior announcement of candidacy. Candidates for president-elect and the speaker and vice speaker, when uncontested, are nominated by a delegate from the floor. All other officer candidates are either self-nominated with a speech or if uncontested, placed in nomination when announced by the speaker or vice speaker.

Currently the AMA-BOT solicits candidate applications for four elected councils: the AMA Council on Constitution and Bylaws, the AMA Council on Medical Education, the AMA Council on Medical Service, and the AMA Council on Science and Public Health. Those candidates who have announced their intent to seek election must submit the necessary application and a conflict of interest form by March 15 to be included in an announcement of approved candidates by the AMA-BOT after their April meeting. The chair of the board then places these candidates in nomination at the Opening Session. Given that the board does not vet officer candidates and has not in recent memory ever disallowed a potential council candidate to stand for office, the ETF2 recommends that the elected council candidate BOT application process be rescinded. Additionally, the task force recommends clarifying that council nominations are made at the opening session of the House in Bylaw 6.8.1. Suggested language for this bylaw change is:

> Members of these Councils, except the medical student member, shall be elected by the House of Delegates. Nominations shall be made by the chair of the Board of Trustees ~~and may also be made from the floor~~ or by a member of the House of Delegates at the opening session of the meeting at which the election will take place.

All officer and council candidates should continue to be required to submit a conflict of interest statement which must be posted after they have announced and before the active campaign window begins or if not previously announced, within 24 hours of the conclusion of the HOD Opening Session at which they were nominated. Additionally, our rules currently use the announcement of approved candidates following the April Board meeting as the official mark for the beginning of the active campaign period. Given that this process would no longer occur, the ETF2 recommends that the rules be amended to state that the active campaign window will begin when announced by the speaker and will generally follow the April meeting of the AMA-BOT.

Election Committee

The ETF2 unanimously agreed that the creation of the Election Committee (EC) has successfully fulfilled its purpose of advising the speakers on their oversight of the campaign and election process. By adding more voices to the review of the election process and disposition of election complaints, the EC has made these processes more transparent and inclusive.

After its inaugural campaign cycle, several concerns were raised regarding the EC and its processes. Providing clarification to the process of investigating a potential campaign violation is a reasonable request, but public release of in-depth details of individual investigations is not. Maintaining confidentiality and privacy when investigating a potential violation is very important to both the complainant and the candidate and something the speakers, the EC, and the task force take seriously. Furthermore, the task force discussed the current EC process in depth and concluded that this process does and must continue to balance the rights of the individual with this need for confidentiality. In addition, the task force notes that the Speaker is currently required to include a summary of the EC activities in the Official Candidate Notification to the House. The task force recommends that this rule be amended to include a report after each meeting at which an election was held.

The task force noted that the speakers and EC only have authority over candidates, and after the elections have taken place, they no longer have that authority. Further, there is no pathway to remove any individual from elected office, short of an officer's or councilor's violation of the Policy of Conduct at AMA Meetings and Events (CCAM) or revoking their AMA membership if they are in violation of a rule over which the AMA Council on Ethical and Judicial Affairs has jurisdiction. The ETF2 recommends that our AMA consider developing bylaw language regarding removal of "elected" individuals and the criteria by which this would be accomplished. The task force also recommends that the definition of harassment in the Policy on Conduct at AMA Meetings and Events be amended to include the harassment of delegates within the voting and election processes.

The ETF2 recommends that candidates, those involved in campaigns, including delegation and caucus staff, and all voting delegates be aware of and abide by the election rules and comply promptly with any request by the speakers or the EC for information regarding campaign activities. The speakers and members of the EC will in turn be compelled to identify themselves and the need for an election related query to the interviewee. The speakers note that many questions about "possible" campaign violations have been quickly resolved by asking a few key individuals without need to initiate a formal process. However, there has been much reticence about answering questions regarding election activities/discussions by interviewees. Therefore, this recommendation enhances your speakers' and the EC's ability to provide clarification and often resolution regarding a "possible violation" in a more timely fashion.

The task force agrees with the speakers and the EC decision not to delineate a "menu" of violations with correlating penalties. Further, the ETF2 agrees with the EC's desire to maintain the ability to seek resolution of complaints thoughtfully, to include education of AMA rules as an option, but respects that the final decision rests with the delegates as they choose to vote or not to vote for a given candidate.

Finally, the ETF2 recommends that the EC rules and processes be widely distributed to the House and that candidates and all identified members of their campaign team be required to attest in writing to having read the rules and commit to abide by them. The ETF2 notes that the EC rules are as "transparent" as they can be given the confidential nature of the investigative process, though some in the House and on campaign teams continue to be unaware of them.

Endorsements

Although endorsements are related to the topic of Announcements and Nominations, no previous rules were made regarding endorsements by ETF1. Therefore, it was discussed by ETF2 as a new topic. The process of seeking endorsements is ill-defined and has been interpreted by some to be "campaigning." In fact, the EC corroborated this assumption by noting that an endorsement process that involves any formal questioning of an announced candidate, including a written questionnaire, is an interview and subject to the rules for interviews. In addition, the task force notes that an endorsement process that includes a "presentation" to an assembly with or without being followed by a discussion, question and answer session, or a vote of the assembly can also be interpreted as an interview, as discussed above. The nebulous nature regarding from whom a candidate may seek an endorsement, the variable ability for candidates to seek endorsements from groups, and the processes involved in obtaining these endorsements can amount to considerable time and effort by those seeking and those offering endorsements.

The general consensus of the task force was that endorsements appear to have little impact on candidate selection by delegates. However, if endorsements are to be continued, they should be equally available to all candidates, not just to some based on various criteria including eligibility for current or past Section membership and whether they are a specialty delegate or not and thus eligible for Specialty and Service Society (SSS) membership. Additionally, the task force notes that based on the current rule that requires parity between specialty and state delegations, the SSS encompasses half of the House and thus unfairly allows for specialty candidates to present to and obtain endorsement from this substantial group.

Therefore, the task force makes the following recommendations in order to level the playing field regarding endorsements. A maximum of four endorsements may be obtained by each candidate. Endorsements may only be obtained from a candidate's state and one specialty organization (must be an active and dues paying member, where applicable) and from caucuses in which your endorsing state or specialty society is a current member. AMA Sections, Advisory Panels, and the SSS would be ineligible to provide endorsements to candidates.

CONCLUSION

The recommendations of ETF1 have made substantive improvements to the AMA election process over the last two election cycles. The ETF2 commends ETF1 for their work to make our AMA HOD elections more fair, equitable and transparent. The ETF2 offers recommendations to codify initial changes from ETF1, enhance and clarify the rules adopted with ETF1, and simplify further the election process. In addition, the ETF2 recommends that these new and modified rules and bylaws changes be effective upon adjournment of the House at I-23, and the remainder of this report be filed.

RECOMMENDATIONS

Stickers, Buttons, and Pins

[Editor's note: Recommendation 1 referred] Recommendation 1: Policy G-610.020, Rules for AMA Elections, paragraph 18 be amended by addition and deletion to read as follows:

> (18) Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMA, AMPAC, the AMA Foundation, and health related causes as approved by the Speaker no less than 30 days prior the Opening Session of the House of Delegates. ~~s~~Specialty society~~ies~~, state and regional delegations~~ and health related causes~~ pins that do not include any candidate identifier may only be worn by members of the designated group. ~~These~~ All pins should be small, and may not be worn on the badge~~ and distributed only to members of the designated group~~. ~~General distribution~~ No other ~~of any~~ pin, button or sticker is ~~dis~~allowed.

Campaign Receptions

[Editor's note: Recommendation 2 adopted] Recommendation 2: Policy D-610.998, Election Task Force, paragraph 1 be amended by addition and deletion to read as follows:

1. Our AMA will ~~investigate the feasibility of a two- (2) year trial of~~ sponsor~~ing a welcome~~ the AMA Candidate R~~r~~eception which will be open to all candidates and all meeting attendees. Any candidate may elect to be "featured" at the AMA Candidate R~~r~~eception. There will not be a receiving line at the AMA Candidate R~~r~~eception. ~~Other receptions sponsored by societies or coalitions, whether featuring a candidate or not, would not be prohibited, but the current~~ The rules regarding cash bars only at campaign receptions and limiting each candidate to be featured at a single reception ~~(the AMA reception or another)~~ will apply to the AMA Candidate Reception. ~~would remain. The Speakers will report back to the House after the two-year trial with a recommendation for possible continuation of the AMA reception.~~

Dinners, Suites and Such

[Editor's note: Recommendation 3 referred] Recommendation 3: An announced candidate in a currently contested election may not be "featured" at any gathering of delegates outside of the single campaign reception they have chosen. For the purpose of AMA elections, the definition of "featured" includes being mentioned in the invitation, whether written or verbal, or publicly acknowledging or discussing a candidacy with attendees at a function

[Editor's note: Recommendation 4 referred] Recommendation 4: Policy G-610.020, Rules for AMA Elections, paragraph 19 be amended by addition and deletion to read as follows:

> 19) At any AMA meeting convened prior to the time period for active campaigning, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, and other formal campaign activities~~ and the distribution of campaign literature and gifts~~ are prohibited. ~~It is permissible for candidates seeking election to engage in individual outreach meant to familiarize others with a candidate's opinions and positions on issues.~~ Candidates may participate in meals provided by groups of which they are a member, such as a delegation or caucus breakfast/lunch, when the meal has other purposes and does not include campaigning by the candidate or campaign team.

[Editor's note: Recommendation 5 referred] Recommendation 5: Policy G-610.020, Rules for AMA Elections, paragraph 21 be amended by deletion to read as follows:

> 21) Group dinners, if attended by an announced candidate in a currently contested election, must be "Dutch treat" - each participant pays their own share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. ~~Gatherings of 4 or fewer delegates or alternates are exempt from this rule.~~

[Editor's note: Recommendation 6 referred] Recommendation 6: Only an announced candidate in a currently

contested election may discuss their candidacy on an individual basis in private conversations from announcement of candidacy until the active campaigning period begins. Prior to the active campaigning period, no other individual may discuss the candidacy including members of campaign teams, delegations or caucuses, and "friends."

Campaign Literature
Electronic Communications
Website and Social Media

[Editor's note: Recommendation7 referred] Recommendation 7: Policy G-610.020, Rules for AMA Elections, paragraph 15 be amended by addition and deletion to read as follows:

> 15) Printed and digital ~~C~~campaign materials may not be distributed to members of the House other than by the HOD office candidate email and on the Candidate Web Pages. ~~by postal mail or its equivalent~~. The AMA Office of House of Delegates Affairs will not ~~longer~~ furnish a file containing the names and mailing addresses of members of the AMA-HOD. ~~Printed campaign materials will not be included in the "Not for Official Business" bag and may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials~~.

[Editor's note: Recommendation 8 referred] Recommendation 8: Policy G-610.020, Rules for AMA Elections, paragraph 16 be amended by addition and deletion to read as follows:

> 16) Active campaigning via mass outreach to delegates by candidates or on behalf of a candidate by any method is prohibited. ~~A reduction in the volume of telephone calls and~~ Personal electronic communication and telephone calls from candidates and on behalf of candidates is discouraged~~encouraged~~. ~~The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of e~~Electronic messages ~~to contact electors should be minimized, and if used~~ must include a simple mechanism to allow recipients to opt out of receiving future messages.

Interviews

[Editor's note: Recommendation 9 adopted] Recommendation 9: Policy G-610.020, Rules for AMA Elections, paragraph 11 be amended by addition and deletion to read as follows:

> (11) ~~The Speaker's Office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker).~~ Groups wishing to conduct interviews must designate their interviewing coordinator and provide the individual's contact information to the Office of House of Delegates Affairs. The Speaker's Office will collect contact information for groups wishing to conduct interviews as well as for candidates and their campaign teams and will provide the information to both groups ~~as requested~~. Groups must indicate whether they wish to interview in-person or virtually and for which contest by the deadlines designated by the speaker.

[Editor's note: Recommendation 10 adopted] Recommendation 10: Policy G-610.020, Rules for AMA Elections, paragraph 12 be amended by addition and renumbered to read as follows:

> f. Recording of interviews is allowed only with the knowledge and consent of the candidate.
> g. Interviews are recommended to be recorded with consent of all participating individuals and disseminated to the interviewing group members when all are not able to be present for the interview.
> ~~g~~h. Recordings of interviews may be shared only among members of the group conducting the interview.

[Editor's note: Recommendation 11 adopted as amended] Recommendation 11: Any formal questioning of an announced candidate, ~~including~~ excluding a written questionnaire, is an interview and subject to the rules for ~~virtual~~ interviews.

[Editor's note: Recommendation 12 referred] Recommendation 12: Any "presentation" to an assembly, with or without being followed by a discussion, question and answer session, or a vote of the assembly, is an interview and subject to the rules on in-person interviews.

Voting Process and Election Session

[Editor's note: Recommendation 13 referred] Recommendation 13: That Bylaws 3.4.2.1.3, 3.4.2.2, and 6.8.1.4 be amended to change the rules for elections of officers and councils with multiple candidates so that the lowest vote getter on each ballot is dropped on the subsequent ballot, with the exception of a tie for lowest vote getter in which case both would be dropped.

[Editor's note: Recommendation 14 referred] Recommendation 14: Policy D-610.998, "Directives from the Election Task Force," paragraph 4 be amended by addition and deletion to read as follows:

> 4. The Speaker is encouraged to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced. If adequate time remains on the agenda when the business session reconvenes after lunch on the day that the Election Session was held, the Speaker is encouraged to allow candidate personal points from the floor confined to the current time limit for testimony. ~~including collecting w~~Written personal points from candidates should be sent to the HOD office within 10 days following the close of the meeting to be shared electronically with the House ~~after the meeting or imposing time limits on such comments~~.

Announcements and Nomination

[Editor's note: Recommendation 15 adopted as amended] Recommendation 15: Policy G-610.020, Rules for AMA Elections, paragraph 2 be amended by addition and deletion to read as follows:

> 2) Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers, generally by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, email address, ~~URL,~~ the office sought and a list of endorsing societies. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed ~~in the venue where the House of Delegates meets. Announcements sent by candidates~~ to members of the House by any method. ~~are considered campaigning and are specifically prohibited prior to the start of active campaigning. The Speakers may use additional means to make delegates aware of those members intending to seek election.~~

[Editor's note: Recommendation 16 referred] Recommendation 16: Candidates may not produce a personal campaign website or direct to personal or professional websites that contain campaign materials other than the AMA Candidates' Page.

[Editor's note: Recommendation 17 adopted] Recommendation 17: Policy G-610.020, Rules for AMA Elections, paragraph 3, be amended by addition and deletion to read as follows:

> (3) Announcement cards of all known candidates will be projected on the last day of the Annual and Interim Meetings of our House of Delegates and posted on the AMA website as per Policy G-610.020, paragraph 2. Following each meeting, an "Official Candidate Notification" will be sent electronically to the House. It will include a list of all announced candidates and all potential newly opened positions which may open as a result of the election of any announced candidate. Additional notices will also be sent out with regular Speaker communications to the HOD and with the Speaker's notice of the opening of active campaigning which generally follows~~ing~~ the April Board meeting ~~and on "Official Announcement Dates" to be established by the Speaker~~.

[Editor's note: Recommendation 18 referred] Recommendation 18: Policy G-610.020, Rules for AMA Elections, paragraph 10, be amended by addition and deletion to read as follows:

> (10) Active campaigning for AMA elective office may not begin until the Speaker so notifies the House, which is generally after the April Board of Trustees~~, after its April~~ meeting.~~, announce the candidates for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates.~~

[Editor's note: Recommendation 19 adopted] Recommendation 19: Policy G-610.020, Rules for AMA Elections, paragraph 25, be amended by addition and deletion to read as follows:

> (25) Our AMA ~~(a)~~ requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election.~~; and~~ Conflict of interest forms must be submitted after an individual has announced their candidacy and before the active campaign window begins or, if not previously announced, within 24 hours of the conclusion of the HOD Opening Session. ~~(b) will expand accessibility to completed conflict of interest information~~ The HOD Office will ~~by~~ post~~ing~~ such information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.

[Editor's note: Recommendation 20 adopted] Recommendation 20: Policy G-610.010, Rules for AMA Elections, paragraphs 3 and 4, be rescinded:

> (3) the date for submission of applications for consideration by the Board of Trustees at its April meeting for the Council on Legislation, Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, Council on Science and Public Health, Council on Long Range Planning and Development, and Council on Ethical and Judicial Affairs is made uniform to March 15th of each year;
> (4) the announcement of the Council nominations and the official ballot should list candidates in alphabetical order by name only; and

[Editor's note: Recommendation 21 adopted] Recommendation 21: That the language in Bylaw 6.8.1, "Nomination and Election" be updated to clarify that nominations are made by the chair of the Board of Trustees or by a member of the House of Delegates at the opening session of the meeting at which elections take place.

Election Committee

[Editor's note: Recommendation 22 adopted] Recommendation 22: Policy D-610.998, "Directives from the Election Task Force," paragraph 7 be amended by addition to read as follows:

> 7. Campaign violation complaints will be investigated by the Election Committee or a subcommittee thereof with the option of including the Office of General Counsel or the Director of the House of Delegates.
> a. The Committee will collectively determine whether a campaign violation has occurred. As part of the investigation process the Election Committee or its subcommittee shall inform the candidate of the complaint filed and give the candidate the opportunity to respond to the allegation.
> b. If the complaint implicates a delegation or caucus, the Election Committee or its subcommittee shall inform the chair of the implicated delegation or caucus of the complaint filed and give the implicated delegation or caucus chair(s) the opportunity to answer to the allegation as a part of the investigative process.
> c. For validated complaints, the Committee will determine appropriate penalties, which may include an announcement of the violation by the Speaker to the House.
> d. Committee members with a conflict of interest may participate in discussions but must recuse themselves from decisions regarding the merits of the complaint or penalties.
> e. Deliberations of the Election Committee shall be confidential.
> f. The Speaker shall include a summary of the Election Committee's activities in "Official Candidate Notifications" sent to the House, following each meeting at which an election was held. Details may be provided at the discretion of the Election Committee and must be provided when the penalty includes an announcement about the violator to the House.

[Editor's note: Recommendation 23 referred] Recommendation 23: Candidates and their identified members of campaign teams will be provided a copy of the current election rules and will be required to attest to abiding by them.

[Editor's note: Recommendation 24 referred] Recommendation 24: Candidates, members of their campaign teams, including Federation staff, and HOD members will agree to be interviewed by the Speakers or members of the Election Committee who will identify themselves and the reason for the request.

[Editor's note: Recommendation 25 adopted] Recommendation 25: Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," be amended by addition and deletion to read as follows:

> Definition
> Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of ~~his/her~~ race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or otherwise, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.
> Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.
> Harassing conduct also includes intimidation of participating individuals by a threat of consequences in order to compel actions by individuals or a group of individuals such as casting a particular vote.

[Editor's note: Recommendation 26 adopted as amended] Recommendation 26: That our AMA consider developing bylaw language regarding removal of elected individuals or candidates and the criteria by which this would be accomplished and to report back at A-24

Endorsements

[Editor's note: Recommendation 27 not adopted] Recommendation 27: A maximum of four endorsements may be obtained by each candidate. These endorsements must be from organizations in which the candidate is an active and dues paying member, where applicable. Endorsements may only be obtained from a candidate's state and one specialty organization and from caucuses in which the endorsing state or specialty society is a current member. Endorsements may not be obtained from the AMA Sections, Advisory Committees, or the Specialty and Service Society.

[Editor's note: Recommendation 28 adopted] Recommendation 28: Policy D-610.998, "Directives from the Election Task Force," paragraph 10 & 11 be rescinded.

> 10. After an interval of 2 years a review of our election process, including the adopted Recommendations from this report, be conducted by the Speaker and, at the Speaker's discretion the appointment of another election task force, with a report back to the House.
> 11. Amended Policy D-610.998 will be widely communicated, including being published in the Election Manual.

[Editor's note: Recommendation 29 adopted] Recommendation 29: That policies G-610.010, Nominations; G-610.020, Rules for AMA Elections; G-610.021, Guiding Principles for House Elections; G-610.030, Election Process; and D-610.998, Election Task Force as amended, be combined into one policy entitled, "AMA Election Rules and Guiding Principles," and that this newly formed policy be widely distributed to the House and included in the Election Manual.