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REPORT OF THE BOARD OF TRUSTEES

B of T Report 03-I-23

Subject: Update on Climate Change and Health – AMA Activities
(BOT Report 17-A-23)

Presented by: Willie Underwood III, MD, MSc, MPH, Chair

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

1 invitations sent to members of AMA Councils and Sections as well as sharing of that invitation
 2 with other interested physicians. A total of sixteen participants (n =16) were chosen from across the
 3 U.S. based on their availability and to ensure diversity in specialty and geography. Sessions were
 4 60 minutes long and followed a semi-structured interview guide.

5
 6 Findings. Participants in the listening sessions were first asked, “What health impacts are
 7 physicians already seeing from climate change?” Participants identified a myriad of health impacts
 8 including an increase in natural disasters (e.g., flooding, hurricanes, and wildfires), longer than
 9 normal allergy seasons, heat waves, rising sea levels and issues with poor water quality due to
 10 higher temperatures (e.g., toxic algae blooms), as well as an increasing range and potential for
 11 vector-borne and zoonotic diseases. While many of the above listed health impacts are direct
 12 effects of climate change, the participants also highlighted indirect impacts in that climate change
 13 has the potential to exacerbate already existing health conditions and that it can act as a “multiplier
 14 effect.” For example, poor air quality caused by wildfires in Canada this summer can exacerbate
 15 illness for those with pre-existing asthma or cardiovascular disease. Additionally, participants
 16 highlighted that there are important equity and environmental justice concerns and that impacts are
 17 experienced differently depending on whether it is an urban versus rural population. The quotes
 18 provided below reflect their responses.

19
 20 *“In Florida, one of our big things is heat. On those hot days people come in in their early 20s who*
 21 *are healthy and fit, but they have kidney injury due to dehydration or heart failure.”*

22
 23 *“We get algae blooms and people otherwise healthy, as well as those later in life, have severe*
 24 *respiratory issues.”*

25
 26 *“My patients are severely affected by wildfires, well beyond asthma. It keeps people from going*
 27 *outdoors which impacts their exercise and it can also impact their income which both impacts their*
 28 *health.”*

29
 30 *“The heat is a huge issue in the cities. Everything is more intense. The radiation of asphalt and*
 31 *cement along with the heat events especially in disinvested neighborhoods cause ER visits to rise*
 32 *dramatically.”*

33
 34 Participants in the listening sessions were also asked, “What steps do you believe the US health
 35 care system should be taking to decarbonize itself?” Responses were largely focused on the
 36 challenges in decarbonizing the health care system, namely a lack of motivation or interest from
 37 hospital/system administration to take steps toward decarbonization, partially due to the financial
 38 investment it would require. Despite these challenges, participants acknowledged the need to work
 39 within their own systems and support the work that is currently happening (e.g., sustainability
 40 efforts), and recommended that hospital systems utilize the newly passed Inflation Reduction Act,
 41 which provides financial supports for climate change adaptation and resilience efforts, to advocate
 42 for change. However, it was recognized that the problem is complex; solutions must be multi-
 43 faceted and address larger policy issues outside of health care.

44
 45 *“In my medical community physicians are supportive but the administration is only concerned*
 46 *about fiscal goals. My CEO wants me to ‘get back in my lane’.”*

47
 48 *“We’re making progress but it’s not to the level we need to be. The goals are there; the action*
 49 *isn’t.”*

50
 51 *“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 disproportionately 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.

1 *AMA Actions to Advance Priority Areas*

2
3 In June of 2023, the AMA hired a new staff member with subject matter expertise in environmental
4 health and climate change. As such, the AMA is better positioned to be more actively engaged
5 around climate change and health moving forward.
6

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

- 8
9
 - The AMA has made climate change education available via the Ed Hub™ from a variety of
10 sources including the AMA Journal of Ethics (JOE), the Journal of the American Medical
11 Association (JAMA), and the American Public Health Association (APHA).
12
 - AMA staff are in the initial planning stages for developing a CME module for physicians
13 and trainees on climate change, which we anticipate will be available in 2024.
14
 - AMA staff participated in a plenary panel session entitled, “Climate – Impact on Health
15 and Health Care” at AcademyHealth’s 2023 Annual Research Meeting, which took place
16 on June 27, 2023, in Seattle, WA. The session examined how the health care system
17 contributes to climate change, what research is needed to reduce health threats from
18 climate change across the lifespan and explored opportunities for the U.S. health system to
19 do its part in alleviating the effects.
20
21

22
23 *2. Identify and disseminate information to physicians on decarbonizing the health care sector and*
24 *reducing GHG emissions.*

- 25
26
 - AMA staff are working to develop and disseminate tools and resources focused on
27 decarbonizing the health care sector, with a focus on smaller practices. This includes
28 reviewing existing resources available to prevent duplication of efforts. (See also NAM
29 Action Collaborative on Decarbonizing the Health Sector)
30

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

- 32
33
 - AMA’s Chief Health & Science Officer joined the August 24, 2023, PermanenteDocs Chat
34 podcast on heat waves and health, with a focus on how physicians can adjust to prepare to
35 care for heat-related conditions brought on by climate change.
36

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

38
39 The AMA continues to engage in the following consortiums and partnerships to advance policies
40 and interventions on climate change and health. As other working groups interested in this topic
41 form, the AMA will consider partnering with them and, in the very least, share relevant
42 information and resources as they become available.
43

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

B of T Report 04-I-23

Subject: Update on Firearm Injury Prevention Task Force

Presented by: Willie Underwood III, MD, MSc, MPH, Chair

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

1 American College of Emergency Physicians
2 American College of Obstetricians and Gynecologists
3 American College of Physician
4 American College of Preventive Medicine
5 American College of Surgeons
6 American Geriatrics Society
7 American Pediatric Surgical Association
8 American Psychiatric Association
9 National Medical Association
10 Society of Critical Care Medicine
11

12 Ex Officio Members:
13 The Health Alliance for Violence Intervention (HAVI)
14

15 Federal Liaisons:
16 Centers for Disease Control and Prevention (to inform on data, latest research)
17 Department of Veterans Affairs (to inform on efforts in normalizing firearm counseling by
18 clinicians and suicide prevention)
19

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

REPORT OF THE BOARD OF TRUSTEES

B of T Report 08-I-23

Subject: AMA Efforts on Medicare Payment Reform

Presented by: Willie Underwood, III, MD, MSc, MPH, MD, Chair

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 met 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.

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

5
6 CONCLUSION

7
8 As we forge ahead in continued partnership with the Federation to advance organized medicine's
9 collective goals in our strategic mission to reshape the Medicare physician payment system, the
10 AMA remains unwavering in its commitment to successfully pursuing the four pillars discussed in
11 this report. Our steadfast dedication ensures that our members' voices are heard, and that we
12 advocate for a system that is fair, sustainable, and reflective of the value physicians bring to patient
13 care. There has been progress so far in 2023, and with every stride we make as we enter the fourth
14 quarter this year and beyond, we move closer to achieving our vision of Medicare physician
15 payment reform. Please follow Advocacy Update, join the Physicians Grassroots Network, and
16 follow other AMA communications vehicles to stay up to date and engaged on this topic.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 09-I-23

Subject: Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

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

4 5 BACKGROUND

6
7 Policy G-605.009, “Establishing A Task Force to Preserve the Patient-Physician Relationship
8 When Evidence-Based, Appropriate Care Is Banned or Restricted,” was adopted at the 2022
9 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD). Policy
10 G-605.009 instructs that:

- 11
12 1. Our AMA will convene a task force of appropriate AMA councils and interested state and
13 medical specialty societies, in conjunction with the AMA Center for Health Equity, and in
14 consultation with relevant organizations, practices, government bodies, and impacted
15 communities for the purpose of preserving the patient-physician relationship.
- 16 2. This task force, which will serve at the direction of our AMA Board of Trustees, will
17 inform the Board to help guide organized medicine’s response to bans and restrictions on
18 abortion, prepare for widespread criminalization of other evidence-based care, implement
19 relevant AMA policies, and identify and create implementation-focused practice and
20 advocacy resources on issues including but not limited to:
 - 21 a. Health equity impact, including monitoring and evaluating the consequences of
22 abortion bans and restrictions for public health and the physician workforce and
23 including making actionable recommendations to mitigate harm, with a focus on the
24 disproportionate impact on under-resourced, marginalized, and minoritized
25 communities;
 - 26 b. Practice management, including developing recommendations and educational
27 materials for addressing reimbursement, uncompensated care, interstate licensure, and
28 provision of care, including telehealth and care provided across state lines;
 - 29 c. Training, including collaborating with interested medical schools, residency and
30 fellowship programs, academic centers, and clinicians to mitigate radically diminished
31 training opportunities;
 - 32 d. Privacy protections, including best practice support for maintaining medical records
33 privacy and confidentiality, including under HIPAA, for strengthening physician,
34 patient, and clinic security measures, and countering law enforcement reporting
35 requirements;
 - 36 e. Patient triage and care coordination, including identifying and publicizing resources for
37 physicians and patients to connect with referrals, practical support, and legal
38 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.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-I-23

Subject: Criminalization of Providing Medical Care
(RES 015-A-23)

Presented by: Willie Underwood, III, MD, MSc, MPH, MD, Chair

At the 2023 Annual Meeting of the House of Delegates (HOD), the HOD adopted Resolution 015, “Report Regarding the Criminalization of Providing Medical Care,” which instructed the American Medical Association (AMA) to, “study the changing environment in which some medical practices have been criminalized including the degree to which such criminalization is based or not based upon valid scientific findings, the degree to which this is altering the actual practice of medicine due to physician concerns and personal risk assessment, and the degree to which hospitals and health care systems are responding to this rapidly changing environment, with report back to the HOD no later than the November 2023 Interim meeting.” This report provides information in response to Resolution 015.

Abortion

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. As of the writing of this report in July 2023, 14 states (Alabama, Arkansas, Idaho, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, West Virginia, and Wisconsin) prohibit the provision of nearly all abortions, one state (Georgia) prohibits abortion after fetal cardiac activity is detected around six weeks of pregnancy, and 10 states (Arizona, Florida, Indiana, Iowa, Kansas, Nebraska, North Carolina, Ohio, South Carolina, and Utah) prohibit abortion later in pregnancy, but before the point at which a fetus is generally considered viable. Many of those latter 10 states have passed laws prohibiting abortion earlier in pregnancy that have been blocked in court. Importantly, the status of state abortion laws is fluid. Legal challenges are ongoing in nearly two dozen states and the legality of abortion in those states is subject to change.

At the time the *Dobbs* decision was published, 13 states had abortion prohibitions that predated the *Roe v. Wade* decision or so-called “trigger laws” that became effective upon the overruling of *Roe*, including several that were enacted in 2022 just prior to the *Dobbs* decision. In August 2022, the Indiana legislature became the first in the country to pass a post-*Dobbs* abortion ban, which has since been enjoined. West Virginia followed in September 2022, and in 2023, seven states enacted new abortion bans. North Dakota and Wyoming enacted near-total bans; Florida, Iowa, and South Carolina enacted six-week bans; and Nebraska and North Carolina enacted 12-week bans. Not all the newly enacted laws are in effect.

Some, but not all, state abortion bans are punishable with criminal penalties. In other states, violations are subject to professional discipline up to mandatory revocation of the health care professional’s license. Two states (Oklahoma and Texas) also authorize civil enforcement of

1 abortion bans by private citizens, though courts in both states have declined to authorize those
2 suits.

3
4 Each state abortion ban contains an exception or affirmative defense, under specified conditions,
5 when abortion is necessary to preserve the life of pregnant women and other pregnant patients.
6 Most, but not all the states' laws, also contain exceptions or affirmative defenses when abortion is
7 necessary to prevent serious health consequences (e.g., "serious and irreversible impairment of a
8 major bodily function"). Some laws also contain exceptions or affirmative defenses in cases where
9 the pregnancy was due to rape or incest or when the fetus is diagnosed with a serious condition
10 incompatible with life.

11
12 These exceptions, however, are not crafted in a way that aligns with the complexity of medical
13 practice and have led to significant confusion about how to practice medicine when pregnancy
14 complications arise. As a result, physicians report significant uncertainty in navigating the new
15 restrictions and describe a chilling effect on the practice of medicine that extends beyond obstetrics
16 and gynecology into a range of specialties including emergency medicine, oncology, rheumatology,
17 cardiology, psychiatry, and others. The AMA is not aware of data that can reliably quantify the
18 degree to which medical practice has been altered in response to abortion restrictions but
19 understands the impact on physicians, their practice, and their patients to be immense. Media
20 reports have profiled numerous patients who describe harrowing experiences in which they
21 suffered preventable medical complications because legal restrictions prevented medical
22 professionals from providing recommended treatment. Similarly, in a lawsuit seeking to clarify the
23 scope of Texas' medical emergency exception, 13 women describe being denied medically
24 necessary and potentially lifesaving treatment when they were experiencing medical emergencies
25 during their pregnancies.¹ To better track these cases, researchers at the University of California in
26 San Francisco have undertaken a study, "The Care Post-Roe Study," to collect stories from
27 clinicians about how abortion laws have altered the usual standard of care. In May, preliminary
28 findings described 50 cases in which abortion laws resulted in delays, worsened health outcomes,
29 and increased the cost and logistic complexity of care.²

30
31 Risk-averse hospital and institutional policies are also likely to contribute to changes in medical
32 practice. In May, the Centers for Medicare & Medicaid Services announced investigations into two
33 Missouri hospitals that allegedly withheld necessary stabilizing care to a pregnant patient
34 experiencing preterm premature rupture of membranes in violation of the Emergency Medical
35 Treatment and Labor Act.³ The government's announcement stated that although the patient's
36 doctors advised her that her pregnancy was no longer viable and her condition could rapidly
37 deteriorate, they could not provide her with the care that would prevent infection, hemorrhage, and
38 potentially death due to hospital policies. Physicians have described other similar hospital policies
39 in which non-clinicians determine whether and at what point abortion care may be provided.

40
41 In addition to changes in the treatment of pregnancy complications, available data indicate that
42 abortion bans have reduced the total number of abortions provided. The #WeCount initiative led by
43 the Society for Family Planning reports that from July 2022 to March 2023 there were 25,640
44 cumulative fewer abortions provided by clinicians across the country.⁴ As expected, the decrease is
45 attributed to states with abortion bans where 65,920 fewer abortions were provided, a 100 percent
46 decrease from the year before. The AMA is not aware of any investigation, criminal prosecution, or
47 medical board disciplinary action taken against a physician for the illegal provision of abortion in a
48 state with a strict prohibition. The lack of enforcement action coupled with the data described
49 above suggests that physicians are complying with the laws and have ceased providing prohibited
50 abortion care except when a legally recognized exception applies.

Conversely, health care professionals in states that do not severely restrict access to abortion have reported an increase in demand for abortion care from out-of-state patients, as well as greater complexity of cases and abortion care, sought later in pregnancy. Reports note that while the number of abortions provided in these states has increased, the increase does not fully correspond to the decrease in the number of abortions provided in restrictive states. Accordingly, the number of live births has risen in some places. For instance, a study from the Johns Hopkins Bloomberg School of Public Health estimated that nearly 9,800 additional live births occurred in Texas in the year after the state's abortion ban took effect.⁵

Abortion bans are also likely to impact the physician workforce. Though data is not available, there have been anecdotal reports of individual physicians opting to leave states with restrictive laws. Similarly, two hospitals in Idaho closed their labor and delivery units, citing difficulties in recruiting staff and the hostile legal environment.⁶ The American Association of Medical Colleges (AAMC) also reported that obstetrics and gynecology residency applications declined significantly in states that have banned abortion.⁷ AAMC posits that restrictive abortion laws may deter applicants from applying to programs in those jurisdictions.

Gender-affirming care for minor patients

As of the writing of this report in July 2023, 21 states (Alabama, Arizona, Arkansas, Florida, Georgia, Iowa, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Montana, Missouri, North Dakota, Nebraska, Oklahoma, South Dakota, Tennessee, Texas, Utah, and West Virginia) have enacted laws that prohibit the provision of gender-affirming care to minor patients, including medications to delay puberty, hormonal therapy, and surgeries. Two of those states (Arizona and Nebraska) prohibit surgical interventions on patients younger than 18 years of age but do not ban non-surgical interventions.

Legislative prohibitions on gender-affirming care have been relatively recent developments. The Arkansas legislature enacted the first such law in 2021, followed in 2022 with legislation in Alabama and Arizona and administrative action in Florida and Texas. To date in 2023, 19 states have enacted legislative prohibitions. Some, but not all, states impose criminal penalties for violations. In other states, violations are subject to professional discipline, including, in some places, mandatory revocation of the health care professional's license. Several state laws also authorize patients and their families to bring civil suits against health care professionals for decades after the care was provided.

Several laws have been successfully challenged in court. Restrictions on medication, including medication to delay puberty and hormone therapy, have been blocked in Alabama, Indiana, Tennessee, and Texas. A court in Arkansas blocked its law in its entirety. In July 2023, however, appeals courts allowed laws in Kentucky and Tennessee to go into effect during litigation. Like abortion laws, the status of laws regulating the provision of gender-affirming care is subject to change as legal challenges progress.

At the start of 2023, no law was in effect that broadly prohibited gender-affirming care for minors, though some clinicians and institutions, including in Texas and Tennessee, paused care for minors in response to political pressure.⁸ Since the start of this year, some laws enacted in 2023 have been implemented, but the full impact is not yet known. It is reasonable to expect that physicians will cease to provide gender-affirming care to their minor patients in compliance with state law. It is possible that the impact may extend to services provided to transgender adults, as well. For instance, the University of Mississippi Medical Center, which also treated adults, recently closed its gender clinic in response to legislative activity.⁹ Conversely, health care professionals in states that

1 protect gender-affirming care may experience increased demand for services. In contrast to
 2 abortion services, however, gender-affirming care generally requires ongoing treatment and
 3 monitoring, which likely complicates patients' ability to seek care at distant locations. Additionally,
 4 while the impact of state laws on patients and the LGBTQ+ community is immense, those patient
 5 outcomes are beyond the scope of this report.

6 CONCLUSION

9 Opposing third-party intrusion into the practice of medicine (including but not limited to
 10 governmental intrusion) has long been a core priority for the AMA. The AMA continues to execute
 11 a multifaceted strategy, including engagement with policymakers at the state and federal levels,
 12 judicial advocacy, and more, to counter the deleterious impact of legislative efforts to criminalize
 13 the practice of medicine. The AMA Advocacy Resource Center continues to work extensively with
 14 state medical associations and national medical specialty societies, both publicly and behind-the-
 15 scenes, to oppose laws targeting abortion and evidence-based gender-affirming care.

16
 17 Additionally, development of the AMA Task Force to Preserve the Patient-Physician Relationship
 18 When Evidence-Based, Appropriate Care Is Banned or Restricted, established by the HO D during
 19 the 2022 Annual Meeting, is in progress and the Task Force will update the HOD on its activities,
 20 as instructed in Policy D-5.998. The Task Force is well-suited to address the issues raised in this
 21 report and will help guide organized medicine's response to the criminalization of medical practice,
 22 as well as identify and create implementation-focused practice and advocacy resources on the
 23 issues identified in Policy G-605.009, including but not limited to:

- 24
25 1. Health equity impact, including monitoring and evaluating the consequences of abortion
26 bans and restrictions for public health and the physician workforce and including making
27 actionable recommendations to mitigate harm, with a focus on the disproportionate impact
28 on under-resourced, marginalized, and minoritized communities;
- 29 2. Practice management, including developing recommendations and educational materials
30 for addressing reimbursement, uncompensated care, interstate licensure, and provision of
31 care, including telehealth and care provided across state lines;
- 32 3. Training, including collaborating with interested medical schools, residency and fellowship
33 programs, academic centers, and clinicians to mitigate radically diminished training
34 opportunities;
- 35 4. Privacy protections, including best practice support for maintaining medical records
36 privacy and confidentiality, including under HIPAA, for strengthening physician, patient,
37 and clinic security measures, and countering law enforcement reporting requirements;
- 38 5. Patient triage and care coordination, including identifying and publicizing resources for
39 physicians and patients to connect with referrals, practical support, and legal assistance;
- 40 6. Coordinating implementation of pertinent AMA policies, including any actions to protect
41 against civil, criminal, and professional liability and retaliation, including criminalizing
42 and penalizing physicians for referring patients to the care they need;
- 43 7. Anticipation and preparation, including assessing information and resource gaps and
44 creating a blueprint for preventing or mitigating bans on other appropriate health care, such
45 as gender affirming care, contraceptive care, sterilization, infertility care, and management
46 of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications; and
- 47 8. Making recommendations including policies, strategies, and resources for physicians who
48 are required by medical judgment and ethical standards of care to act against state and
49 federal laws.

-
- ¹ Plaintiffs' First Amended Verified Petition for Declaratory Judgment and Application for Temporary and Permanent Injunction, *Zurawski v. State of Texas*, No. D-1-GN-23-000968 (Dist. Ct. Travis County).
- ² Daniel Grossman, Carole Joffe, Shelly Kaller, et al., Care Post-Roe: Documenting cases of poor-quality care since the Dobbs decision, preliminary findings (May 2023), available at <https://www.ansirh.org/sites/default/files/2023-05/Care%20Post-Roe%20Preliminary%20Findings.pdf>.
- ³ Press release, U.S. Department of Health and Human Services, HHS Secretary Xavier Becerra Statement on EMTALA Enforcement (May 1, 2023), <https://www.hhs.gov/about/news/2023/05/01/hhs-secretary-xavier-becerra-statement-on-emtala-enforcement.html>.
- ⁴ Society of Family Planning, #WeCount Report April 2022 to March 2023 (Jun. 15, 2023), available at https://societyfp.org/wp-content/uploads/2023/06/WeCountReport_6.12.23.pdf.
- ⁵ Suzanne Bell, Elizabeth Stuart & Alison Gemmill, Texas' 2021 Ban on Abortion in Early Pregnancy and Changes in Live Births, 330 JAMA 3, 281-2 (Jun. 2023).
- ⁶ Press release, Conner General Health, Discontinuation of Labor & Delivery Services at Bonner General Hospital (Mar. 17, 2023), <https://bonnergeneral.org/wp-content/uploads/2023/03/Bonner-General-Health-Press-Release-Closure-of-LD-3.17.2023.pdf>; press release, Valor Health, Discontinuation of Labor & Delivery Services at Valor Health Hospital (Mar. 29, 2023), <https://www.valorhealth.org/wp-content/uploads/2023/03/Press-Release-3.29-scaled.jpg>.
- ⁷ Kendal Orgera, Hasan Mahmood & Atul Grover, Association of American Medical Colleges, Training Location Preferences of U.S. Medical School Graduates Post Dobbs v. Jackson Women's Health Organization Decision (Apr. 13, 2023), available at <https://www.aamc.org/advocacy-policy/aamc-research-and-action-institute/training-location-preferences>.
- ⁸ Rep. Jason Zachary (@JasonZacharyTN), Twitter (Oct. 22, 2022 2:57 PM), <https://twitter.com/JasonZacharyTN/status/1578474545131888640>; Joint statement, University of Texas Southwestern Medical Center & Children's Health (Mar. 28, 2022), <https://www.utsouthwestern.edu/newsroom/articles/year-2022/gender-dysphoria-care.html>; Eleanor Klibanoff & Alex Nguyen, Texas Tribune, Austin doctors who treated trans kids leaving Dell Children's clinic after AG Paxton announces investigation (May 13, 2023), <https://www.texastribune.org/2023/05/13/austin-dell-childrens-gender-affirming>.
- ⁹ Molly Minta, Mississippi Today, UMMC to shut down LGBTQ+ clinic amid political pressure (Jun. 1, 2023), <https://mississippitoday.org/2023/06/01/ummc-shut-down-team-clinic>.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-I-23

Subject: Redefining AMA's Position on ACA and Health Care Reform

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

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

1 federal poverty level (FPL) (133 and 400 percent in Medicaid expansion states) are being
2 provided with refundable and advanceable premium tax credits to purchase coverage on
3 health insurance exchanges.

- 4 • Our AMA has been advocating for enhanced premium tax credits for young adults. In
5 order to improve insurance take-up rates among young adults and help balance the
6 individual health insurance market risk pool, young adults ages 19 to 30 who are eligible
7 for advance premium tax credits could be provided with “enhanced” premium tax credits—
8 such as an additional \$50 per month—while maintaining the current premium tax credit
9 structure that is inversely related to income, as well as the current 3:1 age rating ratio.
- 10 • Our AMA is also advocating for an expansion of the eligibility for and increasing the size
11 of cost-sharing reductions. Currently, individuals and families with incomes between 100
12 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states)
13 also qualify for cost-sharing subsidies if they select a silver plan, which leads to lower
14 deductibles, out-of-pocket maximums, copayments, and other cost-sharing amounts.
15 Extending eligibility for cost-sharing reductions beyond 250 percent FPL, and increasing
16 the size of cost-sharing reductions, would lessen the cost-sharing burdens many individuals
17 face, which impact their ability to access and afford the care they need.

18 19 Cover Uninsured Eligible for Medicaid or Children’s Health Insurance Program

20
21 Before the COVID-19 pandemic, in 2018, 6.7 million of the nonelderly uninsured were eligible for
22 Medicaid or the Children’s Health Insurance Program (CHIP). Reasons for this population
23 remaining uninsured include lack of awareness of eligibility or assistance in enrollment.

- 24
25 • Our AMA has been advocating for increasing and improving Medicaid/CHIP outreach and
26 enrollment, including auto enrollment.
- 27 • Our AMA has been opposing efforts to establish Medicaid work requirements. The AMA
28 believes that Medicaid work requirements would negatively affect access to care and lead
29 to significant negative consequences for individuals’ health and well-being.

30 31 Make Coverage More Affordable for People Not Eligible for ACA’s Premium Tax Credits

32
33 Before the COVID-19 pandemic, in 2018, 5.7 million of the nonelderly uninsured were ineligible
34 for financial assistance under the ACA, either due to their income, or because they have an offer of
35 “affordable” employer-sponsored health insurance coverage. Without the assistance provided by
36 ACA’s premium tax credits, this population can continue to face unaffordable premiums and
37 remain uninsured.

- 38
39 • Our AMA advocates for eliminating the subsidy “cliff,” thereby expanding eligibility for
40 premium tax credits beyond 400 percent FPL.
- 41 • Our AMA has been advocating for the establishment of a permanent federal reinsurance
42 program, and the use of Section 1332 waivers for state reinsurance programs. Reinsurance
43 plays a role in stabilizing premiums by reducing the incentive for insurers to charge higher
44 premiums across the board in anticipation of higher-risk people enrolling in coverage.
45 Section 1332 waivers have also been approved to provide funding for state reinsurance
46 programs.
- 47 • Our AMA also is advocating for lowering the threshold that determines whether an
48 employee’s premium contribution is “affordable,” allowing more employees to become
49 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

1 are offered an employer plan that does not have an actuarial value of at least 60 percent or if the
2 employee share of the premium exceeds 9.83 percent of income in 2021.

3
4 Consistent with Policy H-165.824, ARPA also increased the generosity of premium tax credits for
5 two years, lowering the cap on the percentage of income individuals are required to pay for
6 premiums of the benchmark (second lowest-cost silver) plan. Premiums of the second lowest-cost
7 silver plan for individuals with incomes at and above 400 percent FPL are capped at 8.5 percent of
8 their income. Notably, resulting from the changes, eligible individuals and families with incomes
9 between 100 and 150 percent of the FPL (133 percent and 150 percent FPL in Medicaid expansion
10 states) qualified for zero-premium silver plans, effective until the end of 2022.

11
12 In addition, individuals and families with incomes between 100 and 250 percent FPL (between 133
13 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they
14 select a silver plan, which reduces their deductibles, out-of-pocket maximums, copayments, and
15 other cost-sharing amounts.

16 17 LEGISLATIVE EXTENSION OF ARPA PROVISIONS

18
19 On August 16, 2022, President Biden signed into law the Inflation Reduction Act of 2022 through
20 the highly partisan budget reconciliation process, which allows both the House and Senate to pass
21 the bill with limits on procedural delays. Most significantly, reconciliation allows the Senate to
22 bypass the filibuster and pass legislation with a 50-vote threshold so long as it meets a series of
23 budgetary requirements. The Inflation Reduction Act included provisions that extended for three
24 years to 2025 the aforementioned ACA premium subsidies authorized in ARPA.

25
26 The Inflation Reduction Act did not include provisions to close the Medicaid “coverage gap” in the
27 states that have not chosen to expand.

28 29 ACA ENROLLMENT

30
31 According to the U.S. Department of Health and Human Services (HHS), 16.3 million Americans
32 have signed up for or were automatically re-enrolled in the 2023 individual market health insurance
33 coverage through the marketplaces since the start of the 2022 Marketplace Open Enrollment Period
34 on November 1, 2022, through January 15, 2023.

35 36 CONTINUOUS MEDICAID ENROLLMENT

37
38 During the PHE, the Families First Coronavirus Response Act required states to provide
39 continuous coverage to nearly all Medicaid/CHIP enrollees as a condition of receiving a temporary
40 federal medical assistance percentage (FMAP) increase. With disenrollments frozen, churn out of
41 the program effectively ceased and enrollment increased nationally by 35 percent, from 70,875,069
42 in February 2020 to 93,876,834 in March 2023, after which the continuous enrollment requirement
43 was lifted. Most of this growth was in the Medicaid program, which increased by 22,634,781
44 individuals (35.3 percent), while CHIP enrollment increased during this period by 366,984
45 individuals (5.4 percent). The Consolidated Appropriations Act of 2023 (CAA), which was signed
46 into law in December 2022, established March 31, 2023 as the end date for the Medicaid
47 continuous enrollment requirement and phased down the enhanced FMAP amount through
48 December 2023.

49
50 The CAA established new requirements that states must meet to receive the phased-down FMAP
51 increase and gave CMS authority to require states to submit monthly unwinding data, such as the

1 number of people whose coverage was terminated, the number of those terminated based on
2 eligibility criteria versus for procedural reasons, plus call center volume and wait times. The CAA
3 also authorized several enforcement mechanisms including corrective action plans, financial
4 penalties, and requiring states to temporarily pause terminations

5
6 The AMA continues to advocate that CMS ensure that states are maintaining Medicaid rate
7 structures at levels that ensure sufficient physician participation, so that Medicaid patients can
8 access appropriate, necessary care, including specialty and behavioral health services, in a timely
9 manner and within a reasonable distance to where they live.

10 11 SGR REPEAL

12
13 The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 repealing and replacing
14 the SGR was signed into law by President Obama on April 16, 2015.

15
16 The AMA is now working on unrelated new Medicare payment reduction threats and is currently
17 advocating for a sustainable, inflation-based, automatic positive update system for physicians.

18 19 INDEPENDENT PAYMENT ADVISORY BOARD REPEAL

20
21 The Bipartisan Budget Act of 2018 signed into law by President Trump on February 9, 2018,
22 included provisions repealing the Independent Payment Advisory Board (IPAB). Currently, there
23 are not any legislative efforts in Congress to replace the IPAB.

24 25 CONCLUSION

26
27 Our AMA will remain engaged in efforts to improve the health care system through policies
28 outlined in Policy D-165.938 and other directives of the HOD. Given that most of the ACA fixes
29 that led to calls in 2013 for this report at every HOD meeting have been accomplished, our primary
30 goal now related to health care reform is stabilization of the broken Medicare physician payment
31 system, including the need for inflation-based positive annual updates and reform of budget
32 neutrality rules.

REPORT 16 OF THE BOARD OF TRUSTEES (I-23)
2023 AMA Advocacy Efforts

EXECUTIVE SUMMARY

In 2023, our American Medical Association (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 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;
- 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 House of Delegates (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.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-I-23

Subject: 2023 AMA Advocacy Efforts

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

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

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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.

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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 conversion 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

1 nationwide survey in July and August, to identify policy arguments that are most persuasive to the
 2 public. A major grassroots initiative was held during the August congressional recess.
 3 The AMA is also undertaking a new national study, supported by [173 health care organizations](#), to
 4 collect representative data on physician practice expenses. The aim of the [Physician Practice
 5 Information \(PPI\) Survey](#) is to better understand the costs faced by today's physician practices to
 6 support physician payment advocacy. The study will serve as an opportunity to communicate
 7 accurate financial information to policymakers, including members of Congress and CMS. The
 8 AMA has contracted with Mathematica, an independent research company with extensive
 9 experience in survey methods as well as health care delivery and finance reform, to conduct the
 10 study. The Medicare physician payment schedule, maintained by CMS and used by many other
 11 payers, relies on 2006 cost information to develop practice expense relative values, the MEI, and
 12 resulting physician payments. As the U.S. economy and health care system have undergone
 13 substantial changes since that time, including inflation and the wide-spread adoption of electronic
 14 health records and other information technology systems, practice expense payments no longer
 15 accurately reflect the relative resources that are typically required to provide physician services. In
 16 the Proposed Rule for the 2024 Medicare Physician Payment Schedule, CMS announced that it will
 17 delay MEI weighting of relative value pools, recognizing the pending data from the PPI Survey.
 18 The re-weighting would have led to payment reductions for certain specialties and geographic
 19 localities in 2024.

20 21 *Prior Authorization*

22
 23 Reducing administrative burden is a key to promoting physician wellness and alleviating physician
 24 burnout. Prior authorization is consistently identified by physicians as a major hurdle to promoting
 25 optimal and timely health care for patients. The AMA has led a campaign ([#FixPriorAuth](#)) to try to
 26 “right size” prior authorization and reduce its negative effects.

27
 28 The [2022 AMA Prior Authorization Physician Survey](#) updated previous AMA research and
 29 provides clear evidence once again that prior authorization remains a major burden on physician
 30 practices and continues to harm patients:

- 31
 32 • 94% of respondents said that prior authorization delays access to necessary health care for
 33 patients whose treatment requires prior authorization;
 34 • 80% of respondents reported that prior authorization can at least sometimes lead to treatment
 35 abandonment;
 36 • 33% of respondents reported that prior authorization has led to a serious adverse event for a
 37 patient in their care; and
 38 • 89% of respondents said that prior authorization has a negative impact on patient clinical
 39 outcomes.

40
 41 The AMA pressed CMS successfully to finalize a regulation that right-sizes prior authorization in
 42 Medicare Advantage plans by ensuring continuity of care, improving the clinical validity of
 43 coverage criteria, increasing transparency of health plans' processes, and reducing care
 44 disruptions. The AMA is also strongly advocating to finalize additional CMS rulemaking that
 45 would require government health benefit plans (e.g., Medicare Advantage) to offer electronic prior
 46 authorization, publicly report program statistics, and reduce processing time. With this goal in
 47 mind, the AMA launched a grassroot-effort to secure Congressional co-signers on House and
 48 Senate *Dear Colleague* letters to CMS urging the agency to make these improvements. The AMA
 49 also worked to secure the introduction of new legislation for the 118th Congress that would bring
 50 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

1 regulatory, legislative and other [solutions](#) to direct more funding and resources to support the
2 mental health needs of physicians.

3
4 In the past two years, the AMA has advocated for and supported new laws in multiple states,
5 including Arizona, Delaware, Georgia, Illinois, Kentucky, Mississippi, South Dakota, and Virginia.
6 These laws help protect physicians who seek care for wellness and burnout. Provisions range from
7 providing “safe-haven” type protections to shield records from disclosure to provisions requiring
8 state licensing boards to remove stigmatizing questions from medical licensing applications.
9 Background on these state actions can be found in this [issue brief](#).

10
11 The AMA has worked closely with the Dr. Lorna Breen Heroes’ Foundation (DLBHF), Federation
12 of State Medical Boards (FSMB), and Federation of State Physician Health Programs to encourage
13 all medical boards to remove stigmatizing, inappropriate questions that seek disclosure of past
14 diagnosis of a mental illness or substance use disorder. In the past year, these efforts have resulted
15 in three state medical boards revising their questions, and the AMA is working with eight
16 additional state medical boards on proposed revisions. The AMA is also working directly with
17 more than 30 regional and multistate health systems to revise their credentialing applications to
18 remove stigmatizing questions about past diagnosis or treatment of mental illness and substance
19 use disorders.

20
21 Additional national advocacy efforts have begun to address the ways in which credentialing
22 organizations can play a positive role. This includes urging the National Committee for Quality
23 Assurance and National Association of Medical Staff Services to remove requirements that health
24 systems might misinterpret as requiring stigmatizing questions. The AMA previously helped secure
25 an important public [statement](#) from The Joint Commission that it supported removing such
26 stigmatizing questions. Similarly, the AMA has urged the Accreditation Council for Graduate
27 Medical Education to take additional steps to support trainees’ health and wellness. Staff highlights
28 that the Society for the Teachers of Family Medicine have worked closely with the AMA [to urge](#)
29 [program directors to not ask trainees questions](#) about past mental illness or treatment.

30 31 *Telehealth*

32
33 The use of telehealth as a valuable tool for physicians and patients was showcased during the
34 COVID-19 PHE. The AMA has sought to maintain coverage and payment for telehealth coming
35 out of the pandemic. The AMA won an important victory for physicians and patients with the
36 passage of legislation extending pandemic-related telehealth flexibilities for two more years
37 (through 2024), ensuring that patients could continue to receive remote care regardless of where
38 they lived. The Administration is also using this legislative authority to extend payment for audio-
39 only telehealth services through 2024.

40
41 The AMA is actively engaged in developing legislation for passage by the end of 2024 that will
42 make these flexibilities permanent. Toward this end, a bipartisan group of 60 senators reintroduced
43 “the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for
44 Health Act.” This legislation will expand coverage of telehealth services through Medicare, make
45 permanent COVID-19 telehealth flexibilities, improve health outcomes, and make it easier for
46 patients to connect with their physicians. More specifically, the legislation would:

- 47
48 • Permanently remove all geographic restrictions on telehealth services and expand originating
49 sites to include the home and, by 2025, any other site that is deemed clinically appropriate for
50 the service;
51 • 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

1 AMA model legislation, which was developed in partnership with multiple specialty societies,
 2 helps ensure that pregnant people are not penalized for seeking treatment, including when receiving
 3 medications for opioid use disorder (MOUD). The model legislation also helps support keeping the
 4 family unit intact by ensuring that the presence of MOUD is not deemed abuse or neglect for the
 5 purposes of involving child welfare services. The AMA is actively urging all states to introduce the
 6 model bill.

7
 8 On the judicial front, the AMA signed on to an amicus brief in the *State of Ohio v. Tara*
 9 *Hollingshead*, which concerned a pregnant person who was sentenced to a lengthy prison term for
 10 using illicit drugs during the third trimester. The AMA strongly opposes criminalizing pregnant
 11 individuals who have substance-use disorders. The AMA joined seven other Ohio and national
 12 organizations to file an [amicus brief](#) that urged the court to overturn the verdict that would have
 13 sent the woman to prison for eight to 12 years. They were joined in the brief by 31 experts on
 14 maternal, fetal and neonatal health and the effects of drug use on pregnant people, pregnancies and
 15 babies. In May, the [court vacated](#) the conviction.

16 17 *Access to Health Care*

18
 19 The AMA continues to seek ways to ensure that patients have access to quality health care
 20 coverage. In 2023, the Administration announced those with Deferred Action for Childhood
 21 Arrivals (DACA) status will have access to government-funded health insurance programs. And in
 22 another major development, in March, the continuous enrollment provisions that froze Medicaid
 23 disenrollments during the PHE expired, requiring states to redetermine eligibility for millions of
 24 Medicaid beneficiaries. The AMA has been working closely with stakeholders to minimize
 25 coverage disruptions, and more information on the AMA's activities related to the unwinding of
 26 the continuous enrollment requirement is available in CMS Report 5-I-23. Additionally, the
 27 Administration announced that beginning January 1, 2024, Federally-facilitated Marketplaces and
 28 State-based Marketplaces will have the option to implement a new special enrollment period (SEP)
 29 for people losing Medicaid or CHIP coverage. This will allow consumers to select a plan for
 30 marketplace coverage 60 days before, or 90 days after, losing Medicaid or CHIP coverage. This
 31 SEP works to reduce gaps in coverage and allows for a more seamless transition into Marketplace
 32 coverage—particularly for those patients who received coverage through PHE expansions. The
 33 Administration is also promulgating new rules that would limit short-term plans that promise
 34 coverage but do not deliver appropriate coverage when needed. Finally, at the state level, North
 35 Carolina became the latest state to expand Medicaid.

36 37 *Drug Pricing Transparency*

38
 39 In 2023, the AMA relaunched its [TruthinRx.org](#) website aimed at increasing drug pricing
 40 transparency among pharmaceutical companies, pharmacy benefit managers (PBMs) and health
 41 insurers. In particular, new web content raises awareness around the games PBMs play within the
 42 complex and opaque drug supply chain, while advocating for policymakers to hold PBMs
 43 accountable by passing comprehensive drug pricing transparency legislation. In less than two
 44 months since the reboot in early June, the new look site has attracted over 2,000 new users and
 45 social media promotion has yielded 1,172 engagements. The AMA's newly invigorated campaign
 46 has indeed helped contribute to a growing groundswell of nationwide concern over PBMs which
 47 has in turn helped spur activity on Capitol Hill.

48
 49 On March 13, 2023, the AMA sent a letter in support of both S. 127, the "Pharmacy Benefit
 50 Manager Transparency Act" and S. 113, the "Prescription Pricing for the People Act" both bills
 51 sponsored by Senators Cantwell (D-WA) and Grassley (R-IA). Both bills shed light on PBM

1 business practices, while also prohibiting unfair or deceptive PBM conduct that drives up costs for
2 patients. Both bills have broad bipartisan support and have been passed out of their respective
3 committees.

4 *Mental Health and Substance Use Disorder Parity*

5
6
7 The AMA continues to urge state departments of insurance to meaningfully enforce state mental
8 health and substance use disorder parity laws. AMA advocacy continues with the National
9 Association of Insurance Commissioners to ensure that payers provide timely and accurate
10 information as part of regular compliance reviews with parity laws. Notably, AMA efforts to
11 increase regulators' focus on enforcement has resulted in strong, parity-focused network adequacy
12 regulations in Colorado and enforcement actions in Illinois that highlighted payers' discriminatory
13 actions with respect to medications for people with a mental illness or substance use disorder.

14
15 At the federal level, the AMA issued strong support for the Administration's commitment to
16 addressing insurers' continued failures to comply with the "Mental Health Parity and Addiction
17 Equity Act" (MHPAEA). For more than 15 years, the combined lack of enforcement and
18 compliance with MHPAEA has been a significant factor driving the nation's mental health crisis
19 and substance use disorder epidemic, which have both been exacerbated by the pandemic. Insurers'
20 egregious [violations](#) of MHPAEA contribute to growing inequities in mental health and substance
21 use disorder care, which often falls disproportionately to historically marginalized and minoritized
22 communities. The AMA is urging the Administration to provide the Labor Department with the
23 necessary resources to make oversight and enforcement of MHPAEA a top priority.

24 *Overdose Epidemic*

25
26
27 Ending the nation's drug-related overdose and death epidemic—as well as improving care for
28 patients with pain, mental illness, or substance use disorder—requires partnership, collaboration,
29 and commitment to individualized patient care decision-making to implement impactful changes.
30 At the federal level, the AMA advocated for manufacturers to submit over-the-counter (OTC)
31 applications for naloxone and that the FDA help make naloxone available OTC—the FDA
32 approved its first naloxone product to be available for OTC status in March. The AMA is
33 continuing advocacy efforts to urge manufacturers to responsibly price naloxone and for insurers to
34 continue to cover the lifesaving medication.

35
36 The AMA also opposed the new eight-hour training requirements regarding substance abuse
37 disorder management contained in "the Medication Access and Training Expansion (MATE) Act."
38 On June 27, the new requirements went into effect for physicians applying for or renewing their
39 Drug Enforcement Administration (DEA) registration to prescribe controlled substances. The
40 AMA has been working with the DEA, and the agency is trying to be flexible. There is confusion
41 about which training counts and which courses do not. The DEA has streamlined the
42 implementation by adding three questions to the application, and physicians are not required to
43 submit any documentation and must only attest to one of the questions by checking a box. During
44 the 60 days before their renewal is due, the DEA will contact physicians five times to make sure
45 they are aware of it, and each time will tell them about the training requirement. The DEA has also
46 been accessible, hosting webinars for medical societies.

47
48 Efforts by AMA to support decriminalization of fentanyl test strips has helped with more than 10
49 new state laws in 2022-2023 (Arizona, Florida, Georgia, Kansas, Kentucky, Mississippi, Montana,
50 New Mexico, Ohio, Pennsylvania, Texas, Utah, and Wisconsin). The AMA also supported the
51 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](#).

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

5
6 CONCLUSION

7
8 The AMA has an incredible amount of work to do on the advocacy front, and it needs continued
9 partnership with the Federation to advance organized medicine's collective goals. There has been
10 progress so far in 2023, but there is still substantial work to be done on the Recovery Plan topics as
11 well as many other ones directly affecting physicians and patients.

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 01-I-23

Subject: Responsibilities to Promote Equitable Care

Presented by: David A. Fleming, MD, Chair

At the 2023 Annual Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 4-A-23, “Responsibilities to Promote Equitable Care.” The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-11.2.7 – Responsibilities to Promote Equitable Care

Medicine at its core is a moral activity rooted in the encounter between a patient who is ill and a physician who professes to heal. The “covenant of trust” established in that encounter binds physicians in a duty of fidelity to patients. As witness to how public policies ultimately affect the lives of sick persons, physicians’ duty of fidelity also encompasses a responsibility to recognize and address how the policies and practices of the institutions within which physicians work shape patients’ experience of health, illness, and care. As the physical and social settings of medical practice, hospitals and other health care institutions share the duty of fidelity and, with physicians, have a responsibility to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable.

Enduring health disparities across patient populations challenge these duties of fidelity. Disparities reflect the habits and practices of individual clinicians and the policies and decisions of individual health care institutions, as well as deeply embedded, historically rooted socioeconomic and political dynamics. Neither individual physicians nor health care institutions can entirely resolve the problems of discrimination and inequity that underlie health disparities, but they can and must accept responsibility to be agents for change.

In their individual practice, physicians have an ethical responsibility to address barriers to equitable care that arise in their interactions with patients and staff. They should:

- (a) Cultivate self-awareness and strategies for change, for example, by taking advantage of training and other resources to recognize and address implicit bias;
- (b) Recognize and avoid using language that stigmatizes or demeans patients in face-to-face interactions and entries in the medical record;

* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

- 1 (c) Use the social history to capture information about non-medical factors that affect a
2 patient's health status and access to care to inform their relationships with patients and the
3 care they provide.
4

5 Within their institutions, as professionals with unique knowledge, skill, experience, and status,
6 physicians should collaborate with colleagues to promote change. They should:
7

- 8 (d) Support one another in creating opportunities for critical reflection across the institution;
9

- 10 (e) Identify institutional policies and practices that perpetuate or create barriers to equitable
11 care;
12

- 13 (f) Participate in designing and supporting well-considered strategies for change to ensure
14 equitable care for all.
15

16 As institutions in and through which health care occurs, hospitals and other health care
17 institutions share medicine's core values and commitment of fidelity, and with it ethical
18 responsibility to promote equitable care for all. Moreover, as entities that occupy positions of
19 power and privilege within their communities, health care institutions are uniquely positioned
20 to be agents for change. They should:
21

- 22 (g) Support efforts within the institution to identify and change institutional policies and
23 practices that may perpetuate or create barriers to equitable care;
24

- 25 (h) Engage stakeholders to understand the histories of the communities they serve and
26 recognize local drivers of inequities in health and health care;
27

- 28 (i) Identify opportunities and adopt strategies to leverage their status within the community to
29 minimize conditions of living that contribute to adverse health status. (I, VII, VII, IX)

EXECUTIVE SUMMARY

This report provides information on the fundamentals of generative AI in medicine and health care: terminologies and components of artificial intelligence (AI) and augmented intelligence, definitions, prominent models (Open AI ChatGPT, Google Bard and Med-PaLM, and Microsoft Bing), promises, challenges, and pitfalls, AMA partnerships and resources, and potential ethical and regulatory frameworks. The report concludes with insight from CLRPD members on the trend.

Generative AI models are commercial natural language processing tools known as large language models (LLMs). At their core, all AI innovations utilize sophisticated statistical techniques to discern patterns within extensive datasets using increasingly powerful computational technologies. Three components—big data, advanced statistical methods, and computing resources—have not only become available recently but are also being democratized and made accessible to at a pace unprecedented in previous technological innovations.

While LLMs show promise to make a significant contribution to health care in the future, physicians currently considering using generative AI models in a clinical setting or direct patient care should exercise caution and be aware of the real challenges that remain to ensure reliability: confident responses that are not justified by the model’s training data, the “black box” nature of AI, biased and discriminatory tendencies in outputs, lack of knowledge-based reasoning, lack of current ethical and regulatory frameworks, patient privacy and security concerns, and potential liability.

Generative AI systems are not sentient, they simply use massive amounts of text to predict one word after another, and their outputs may mix truth with patently false statements. As such, physicians will need to learn how to integrate these tools into clinical practice, defining clear boundaries between full, supervised, and proscribed autonomy. Physicians should be clear-eyed about the risks inherent to any new technology, especially ones that carry existential implications, while cautiously optimistic about a future of improved health care system efficiency, better patient outcomes, and reduced burnout. Extant AI-assistant programs and rapidly developing systems are incredibly sophisticated, and as physicians have already begun to demonstrate on social media, they might soon be able to reliably perform test result notifications, work letters, prior authorizations, and the like—the mundane necessities that not only cumulatively consume valuable time but are substantial contributors to physician burnout.

Projecting further into an AI-enhanced future, imagine that instead of writing follow-up care instructions, physicians could ask a generative AI system to create a synopsis of the patient’s treatment course. With the time saved, physicians could step away from the computer, face the patient, and explain the most salient follow-up items, prepped with materials that are compatible with best practices in health literacy. Likewise, these programs might help actualize the admirable intentions behind the provisions in the 21st Century Cures Act that have given patients access, but not accessibility, to their jargon-laden electronic medical records.

Given opportunities to offer clinical insight into the development and deployment of these systems, Generative AI may provide physicians with technological tools that reduce administrative burden and enable them to get back to the reason why they decided to pursue medicine in the first place—to improve patients’ lives—meanwhile, improving physicians’ wellbeing.

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 2-I-23

Subject: Generative AI in Medicine and Health Care

Presented by: Gary Thal, MD, Chair

BACKGROUND

The functions of the Council on Long Range Planning and Development (CLRPD) include to study and make recommendations concerning the long-range objectives of the American Medical Association (AMA), and to serve in an advisory role to the Board of Trustees concerning strategies by which the AMA attempts to reach its long-range objectives. To accomplish its role, the Council studies anticipated changes in the environment in which medicine and the AMA must function and develops memos to the Board, which include CLRPD deliberations and insight on emerging issues, such as generative artificial intelligence (AI).

This informational report presents material on the fundamentals of generative AI in medicine and health care including terminologies and components, definition, prominent models, promises and pitfalls, AMA partnerships and resources, potential ethical and regulatory frameworks, and CLRPD insight.

TERMINOLOGIES AND COMPONENTS OF AI

CLRPD Report 1-A-18, A Primer on Artificial and Augmented Intelligence¹ defines the relative terminologies of artificial intelligence (AI), which are not well understood:

- *Algorithms* are a sequence of instructions used to solve a problem. Developed by programmers to instruct computers in new tasks, algorithms are the building blocks of the advanced digital world. Computer algorithms organize enormous amounts of data into information and services, based on certain instructions and rules.
- *Artificial Intelligence* is the ability of a computer to complete tasks in a manner typically associated with a rational human being—a quality that enables an entity to function appropriately and with foresight in its environment. True AI is widely regarded as a program or algorithm that can beat the Turing Test, which states that an artificial intelligence must be able to exhibit intelligent behavior that is indistinguishable from that of a human.
- *Augmented Intelligence* is an alternative conceptualization that focuses on AI's assistive role, emphasizing the fact that its design enhances human intelligence rather than replaces it.
- *Machine Learning* is a part of the discipline of artificial intelligence and refers to constructing algorithms that can make accurate predictions about future outcomes. Machine learning can be supervised or unsupervised.

- In supervised learning, algorithms are presented with “training data” that contain examples with their desired conclusions, such as pathology slides that contain cancerous cells as well as slides that do not.
- Unsupervised learning does not typically leverage labeled training data. Instead, algorithms are tasked with identifying patterns in data sets on their own by defining signals and potential abnormalities based on the frequency or clustering of certain data.
- *Deep Learning* is a subset of machine learning that employs artificial neural networks (ANNs) and algorithms structured to mimic biological brains with neurons and synapses. ANNs are often constructed in layers, each of which performs a slightly different function that contributes to the result. Deep learning is the study of how these layers interact and the practice of applying these principles to data.
- *Cognitive Computing*, a term coined by IBM, is often used interchangeably with machine learning and artificial intelligence. However, cognitive computing systems do not necessarily aspire to imitate intelligent human behavior, but instead to supplement human decision-making power by identifying potentially useful insights with a high degree of certainty. Clinical decision support and augmented intelligence come to mind when considering this definition.
- *Natural Language Processing* (NLP) forms the foundation for many cognitive computing exercises. The ingestion of source materials, such as medical literature, clinical notes, or audio dictation records requires a computer to understand what is written, spoken, or otherwise being communicated. One commonly used application of NLP is optical character recognition (OCR) technology that can turn static text, such as a PDF of a lab report or a scan of a handwritten clinical note, into machine readable data. Once data is in a workable format, the algorithm parses the meaning of each element to complete a task such as translating into a different language, querying a database, summarizing information, or supplying a response to a conversation partner. In the health care field, where acronyms and abbreviations are common, accurately parsing through this “incomplete” data can be challenging.

DEFINITION OF GENERATIVE AI

Generative AI is a broad term used to describe any type of artificial intelligence that can be used to create new text, images, video, audio, code, or synthetic data. Progress with generative AI was relatively slow until around 2012, when a single idea shifted the entire field. It was called a neural network—inspired by the inner workings of the human brain—a mathematical system that learns skills by finding statistical patterns in enormous amounts of data. By analyzing thousands of cat photos, for instance, it can learn to recognize a cat. Neural networks enable Siri and Alexa to understand what you are saying, identify people and objects in Google Photos and instantly translate dozens of languages.²

The next big change was large language models (LLMs), which consist of a neural network. Around 2018, companies like Google, Microsoft, and OpenAI began building neural networks that were trained on vast amounts of text from the internet, including Wikipedia articles, digital books, and academic papers. Somewhat to the experts’ surprise, these systems learned to write unique prose and computer code and carry-on sophisticated conversations, which is termed generative AI.³

1 LLMs are a class of technologies that drive generative AI systems. The first LLMs appeared about
2 five years ago, but were not very sophisticated; however, today they can draft emails,
3 presentations, and memos. Every AI system needs a goal. Researchers call this an objective
4 function. It can be simple, such as “win as many chess games as possible” or complicated, such as
5 “predict the three-dimensional shapes of proteins, using only their amino acid sequences.”⁴ Most
6 LLMs have the same basic objective function, which is, given a sequence of text, to guess what
7 comes next. Though trained on simple tasks along the lines of predicting the next word in a
8 sentence, neural language models with sufficient training and parameter counts are found to
9 capture much of the syntax and semantics of human language. In addition, LLMs demonstrate
10 considerable general knowledge about the world and can memorize a great quantity of facts during
11 training.

12
13 Training the model involves feeding algorithms large amounts of data, which serves as the
14 foundation for the AI model to learn from. This can consist of text, code, graphics, or any other
15 types of content relevant to the task at hand. Once the training data has been collected, the AI
16 model analyzes the patterns and relationships within the data to understand the underlying rules
17 governing the content. Continuously, the AI model fine-tunes its parameters as it learns, improving
18 its ability to simulate human-generated content. The more content the AI model generates, the
19 more sophisticated and convincing its outputs become.⁵

20
21 Typing in the precise words and framing to generate the most helpful answers is an art. Beginning
22 a prompt with “act as if” will instruct the model to emulate an expert. For example, typing “Act as
23 if you are a tutor for the SATs” or “Act as if you are a personal trainer” will guide the systems to
24 model themselves around people in those professions. These prompts provide additional context for
25 the generative AI model to produce its response by helping the tool to draw on specific statistical
26 patterns in its training data.⁶

27
28 Generative AI outputs are calibrated combinations of the data used to train the algorithms. Because
29 the amount of data used to train these algorithms is so incredibly massive—multiple terabytes of
30 text data—the models can appear to be “creative” when producing outputs. Moreover, the models
31 usually have random elements, which means they can produce a variety of outputs from one input
32 request—making them seem even more lifelike. The unmanageably huge volume and complexity
33 of data (unmanageable by humans, anyway) that is now being generated has increased the potential
34 of the technologies.⁷

35
36 Tech companies are confronting a challenge: how to balance asking users for more data to deliver
37 new AI features without scaring away privacy-conscious businesses and consumers that
38 consistently tell pollsters they want transparency about when AI is used and trained. But when
39 companies provide such detail, it is often written in legalese and buried in fine print that is often
40 being rewritten to give tech companies more rights. Video conferencing company Zoom
41 encountered a massive backlash over concerns the contents of video chat might be used to train AI
42 systems. The move prompted an apologetic post from Zoom’s CEO, but the company is far from
43 alone in seeking more consumer data to train AI models. Companies are deploying different
44 approaches to ensure they have access to user data. At the same time, many are also adding in
45 language to prevent anyone else from scraping their websites to train AI systems.⁸

46
47 According to the JAMA Forum article, “ChatGPT and Physicians’ Malpractice Risk,”⁹ most LLMs
48 are trained on indiscriminate assemblages of web text with little regard to how sources vary in
49 reliability. They treat articles published in the *New England Journal of Medicine* and Reddit
50 discussions as equally authoritative. In contrast, Google searches let physicians distinguish expert
51 from inexperienced summaries of knowledge and selectively rely on the best. Other decision-support

1 tools provide digests based on the best available evidence. Although efforts are underway¹⁰ to train
2 LLMs on exclusively authoritative, medically relevant texts, they are still nascent and prior efforts
3 have faltered.¹¹

4
5 Generative AI models have been observed to experience-confabulations or delusions— confident
6 responses by an AI model that does not seem to be justified by its training data. Such phenomena
7 are termed by the tech industry as “hallucinations,” in loose analogy with the phenomenon
8 of hallucination in human psychology; however, one key difference is that human hallucinations
9 are usually associated with false percepts, while an AI hallucination is associated with the category
10 of unjustified responses or beliefs.¹²

11 12 GENERATIVE AI MODELS

13
14 There are several types of generative AI models, each designed to address specific challenges and
15 applications. These generative AI models can be broadly categorized into the following types:¹³

- 16
17 • Transformer-based models: These models, such as OpenAI’s ChatGPT and GPT-3.5, are
18 neural networks designed for natural language processing. They are trained on large
19 amounts of data to learn the relationships between sequential data — like words and
20 sentences — making them useful for text-generation tasks.
- 21
22 • Generative adversarial networks (GANs): GANs are made up of two neural networks, a
23 generator, and a discriminator that work in a competitive or adversarial capacity. The
24 generator creates data, while the discriminator evaluates the quality and authenticity of said
25 data. Over time, both networks get better at their roles, leading to more realistic outputs.
- 26
27 • Variational autoencoders (VAEs): VAEs use an encoder and a decoder to generate content.
28 The encoder takes the input data, such as images or text, and simplifies it into a more
29 compact form. The decoder takes this encoded data and restructures it into something new
30 that resembles the original input.
- 31
32 • Multimodal models: Multimodal models can process multiple types of input data,
33 including text, audio, and images. They combine different modalities to create more
34 sophisticated outputs, such as DALL-E 2¹⁴ and OpenAI’s GPT-4¹⁵, which is also capable
35 of accepting image and text inputs.

36 37 *OpenAI ChatGPT*

38
39 Researchers have been working on generative AI for a long time. OpenAI, developer of ChatGPT
40 (Generative Pretrained Transformer), is over seven years old. Launched in November 2022,
41 ChatGPT is a LLM that leverages huge amounts of data to mimic human conversation and assess
42 language patterns. Currently, the basic system is free via a simple web interface that lets users pose
43 questions and give directions to a bot that can answer with conversation, term papers, sonnets,
44 recipes—almost anything.¹⁶

45
46 GPT-4 is the newest version of OpenAI’s language model systems, and it is much more advanced
47 than its predecessor GPT-3.5, which ChatGPT runs on. GPT-4 is a multimodal model that accepts
48 both text and images as input and output text. This can be useful for uploading worksheets, graphs,
49 and charts to be analyzed. GPT-4 has advanced intellectual capabilities that allow it to outperform

1 GPT-3.5 in a series of simulated benchmark exams. It has also reduced the number of
2 “hallucinations” produced by the chatbot.¹⁷

3
4 ChatGPT has passed a series of benchmark exams. Christian Terwiesch, a professor at Wharton,
5 the University of Pennsylvania’s business school, used ChatGPT to take an MBA exam. ChatGPT
6 not only passed the exam but also scored a B to B-. The professor was impressed at its basic
7 operations management, process analysis questions, and explanations. Although ChatGPT could
8 pass many of these benchmark exams, its scores were usually in the lower percentile. However,
9 with GPT-4, scores were much higher. For example, ChatGPT in the 3.5 series scored in the lower
10 10th percentile of a simulated Bar Exam, while GPT-4 scored in the top 10th percentile.¹⁸

11 12 *Google Bard and Med-PaLM*

13
14 Bard is Google’s AI chat service, a rival to ChatGPT.¹⁹ On February 6, 2023, Google introduced its
15 experimental AI chat service. Over a month after the announcement, Google began rolling
16 out access to Bard via a waitlist. Bard uses a lightweight version of Google’s Language Model for
17 Dialogue Applications (LaMDA)²⁰ and draws on all the information from the web to respond -- a
18 stark contrast from ChatGPT, which does not have internet access. Google’s chat service had a
19 rough launch, with a demo of Bard delivering inaccurate information about the James Webb Space
20 Telescope.²¹ ChatGPT’s advanced capabilities exceed those of Google Bard. Even though Google
21 Bard has access to the internet and ChatGPT does not, it fails to produce answers much more often
22 than ChatGPT.

23
24 In April 2023, Google announced a new version of its medical LLM, called Med-PaLM 2.²² An AI
25 platform for analyzing medical data, it aims to assist physicians with routine tasks and provide
26 more reliable answers to patient questions than “Dr. Google.” *PaLM 2, the Pathways Language*
27 *Model*, is more critical than Bard for medicine. With 540 billion parameters, it draws knowledge
28 from scientific papers and websites, can reason logically, and perform complex mathematical
29 calculations.²³ Google is actively developing its large language model (LLM), Med-PaLM 2, which
30 they anticipate will excel at healthcare discussions over general-purpose algorithms, given its
31 training on questions and answers from medical licensing exams. They are collaborating with
32 Mayo Clinic and other health systems and partnering with the healthcare technology vendor,
33 CareCloud.²⁴

34 35 *Microsoft Bing AI*

36
37 In early February 2023, Microsoft unveiled²⁵ a new version of Bing²⁶ -- and its standout feature is
38 its integration with GPT-4. When it was announced, Microsoft shared that Bing Chat was powered
39 by a next-generation version of OpenAI’s large language model, making it “more powerful than
40 ChatGPT.”²⁷

41
42 Five weeks after launch, Microsoft revealed that, since its launch, Bing Chat had been running on
43 GPT-4, the most advanced Open AI model, before the model even launched. Because Bing’s
44 ChatGPT is linked to the internet, the biggest difference from ChatGPT is that Bing’s version has
45 information on current events, while ChatGPT is limited to knowledge before 2021. Another major
46 advantage of the new Bing is that it links to the sites it sourced its information from using
47 footnotes, whereas ChatGPT does not.

48
49 Building a generative AI model has for the most part been a major undertaking, to the extent that
50 only a few well-resourced tech heavyweights have tried. OpenAI, the company behind ChatGPT,
51 former GPT models, and DALL-E (a tool for AI-generated art), has billions in funding from high-

profile donors. DeepMind is a subsidiary of Alphabet, the parent company of Google, and Meta has released its Make-A-Video product based on generative AI. These companies employ some of the world's best computer scientists and engineers. However, when you are asking a model to train using nearly the entire internet, it is going to be costly. OpenAI has not released exact costs, but estimates indicate that GPT-3 was trained on a vast amount of text data that was equivalent to one million feet of bookshelf space, or a quarter of the entire Library of Congress at an estimated cost of several million dollars. These are not resources that your garden-variety start-up can access.²⁸

PROMISES AND PITFALLS

The latest McKinsey Global Survey breaks down how corporate leaders worldwide are using generative AI. By interviewing thousands of managers and executives across the globe, McKinsey gained a high-level view on where AI is being deployed already (especially in marketing, product development, and service operations), as well as the biggest perceived risks of implementing AI (including inaccurate outputs, cybersecurity threats, and intellectual property infringement).²⁹ In June, McKinsey projected that generative AI could add \$4.4 trillion to global GDP, 75% of which would emerge from use cases in customer operations, marketing and sales, software engineering, and R&D.³⁰

In the medical device industry, product developers are integrating AI capabilities into a wide variety of health care technologies, from imaging and surgical systems to vital sign monitors, endoscopes, and diagnostic devices. New players range from Big Tech behemoths to entrepreneurial startups to the individual visionaries who, in the digital age, create algorithms that could lead to the next breakthrough technology.

AMA surveys of physicians conducted in 2016, 2019, and 2022 show growing use of and plans to use AI in the short term. In the latest survey, nearly one in five physicians say their practice incorporates AI for practice efficiencies and clinical applications, while just over one in 10 use biometrics, precision and personalized medicine, or digital therapeutics. More than twice as many expect to adopt such advanced technologies within one year. However, unlike other health care technologies, AI-enabled medical devices can perform in mysterious and unexpected ways—introducing a whole new set of uncertainties. This so-called “black box conundrum”—knowing what goes in and what comes out of the system, but not what happens in between—can be disconcerting.³¹

In 2021, two experts explained the fundamentals of machine learning, what it means in the clinical setting and the possible risks of using the technology, “Machine Learning: An Introduction and Discussion of Medical Applications” that took place during the June 2021 AMA Sections Meetings and was hosted by AMA Medical Student Section:³²

- A key aspect of machine learning is that it continuously improves the model by weighing the data with minimal human interaction, explained Herbert Chase, MD, MA, professor of clinical medicine in biomedical informatics at Vagelos College of Physicians and Surgeons at Columbia University. It may be able to pick up factors leading to disease that a physician does not. For example, people who all worked in a factory that had heavy metals in the atmosphere or people in the same zip code are experiencing the same thing. People with a certain disease are taking the same vitamins or they all had a previous surgery. “The EHR has hundreds of different attributes, thousands of different values that can be mined. This is classic data mining in an unsupervised way to make the prediction model better and there are many examples in the literature now of how this approach has dramatically

improved the prediction for coronary artery disease, heart failure and many other chronic conditions,” Dr. Chase said.

- While machine learning can help medicine in tremendous ways, physicians must also be mindful that bias in machine learning is a problem, Ravi Parikh, MD, MPP, assistant professor of medical ethics and health policy and medicine at the University of Pennsylvania, explained during the educational session. There are three distinct things you need to specify for a supervised machine-learning algorithm. You start with a population. A series of variables is derived from the population. Those variables are then used for a predictive algorithm to predict an outcome.
- “Any amount of those three steps could be biased and could generate bias in the context of the algorithm,” Dr. Parikh said. So, how can bias be addressed? Dr. Parikh said physicians can identify bias and potentially flawed decision making in real time, use unbiased data sources and track algorithm outputs continuously to monitor bias.
- Drs. Parikh and Chase said physicians do not need to worry about machine learning eliminating physicians’ jobs. “The workforce will just be the same as it always has been ... but you will be operating at a higher level and I think that will make the profession to some extent more interesting,” Dr. Chase said.

Augmented intelligence promises to be a transformational force in health care, especially within primary care. Experts outline ways that innovations driven by this technology can aid rather than subvert the patient-physician relationship. Steven Y. Lin, MD, and Megan R. Mahoney, MD, associate clinical professor of medicine and clinical professor of medicine, respectively, in the Division of Primary Care and Population Health at Stanford University School of Medicine, and AMA vice president of professional satisfaction Christine A. Sinsky, MD—reviewed promising inventions in 10 distinct problem areas:³³

- Risk prediction and intervention: Drawing on EHR data, AI-driven predictive modeling can outperform traditional predictive models in forecasting in-hospital mortality, 30-day unplanned readmission, prolonged length of stay and final discharge diagnoses.
- Population health management: With the move from fee-for-service to value-based payments, AI could help identify and close care gaps and optimize performance with Medicare quality payment programs.
- Medical advice and triage: Some companies have developed “AI doctors” to provide health advice to patients with common symptoms, freeing up primary care appointments for patients requiring more complex care. “Rather than replacing physicians for some conditions, AI support can be integrated into team-based care models that make it easier for primary care physicians to manage a patient panel,” the authors wrote. Risk-adjusted paneling and resourcing EHR data on utilization can be used to create algorithms for weighing panel sizes in primary care. This can be used to determine the level of staffing support needed for primary care practices based on the complexity and intensity of care provided.
- Device integration: Wearable devices can track vital signs and other health measures, but their data’s volume and its incompatibility with EHRs make it unwieldy without the help

of AI. Apple's Health Kit is a tool that integrates data from multiple wearable devices into the EHR, enabling care teams to map trends and spot deviations that suggest illness.

- Digital health coaching: Companies are now offering digital health coaching for diabetes, hypertension and obesity, and similar programs integrated in health systems have shown reductions in cost per patient through reduced office and hospital visits.
- Chart review and documentation: Technology companies with expertise in automatic speech recognition are teaming up with health systems to develop AI-driven digital scribes that can listen in on patient-physician conversations and automatically generate clinical notes in the EHR.
- Diagnostics: AI-powered algorithms for diagnosing disease "are now outperforming physicians in detecting skin cancer, breast cancer, colorectal cancer, brain cancer and cardiac arrhythmias," the authors wrote, citing numerous tools, such as IDx-DR, Aysa, and Tencent. "This could reduce the need for unnecessary referrals, increase continuity with patients and enhance mastery for primary care physicians."³⁴
- Clinical decision-making: Next generation platforms do much more than provide alerts and best practice advisories. eClinicalWorks, for example, is developing a new version of its EHR that will feature an AI assistant that provides evidence-based clinical suggestions in real time.
- Practice management: AI can also automate repetitive clerical tasks. Eligibility checks, insurance claims, prior authorizations, appointment reminders, billing, data reporting and analytics can all now be automated using AI, and some companies have developed AI-powered category auditors to help optimize coding for quality payment programs.

AMA partners with technology and health care leaders to bring physicians critical insights on AI's potential applications and ensure that physicians have a voice in shaping AI's role in medicine.

- Health2047, the innovation subsidiary of the American Medical Association (AMA), has launched a startup that develops augmented intelligence technologies to support clinical decision making.³⁵ Called RecoverX, the startup creates technologies that leverage research, medical charts, patient conversations, and test results to provide evidence-based clinical insights and suggested actions for clinicians in real time. For example, one of the technologies on the core RecoverX platform, called Diagnostic Glass, provides decision-making support to clinicians in more than 30 specialties.³⁶
- To develop actionable guidance for trustworthy AI in health care, the AMA reviewed literature on the challenges health care AI poses and reflected on existing guidance. These findings are published in a paper in *Journal of Medical Systems: Trustworthy Augmented Intelligence in Health Care*.³⁷
- The AMA Intelligent Platform's CPT® Developer Program allows developers to access the latest content and resources, Access the Developer Portal on the AMA Intelligent Platform.³⁸
- Kimberly Lomis, MD, AMA vice president of undergraduate medical innovations, co-authored a discussion paper, Artificial Intelligence for Health Professions Educators in *NAM Perspectives*.³⁹

The technological capacity exists to use AI algorithms and tools to transform health care, but real challenges remain in ensuring that tools are developed, implemented and maintained responsibly, according to a *JAMA* Viewpoint column, “Artificial Intelligence in Health Care: A Report From the National Academy of Medicine.”⁴⁰ The NAM report recommends that people developing, using, implementing, and regulating health care AI do seven key things:⁴¹

- Promotion of population-representative data with accessibility, standardization and quality is imperative: This is the way to ensure accuracy for all populations. While there is a lot of data now, there are issues with data quality, appropriate consent, interoperability, and scale of data transfers.
- Prioritize ethical, equitable and inclusive medical AI while addressing explicit and implicit bias: Underlying biases need to be scrutinized to understand their potential to worsen or address existing inequity and whether and how it should be deployed.
- Contextualize the dialogue of transparency and trust, which means accepting differential needs: AI developers, implementers, users, and regulators should collaboratively define guidelines for clarifying the level of transparency needed across a spectrum and there should be a clear separation of data, performance, and algorithmic transparency.
- Focus in the near term on augmented intelligence rather than AI autonomous agents: Fully autonomous AI concerns the public and faces technical and regulatory challenges. Augmented intelligence—supporting data synthesis, interpretation and decision-making by clinicians and patients—is where opportunities are now.
- Develop and deploy appropriate training and educational programs: Curricula must be multidisciplinary and engage AI developers, implementers, health care system leadership, frontline clinical teams, ethicists, humanists, patients, and caregivers.
- Leverage frameworks and best practices for learning health care systems, human factors, and implementation science: Health care delivery systems should have a robust and mature information technology governance strategy before embarking on a substantial AI deployment and integration.
- Balance innovation with safety through regulation and legislation to promote trust: AI developers, health system leaders, clinical users, and informatics and health IT experts should evaluate deployed clinical AI for effectiveness and safety based on clinical data.

The AMA recently developed a ChatGPT primer for physicians with questions regarding the technology and use in medical practice. The primer outlines considerations for physicians and patients when considering utilizing the tool and is available on the AMA website.⁴²

Researchers from the University of Arizona Health Sciences found that patients are almost evenly split about whether they would prefer a human clinician or an AI-driven diagnostic tool, with preferences varying based on patient demographics and clinician support of the technology.⁴³ The results of the study, demonstrated that many patients do not believe that the diagnoses provided by AI are as trustworthy as those given by human health care providers. However, patients’ trust in their clinicians supported one of the study’s additional findings: that patients were more likely to trust AI if a physician supported its use.⁴⁴

Health systems are watching to see where generative AI could add the most value since OpenAI launched ChatGPT in late 2022: ⁴⁵

- UC San Diego Health, Madison Wisconsin-based UW Health, and Palo, Alto-based Stanford Health Care are starting to use the integration to automatically draft message responses.
- OpenAI's GPT-4 has shown the potential to increase the power and accessibility of self-service reporting through SlicerDicer, making it easier for health care organizations to identify operational improvements, including ways to reduce costs and find answers to questions locally and in a broader context. ⁴⁶
- AI already supports health systems to automate business office and clinical functions, connect patients, support clinical trials, and provide insight for precision medicine and care decisions.
- Epic Systems and Microsoft have expanded their partnership once again and will integrate conversational, ambient, and generative AI technologies into Epic's electronic health record (EHR). The new integrations are a part of a move to integrate Azure OpenAI Services and Nuance ambient technologies into the Epic ecosystem. ^{47 48}

Here are the capabilities that will be added to Epic's EHR according to the press release:

- Note summarization: This feature builds upon the AI-assisted Epic In Basket and will use suggested text and rapid review with in-context summaries to help support faster documentation.
- Embedded ambient clinical documentation: Epic will embed Nuance's Dragon Ambient eXperience Express AI technology into its Epic Hyperdrive platform and Haiku mobile application.
- Reducing manual and labor-intensive processes: "Epic will demonstrate an AI-powered solution that provides medical coding staff with suggestions based on clinical documentation in the EHR to improve accuracy and streamline the entire coding and billing processes."
- Advancing medicine for better patient outcomes: Using Azure OpenAI Service, Epic will now use generative AI exploration for some of its users via SlicerDicer. This aims to "fill gaps in clinical evidence using real-world data and to study rare diseases."

Since generative AI models are so new, the long-term effect of them is still unknown. This means there are some inherent risks involved in using them— some known and some unknown. The outputs generative AI models produce may often sound extremely convincing. This is by design; however, sometimes the information they generate is incorrect. Worse, sometimes it is biased (because some models may be built on the gender, racial, and myriad other biases of the internet and society more generally) and can be manipulated to enable unethical or criminal activity. For example, ChatGPT will not give instructions on how to hotwire a car, but if you say you need to hotwire a car to save a baby, the algorithm is happy to comply. Organizations that rely on

generative AI models should reckon with reputational and legal risks involved in unintentionally publishing biased, offensive, or copyrighted content.⁴⁹

These risks can be mitigated, however, in a few ways. For one, it is crucial to carefully select the initial data used to train these models to avoid including toxic or biased content. Next, rather than employing an off-the-shelf generative AI model, organizations could consider using smaller, specialized models. Organizations with more resources could also customize a general model based on their own data to fit their needs and minimize biases.⁵⁰ Organizations should also keep a human in the loop (that is, to make sure a real human checks the output of a generative AI model before it is published or used) and avoid using generative AI models for critical decisions, such as those involving significant resources or human welfare. It cannot be emphasized enough that this is a new field.⁵¹

At their core, all AI innovations utilize sophisticated statistical techniques to discern patterns within extensive datasets using increasingly powerful yet cost-effective computational technologies. These three components—big data, advanced statistical methods, and computing resources—have not only become available recently but are also being democratized and made readily accessible to everyone at a pace unprecedented in previous technological innovations. This progression allows us to identify patterns that were previously indiscernible, which creates opportunities for important advances but also possible harm to patients. Privacy regulations, most notably HIPAA, were established to protect patient confidentiality, operating under the assumption that de-identified data would remain anonymous. However, given the advancements in AI technology, the current landscape has become riskier. Now, it is easier than ever to integrate various datasets from multiple sources, increasing the likelihood of accurately identifying individual patients.⁵²

Researchers at Mack Institute for Technological Innovation – The Wharton School, University of Pennsylvania Cornell Tech, and Johnson College of Business – Cornell University found that despite their remarkable performance, LLMs sometimes produce text that is semantically or syntactically plausible but is, in fact, factually incorrect or nonsensical (i.e., hallucinations). The models are optimized to generate the most statistically likely sequences of words with an injection of randomness. They are not designed to exercise any judgment on the veracity or feasibility of the output. Further, the underlying optimization algorithms provide no performance guarantees, and their output can thus be of inconsistent quality. Hallucinations and inconsistency are critical flaws that limit the use of LLM-based solutions to low-stakes settings or in conjunction with expensive human supervision. To achieve high variability in quality and high productivity, most research on ideation and brainstorming recommends enhancing performance by generating many ideas while postponing evaluation or judgment of ideas (Girotra et al., 2010). This is hard for human ideators to do, but LLMs are designed to do exactly this— quickly generate many somewhat plausible solutions without exercising much judgment. Further, the hallucinations and inconsistent behavior of LLMs increase the variability in quality, which, on average, improves the quality of the best ideas. For ideation, an LLM’s lack of judgment and inconsistency could be prized features, not bugs. Thus, the researchers hypothesize that LLMs will be excellent ideators.⁵³

The landscape of risks and opportunities is likely to change rapidly in the coming weeks, months, and years. New use cases are being tested monthly, and new models are likely to be developed in the coming years. As generative AI becomes increasingly, and seamlessly, incorporated into business, society, and our personal lives, we can also expect a new regulatory climate to take shape. As organizations begin experimenting—and creating value—with these tools, physicians will do well to keep a finger on the pulse of benefits and drawbacks with the use of generative AI in medicine and health care.⁵⁴

ETHICS FRAMEWORK FOR USE OF GENERATIVE AI IN HEALTH CARE

A new paper published by leading Australian AI ethicist Stefan Harrer PhD proposes for the first time a comprehensive ethical framework for the responsible use, design, and governance of Generative AI applications in health care and medicine. The study highlights and explains many key applications for health care.⁵⁵

- assisting clinicians with the generation of medical reports or preauthorization letters,
- helping medical students to study more efficiently,
- simplifying medical jargon in clinician-patient communication,
- increasing the efficiency of clinical trial design,
- helping to overcome interoperability and standardization hurdles in EHR mining,
- making drug discovery and design processes more efficient.

However, the paper also highlights that the inherent danger of LLM-driven generative AI arising from the ability of LLMs to produce and disseminate false, inappropriate, and dangerous content at unprecedented scale is increasingly being marginalized in an ongoing hype around the recently released latest generation of powerful LLM systems authoritatively and convincingly.

Dr. Harrer proposes a regulatory framework with 10 principles for mitigating the risks of generative AI in health care:

1. Design AI as an assistive tool for augmenting the capabilities of human decision makers, not for replacing them.
2. Design AI to produce performance, usage and impact metrics explaining when and how AI is used to assist decision making and scan for potential bias.
3. Study the value systems of target user groups and design AI to adhere to them.
4. Declare the purpose of designing and using AI at the outset of any conceptual or development work.
5. Disclose all training data sources and data features.
6. Design AI systems to label any AI-generated content clearly and transparently as such.
7. Ongoingly audit AI against data privacy, safety, and performance standards.
8. Maintain databases for documenting and sharing the results of AI audits, educate users about model capabilities, limitations, and risks, and improve performance and trustworthiness of AI systems by retraining and redeploying updated algorithms.
9. Apply fair-work and safe-work standards when employing human developers.
10. Establish legal precedence to define under which circumstances data may be used for training AI, and establish copyright, liability, and accountability frameworks for governing the legal dependencies of training data, AI-generated content, and the impact of decisions humans make using such data.

Dr. Harrer said, “Without human oversight, guidance and responsible design and operation, LLM-powered generative AI applications will remain a party trick with substantial potential for creating and spreading misinformation or harmful and inaccurate content at unprecedented scale.” He predicts that the field will move from the current competitive LLM arms race to a phase of more nuanced and risk-conscious experimentation with research-grade generative AI applications in health, medicine, and biotech, which will deliver first commercial product offerings for niche applications in digital health data management within the next 2 years. “I am inspired by thinking about the transformative role generative AI and LLMs could one day play in health care and

1 medicine, but I am also acutely aware that we are by no means there yet and that despite the
 2 prevailing hype, LLM-powered generative AI may only gain the trust and endorsement of
 3 clinicians and patients if the research and development community aims for equal levels of ethical
 4 and technical integrity as it progresses this transformative technology to market maturity.”

5
 6 “Ethical AI requires a lifecycle approach from data curation to model testing, to ongoing
 7 monitoring. Only with the right guidelines and guardrails can we ensure our patients benefit from
 8 emerging technologies while minimizing bias and unintended consequences,” said John Halamka,
 9 MD, MS, President of Mayo Clinic Platform, and a co-founder of the Coalition for Health AI
 10 (CHAI).⁵⁶

11
 12 “This study provides important ethical and technical guidance to users, developers, providers, and
 13 regulators of generative AI and incentivizes them to responsibly and collectively prepare for the
 14 transformational role this technology could play in health and medicine,” said Brian Anderson,
 15 MD, Chief Digital Health Physician at MITRE.⁵⁷

16 17 REGULATORY FRAMEWORK FOR USE OF GENERATIVE AI IN MEDICINE

18
 19 AMA’s President Jesse Ehrenfeld, MD, MPH co-chairs the AI committee of the Association for the
 20 Advancement of Medical Instrumentation (AAMI)⁵⁸ and co-authored an article, “Artificial
 21 Intelligence in Medicine & ChatGPT: De-Tether the Physician,” published in the *Journal of*
 22 *Medical Systems*. He says, “A competitive marketplace requires regulatory flexibility from the
 23 Federal Drug Administration (FDA). Regulation of AI systems is still in its infancy but AI that
 24 improves physician workflow should require less regulatory oversight than algorithms that make
 25 diagnoses, recommend treatments, or otherwise impact clinical decision making. While AI
 26 algorithms may one day independently learn to read CT scans, identify skin lesions, and provide
 27 medical diagnoses, the low-hanging fruit is in improving physician efficiency, e.g., de-tethering
 28 clinicians from the computer. This should be embraced by the health care industry now.”
 29 Physicians have a critical role to play in this endeavor. Without physician knowledge, expertise and
 30 guidance on design and deployment, most of these digital innovations will fail, he predicted. They
 31 will not be able to achieve their most basic task of streamlining workflows and improving patient
 32 outcomes.

33
 34 Dr. Ehrenfeld said, the AMA is working closely with the FDA to support efforts that create new
 35 pathways and approaches to regulate AI tools:

- 36
 37 • Any regulatory framework should ensure that only safe, clinically validated, high-quality
 38 tools enter the marketplace. “We can’t allow AI to introduce additional bias” into clinical
 39 care, cautioning that this could erode public confidence in the tools that come to the
 40 marketplace.⁵⁹
- 41
 42 • There also needs to be a balance between strong oversight and ensuring the regulatory
 43 system is not overly burdensome to developers, entrepreneurs, and manufacturers, “while
 44 also thinking about how we limit liability in appropriate ways for physicians,” added Dr.
 45 Ehrenfeld.
- 46
 47 • The FDA has a medical device action plan on AI and machine-learning software that
 48 would enable the agency to track and evaluate a software product from premarket
 49 development to post market performance.⁶⁰ The AMA has weighed in on the plan, saying
 50 the agency must guard against bias in AI and focus on patient outcomes.⁶¹

1 In April 2023, the European Union (EU) proposed new copyright rules for generative AI.⁶² In its
2 most recent AI Act, the EU requires that AI-generated content be disclosed to consumers to prevent
3 copyright infringement, illegal content, and other malfeasance related to end-user lack of
4 understanding about these systems.⁶³ As more chatbots mine, analyze, and present content in
5 accessible ways for users, findings are often not attributable to any one or multiple sources, and
6 despite some permissions of content use granted under the fair use doctrine in the United States
7 that protects copyright-protected work, consumers are often left in the dark around the generation
8 and explanation of the process and results.⁶⁴

10 In the United States, the U.S. Food and Drug Administration (FDA) published a regulatory
11 framework for AI applications in medicine in April 2019 and an action plan in January 2021. The
12 FDA's leadership role in formulating regulatory guidance is a manifestation of the broader U.S.
13 national approach to the regulation of AI. In contrast to the EU, the U.S. policy sustains from broad
14 and comprehensive regulation of AI and instead delegates responsibilities to specific federal
15 agencies, with an overarching mandate to avoid overregulation and promote innovation.⁶⁵

17 CLRPD DISCUSSION

19 Generative AI systems are not sentient, they simply use massive amounts of text to predict one
20 word after another, and their outputs may mix truth with patently false statements. As such,
21 physicians will need to learn how to integrate these tools into clinical practice, defining clear
22 boundaries between full, supervised, and proscribed autonomy. Physicians should be clear-eyed
23 about the risks inherent to any new technology, especially ones that carry existential implications,
24 while cautiously optimistic about a future of improved health care system efficiency, better patient
25 outcomes, and reduced burnout.

27 Extant AI-assistant programs and rapidly developing systems are incredibly sophisticated, and as
28 physicians have already begun to demonstrate on social media, they might soon be able to reliably
29 perform test result notifications, work letters, prior authorizations, and the like—the mundane
30 necessities that not only cumulatively consume valuable time but are a substantial contributor to
31 physician burnout.

33 Projecting further into an AI-enhanced future, imagine that instead of writing discharge
34 instructions, physicians could ask a generative AI system to create a synopsis of the patient's
35 hospital course. With the time saved, physicians could step away from the computer, go to the
36 patient's room, and explain the most salient follow-up items face-to-face, prepped with materials
37 that are compatible with best practices in health literacy. Integrating AI into routine clinical
38 practice will require careful validation, training, and ongoing monitoring to ensure its accuracy,
39 safety, and effectiveness in supporting physicians to deliver care. While AI can be an asset in the
40 medical field, it cannot replace the human element. However, AI can and should be used to
41 enhance the practice of medicine, empowering physicians with the latest technological tools to
42 serve our patients better. Moreover, Generative AI may provide physicians with a future that
43 enables them to fully experience the reason why they decided to pursue medicine in the first
44 place—to interact with their patients.

46 The AMA has addressed the importance of AI, has advocated for the use of the expression
47 augmented intelligence, and has assumed thought leadership with its reports and guidelines for
48 physicians. AMA policy states, “as a leader in American medicine, our AMA has a unique
49 opportunity to ensure that the evolution of AI in medicine benefits patients, physicians, and the
50 health care community.”

Relevant AMA Policy

Augmented Intelligence in Health Care H-480.939⁶⁶

Augmented Intelligence in Health Care H-480.940⁶⁷

Augmented Intelligence in Medical Education H-295.857⁶⁸

Professionalism in Health Care Systems E-11.2.1⁶⁹

Assessing the Potentially Dangerous Intersection Between AI and Misinformation H-480.935⁷⁰

Three AI-related resolutions were introduced for consideration by the House of Delegates at the 2023 AMA Annual Meeting. They were combined into one measure, RES 609-A-23 Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development, urging physicians to educate patients on benefits and risks and directing the AMA to work with the federal government to protect patients from false or misleading AI-generated medical advice. The HOD action was referral. A BOT report is scheduled for consideration by the HOD at the 2024 AMA Annual Meeting.

Specifically, the AMA was directed to:

- Study and develop recommendations on the benefits of and unforeseen consequences to the medical profession of large-language models (LLMs) such as generative pretrained transformers (GPTs) and other augmented intelligence-generated medical advice or content.
- Propose appropriate state and federal regulations with a report back at the 2024 AMA Annual Meeting.
- Work with the federal government and other appropriate organizations to protect patients from false or misleading AI-generated medical advice.
- Encourage physicians to educate patients about the benefits and risks of LLMs including GPTs.
- Support publishing groups and scientific journals to establish guidelines to regulate the use of augmented intelligence in scientific publications that include detailing the use of augmented intelligence in the methods and exclusion of augmented intelligence systems as authors and the responsibility of authors to validate veracity of any text generated by augmented intelligence.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-I-23

Subject: Update on Continuing Board Certification

Presented by: Cynthia Jumper, MD, MPH, Chair

Referred to: Reference Committee C

At the 2022 Annual Meeting, the House of Delegates (HOD) called upon the American Medical Association (AMA) to “continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a report regarding the CBC process at the request of the House of Delegates or when deemed necessary by the Council on Medical Education” (Policy [D-275.954](#)). This policy resulted from [CME Report 2-A-22](#), “An Update on Continuing Board Certification,” which provided a detailed account of updates as well as a list of improvements to assessment of knowledge, judgment, and skills (Part III) and improvement in medical practice (Part IV) found in the appendix.

Further, the AMA reaffirmed Policy [H-275.924](#), “Continuing Board Certification,” at the 2022 Interim Meeting and amended Policy D-275.954 to include a new clause that the AMA “continue to publicly report its work on enforcing AMA Principles on Continuing Board Certification.”

Given the interest of the HOD demonstrated at A-22 and I-22, the Council offers this informational report to provide allopathic and osteopathic updates on CBC since the last report was adopted at A-22.

BACKGROUND

CBC is an ongoing process that simultaneously supports diplomates in keeping their knowledge and skills current while validating their increasing expertise in a specialty. First established in 1933, the American Board of Medical Specialties (ABMS) is comprised of 24 certifying boards, representing nearly one million active board-certified physicians. The ABMS oversees continuing certification, and its mission is “to serve the public and the medical profession by improving the quality of health care through setting professional standards for lifelong certification in partnership with Member Boards.”¹ The ABMS has been very engaged in the continued evolution of CBC. Such efforts are summarized in this report.

Standards for Continuing Certification

In 2018, the ABMS formed an independent body comprised of 27 individuals representing diverse stakeholders called the [Vision for the Future Commission](#) (“Commission”). They were tasked with reviewing continuing certification within the current context of the medical profession. The Commission released draft recommendations, on which the AMA Council on Medical Education provided comments.² The Commission released their final report in 2019, which contained research, testimony, and public feedback from stakeholders throughout the member boards and

health care communities. The report offered 14 recommendations intended to modernize CBC and included a commitment by the ABMS to develop new, integrated Standards for continuing certification programs.³ Delayed due to the COVID-19 pandemic, the final [Standards](#) were released in late 2021.⁴ The Commission and new Standards are described in detail in [CME 2-A-22](#).⁵

ALLOPATHIC CONTINUING CERTIFICATION UPDATES

As of June 30, 2022, the ABMS database of board certification reflects 975,000 ABMS board-certified diplomates across 40 specialties and 89 subspecialties. Among them, 690,518 diplomates participate in continuing certification.⁶ Board-certified diplomates are required to participate in continuing certification; however, some individuals do not as the requirement may not have been in place when they were first certified. Voluntary participation is strongly encouraged.

ABMS Strategic Plan

In 2022, the ABMS began drafting a five-year [Strategic Plan](#) (2023-2028) to define major needs, expectations, and opportunities and define guiding themes and topics (“imperatives”) as well as to anticipate key changes and new demands in the external environment.⁷ Approximately 100 individuals from ABMS, the Member Boards, and partner organizations participated in the development of this plan and formed 10 workgroups using a community-based process of exploration, discussion, and decision-making while also being mindful of internal and external conditions. The title of each workgroup represents an identified “imperative.” The titles/imperatives are Advocacy; Communications; Culture; Diversity, Equity, and Inclusion (DEI); Governance; Innovation; Metrics; Products and Services; Professionalism; and Program Evaluation. Each workgroup developed an aim and strategic goals for their respective imperative. These imperatives are represented within five strategic themes. Specific initiatives and tactics are being established and deployed to meet the goals of these five strategic themes: increase value for stakeholders, promote professionalism, commit to DEI, promote and protect the ABMS brand, and enhance ABMS culture and decision-making. More information is available in the [Executive Summary](#) of the strategic plan.⁸

Given the advent of the workgroups and plan, the previous task forces of the Vision Commission were disbanded. Those task forces, as described in CME 2-A-22, were: Achieving the Vision, Improving Health & Health Care, Information and Data Sharing, Professionalism, Remediation, and Standards.

ABMS Committees

The Committee on Continuing Certification (“3C”) oversees the review process of Member Boards’ continuing certification programs and any progress regarding the implementation of the new Standards by collecting data, developing metrics, and monitoring progress toward meeting the new Standards. Also, 3C reviews and makes recommendations for program and policy improvements, performance standards, security considerations, and psychometric characteristics of longitudinal assessment programs. ABMS staff provide additional support to the Member Boards. This committee continues to work with Member Boards to review assessment data and make recommendations for modifications in their longitudinal assessment programs. Specifically, a Psychometrician Advisory Group is working to define best practices for Member Boards so that 3C may consider them in designing and assessing continuing certification assessments.

The ABMS Stakeholder Council, established in 2018 to ensure that the decisions of the ABMS Board of Directors are grounded in an understanding of the perspectives, concerns, and interests of

the multiple constituents impacted by ABMS' work, is an advisory body representing the viewpoints of practicing physicians, patients, and the public. Since the publication of the Council on Medical Education's last *Update on Continuing Board Certification*, the Stakeholder Council has provided guidance to the ABMS Board of Directors regarding a comprehensive communications strategy, including engagement with hospitals, patients, and diplomates; offered input into ABMS' recently completed five year strategic planning process; described insights related to a more transparent display of diplomate certification status; shared thinking regarding how to better communicate recent changes to ABMS Member Board certification programming; reviewed a draft ABMS policy related to diplomate professionalism; discussed the role of Member Boards in supporting diplomate mental health; and made recommendations in support of efforts related to diversity, equity, and inclusion.

The Accountability and Resolution Committee (ARC) is a dispute resolution body that has jurisdiction over allegations against directors or members of the ABMS regarding violations of or a failure to comply with actions or standards adopted by the Board of Directors; the amended and restated bylaws of the ABMS; and any other policies, procedures, regulations, rules, or standards adopted by the Board of Directors. Upon receipt of a referral for noncompliance that has not been resolved through other mechanisms, ARC is authorized to attempt to resolve the complaint through an established dispute resolution process, after which it may issue findings of fact and recommendations to the Board of Directors for its consideration and adoption. The ARC also maintains oversight of the ABMS Organizational Standards, which establish core standards for the Member Boards regarding issues related to organizational mission; governance and leadership; financial and organizational management; stakeholder engagement; examinations; and data management.

After the release of the new Standards, the ABMS formed the Improving Health and Health Care Learning Collaborative (IHHC-LC) to assist Member Boards with meeting Standards 18 and 19. They host quarterly meetings to foster meaningful engagement opportunities for diplomates across all specialties.

Updates and Innovations in Assessment

All 24 ABMS Member Boards have implemented formative assessments for continuing certification since the release of ABMS' Vision [recommendations](#), which called for Member Boards to create formative processes that offer opportunities for learning and improvement and an alternative to the secure, point-in-time examinations of knowledge. Longitudinal assessment is now implemented by 17 of the Member Boards, offering assessments that are shorter, content specific, current, and based on needs and interests; recurring assessments over time to reinforce concepts and promote retention; ongoing performance feedback to note areas of additional learning; and follow-up assessments to gauge proficiency. Physicians can choose when, where, and how they answer questions given accessibility of longitudinal assessments on personal devices. Of the 17, seven Member Boards execute their longitudinal assessments via [CertLink®](#), a technology platform developed by ABMS; more than four million questions have been answered to date. Further updates from Member Boards include:

- Four boards now provide point-in-time knowledge assessments, offered at less frequent intervals (e.g., semi-annual, every three years). They are the American Board of Allergy and Immunology (ABAI), American Board of Emergency Medicine, American Board of Neurological Surgery, and American Board of Surgery.
- Three boards have implemented "customized to practice" assessments whereby physicians can select from among topic areas based on practice setting and/or patient mix. They can be question-based and use multiple-choice questions or article-based and involve

reviewing articles and responding to related questions. They are the American Board of Obstetrics & Gynecology (ABOG), American Board of Psychiatry and Neurology (ABPN), and American Board of Thoracic Surgery (ABTS).

- Eight boards no longer offer the traditional exam. They are the American Board of Colon and Rectal Surgery, American Board of Dermatology, American Board of Emergency Medicine, American Board of Medical Genetics and Genomics, American Board of Neurological Surgery, American Board of Ophthalmology, American Board of Pathology, American Board of Plastic Surgery, and ABTS.
- Three boards only use the traditional exam for re-entry. They are the American Board of Anesthesiology, American Board of Urology, and ABAI.
- Twelve boards have elected to keep an exam option, at the discretion of the physician. They are the American Board of Family Medicine, American Board of Internal Medicine, American Board of Nuclear Medicine, American Board of Orthopaedic Surgery, American Board of Otolaryngology – Head and Neck Surgery (2023 is the last year), American Board of Pediatrics, American Board of Physical Medicine and Rehabilitation, American Board of Preventive Medicine, American Board of Radiology, ABU, ABOG, and ABPN (ABMS, written communications, June-August, 2023).

In addition, there are examples of new board-specific innovations. According to the ABMS, the American Board of Pediatrics (ABP) reports that nearly 30,000 board-certified pediatricians and pediatric subspecialists now participate in an ABP continuing certification activity called “Question of the Week.” It provides participants with relevant, high-quality questions and supporting material. Each question features a case scenario, pre-test, abstract, commentary, and final question. Participants can answer as many questions as they wish and can share their thoughts with each other by leaving comments. Feedback to ABP has been positive.

In 2024, the American Board of Internal Medicine (ABIM), in collaboration with the Society of Hospital Medicine, will launch assessment options designed for those who practice primarily in an inpatient setting, including an Internal Medicine Longitudinal Knowledge Assessment (LKA[®]) and a traditional, 10-year exam. These options will be available to any eligible diplomate certified in internal medicine.

Following the successful pilot and launch of longitudinal assessment for continuing certification in Physical Medicine and Rehabilitation, the American Board of Physical Medicine and Rehabilitation (ABPMR) will offer longitudinal assessment for Brain Injury Medicine (LA-BIM). Starting in 2024, this assessment for continuing certification in BIM is shorter and will be offered quarterly with a five-year cycle. The BIM examination will be offered for diplomates with cycle end dates in 2024. All BIM diplomates are encouraged to participate in LA-BIM to continue their certification.

ABMS Portfolio Program

The [ABMS Portfolio Program](#)[™] enables a national network of organizations (“sponsors”) to assist physicians and physician assistants in submitting their quality improvement (QI) efforts for continuing certification credit. Program sponsors administer activity submissions and attestation approvals and send confirmation of activity completion to ABMS. These sponsors have facilitated more than 27,000 individuals in receiving certification credit for thousands of QI activities. The ABMS supports a myriad of [sponsors](#) including the AMA. To aid sponsors in their work, ABMS offered a webinar in May 2023 entitled “Offer a More Meaningful and Relevant QI Experience with the ABMS Portfolio Program” that featured two program sponsors who are creating thriving programs in their organization.

Exploring Competency-Based Medical Education

The ABMS is collaborating with the Accreditation Council for Graduate Medical Education (ACGME) to investigate competency-based medical education (CBME) as it relates to CBC. The ACGME accredits programs that assess individuals during residency, and the ABMS Member Boards assess individuals for specialty certification as they make the transition from training into practice. Given some of the boards are incorporating, piloting, or exploring assessment approaches as part of a CBME model, this collaborative will foster communication and information sharing.

OSTEOPATHIC CONTINUING CERTIFICATION UPDATES

The American Osteopathic Association (AOA) is the professional home for more than 178,000 osteopathic physicians (DOs) and medical students. AOA offers board certification in 27 primary specialties and 48 subspecialties (including certificate of added qualification). Nine of the 48 subspecialties are conjoint certifications managed by multiple AOA specialty boards. As of December 31, 2022, a total of 39,111 physicians held 46,101 active certifications issued by the AOA's specialty certifying boards. AOA Certifying Board Services Department, in collaboration with each of the 16 osteopathic medical specialty certifying boards, develops and implements certification programs and assessments. With the guidance of the AOA Bureau of Osteopathic Specialists, specialty certifying boards commit to enhancing board certification services that better serve candidates and diplomates pursuing and maintaining AOA board certification and life-long learning. AOA specialty certifying boards provide a modernized, expedited approach to the delivery of relevant and meaningful competency assessment for board-certified diplomates. As part of Osteopathic Continuous Certification (OCC), longitudinal assessment programs have been developed and implemented for each of the 27 primary specialty board certifications. The longitudinal assessments replaced the high stakes recertification exams previously required. AOA specialty certifying boards are beginning the process of developing longitudinal assessment programs for 14 of the subspecialty board certifications, five of which are anticipated to launch in 2024. AOA continues to offer its candidates and diplomates online remote proctored delivery of its certification and OCC exams. (AOA, written communications, June-August, 2023).

LITERATURE REVIEW

The body of evidence regarding the value and importance of CBC continues to grow. A review of the literature published between January 1, 2022 – July 4, 2023, illuminated a number of relevant articles addressing continuing certification and maintenance of certification. An annotated bibliography of such articles can be found in Appendix A of this report.

AMA ENGAGEMENT IN CBC

Council on Medical Education

The AMA and its [Council on Medical Education](#) (CME) have been actively engaged in the evolution of CBC, formerly called maintenance of certification (MOC) in past reports and resolutions, for many years. At this time, the Council has made available on its [webpage](#) 18 reports addressing certification and licensure since 2012. These reports are informed by the work of the ABMS. The board certification program of the ABMS provides continuous development and professional assessment.

The CME maintains a close relation with the ABMS and its member boards. The 2023-2024 chair of the Council also serves as a member of the ABMS Stakeholders Council. Dr. Richard Hawkins,

1 president and CEO of the ABMS, was invited by the Council to attend its fall 2022 meeting to
 2 provide an update on the new [Standards](#) for continuing certification. He also presented to the AMA
 3 on April 5, 2023, co-hosted by the Academic Physician Section and Young Physician Sections, to
 4 further discuss the new Standards as well as share related concerns from physicians and the ABMS
 5 response to those concerns. Dr Hawkins also discussed structural changes to ABMS governance
 6 and the organization's collaboration with associate members. He clarified current misinformation.
 7 Further, the Council invited Dr. Hawkins to attend their assembly during the 2023 Annual Meeting.
 8 Dr. Hawkins shared that they've received largely favorable feedback on the new Standards. Boards
 9 are working on their implementation plans given that the Standards take effect January 1, 2024; the
 10 Council asked that ABMS consider challenges faced by physicians in independent private practice.
 11 Also, Dr. Hawkins reported on their collaboration with ACGME on CBME and attentiveness to
 12 equity in assessment. He shared concerns regarding alternative certifying bodies, specifically the
 13 National Board of Physicians and Surgeons, citing how they fall short of the norms set by the
 14 ABMS as publicly addressed in their July 2022 [statement](#).⁹ Lastly, Dr. Hawkins shared that ABMS
 15 is looking into ways continuing certification can promote well-being and decrease burnout.

16
 17 In addition, the Council will proffer a report at the 2023 Interim Meeting that provides an overview
 18 of several entities that provide board certification including the ABMS, AOA Bureau of
 19 Osteopathic Specialists (BOS), National Board of Physicians and Surgeons (NBPAS), American
 20 Board of Physician Specialties (ABPS), and American Board of Cosmetic Surgery (ABCS) and
 21 how their standards for board certification differ. It is important to note that while there are
 22 different ways to achieve continuing board certification, it is debatable whether they produce the
 23 same outcomes for patients.

24 *Relevant AMA policies*

25
 26
 27 AMA policy related to CBC and lifelong learning can be accessed in the [AMA PolicyFinder](#)
 28 database. Policies most relevant to CBC are provided in Appendix B and are listed here:

- 29 • [H-275.924](#), "Continuing Board Certification"
- 30 • [D-275.954](#), "Continuing Board Certification"
- 31 • [H-275.926](#), "Medical Specialty Board Certification Standards"
- 32 • [D-275.957](#), "An Update on Maintenance of Licensure"

33 34 CONCLUSION

35
 36 The AMA will continue to monitor the evolution of CBC and provide updates, as directed by this
 37 House of Delegates. The Council is grateful to ABMS and AOA for their contributions to the
 38 creation of this report. Following this report, the Council will provide further updates in the form of
 39 issue briefs as pertinent information arises. In the event of significant changes to CBC impacting
 40 practicing physicians, the Council will consider initiating a report to the House of Delegates.
 41 Reports and issue briefs are posted to the Council's report [webpage](#) and promoted through various
 42 AMA medical education communications. Reports can also be found via the AMA [Council Report](#)
 43 [Finder](#) search tool.

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 47 Fiscal note: \$500

APPENDIX A: ANNOTATED BIBLIOGRAPHY

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APPENDIX B: RELEVANT AMA POLICIES

H-275.924, Continuing Board Certification

AMA Principles on Continuing Board Certification

1. Changes in specialty-board certification requirements for CBC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in CBC must be reasonable and take into consideration the time needed to develop the proper CBC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the CBC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for CBC.
4. Any changes in the CBC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. CBC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of CBC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for CBC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of CBC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with CBC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): “Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for CBC Part II. The content of CME and self-assessment programs receiving credit for CBC will be relevant to advances within the diplomate’s scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit”, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A).”
10. In relation to CBC Part II, our AMA continues to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. CBC is but one component to promote patient safety and quality. Health care is a team effort, and changes to CBC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. CBC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The CBC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. CBC should be used as a tool for continuous improvement.

15. The CBC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing CBC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. CBC activities and measurement should be relevant to clinical practice.
19. The CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in CBC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in CBC.
27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Continuing Board Certification from their specialty boards. Value in CBC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of CBC requirements with other regulator and payer requirements, and adherence to an evidence basis for both CBC content and processes.

D-275.954, Continuing Board Certification

Our AMA will:

1. Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a report regarding the CBC process at the request of the House of Delegates or when deemed necessary by the Council on Medical Education.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review CBC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.

6. Work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physician's current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC; (b) support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether CBC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of CBC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.
22. Continue to participate in the Coalition for Physician Accountability, formerly known as the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.
24. Continue to assist physicians in practice performance improvement.

25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's CBC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.
28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.
29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
34. Increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.
35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.
36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.
37. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.
38. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS) and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development and release of new, integrated standards for continuing certification programs that will address the Commission's recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency.
39. Our AMA will work with the ABMS and its member boards to reduce financial burdens for physicians holding multiple certificates who are actively participating in continuing certification

through an ABMS member board, by developing opportunities for reciprocity for certification requirements as well as consideration of reduced or waived fee structures.

40. Our AMA will continue to publicly report its work on enforcing AMA Principles on Continuing Board Certification.

H-275.926, Medical Specialty Board Certification Standards

1. Our AMA:

- (1) Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
- (2) Opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
- (3) Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, the certification program must first meet accepted standards for certification that include both a) a process for defining specialty-specific standards for knowledge and skills and b) offer an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty. In addition, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination.
- (4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
- (5) Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
- (6) Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.

D-275.957, An Update on Maintenance of Licensure

Our American Medical Association will: 1. Continue to monitor the evolution of Maintenance of Licensure (MOL), continue its active engagement in discussions regarding MOL implementation, and report back to the House of Delegates on this issue.

2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOL issues.

3. Work with the Federation of State Medical Boards (FSMB) to study whether the principles of MOL are important factors in a physician's decision to retire or have a direct impact on the U.S. physician workforce.

4. Work with interested state medical societies and support collaboration with state specialty medical societies and state medical boards on establishing criteria and regulations for the

implementation of MOL that reflect AMA guidelines for implementation of state MOL programs and the FSMB's Guiding Principles for MOL.

5. Explore the feasibility of developing, in collaboration with other stakeholders, AMA products and services that may help shape and support MOL for physicians.

6. Encourage the FSMB to continue to work with state medical boards to accept physician participation in the American Board of Medical Specialties maintenance of certification (MOC) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and advocate that MOC or OCC not be the only pathway to MOL for physicians.

7. Continue to work with the FSMB to establish and assess MOL principles, with the AMA to assess the impact of MOL on the practicing physician and the FSMB to study its impact on state medical boards.

8. Encourage rigorous evaluation of the impact on physicians of any future proposed changes to MOL processes, including cost, staffing, and time.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-I-23

Subject: Physician-Owned Hospitals

Presented by: Sheila Rege, MD, Chair

At the 2023 Annual Meeting, the House of Delegates adopted Policy D-215.983, Physician-Owned Hospitals, which asked the American Medical Association (AMA) to study and research the impact of the repeal of the ban on physician-owned hospitals (POHs) on the access to, cost, and quality of patient care and the impact on competition in highly concentrated hospital markets.

The Council presents this informational report, which provides background on POHs, and highlights extensive AMA policy and advocacy to repeal the ban on physician-owned hospitals.

BACKGROUND

There are more than 250 hospitals in the United States that are owned and operated by physicians, under various models: community hospitals, specialty hospitals, joint ventures, and rural hospitals. Community hospitals provide the services of a full-service hospital, such as labor and delivery, I&CU care, and surgery. Specialty hospitals focus on certain specialties, such as cardiac care, orthopedic care, or children's hospitals. Many nonprofit community hospital systems across the country choose to partner with physicians in joint venture models. In some cases, physicians own 100 percent of the hospital. In joint venture arrangements, a nonprofit community hospital system holds majority ownership and physicians have a minority stake. One in eight POHs serve rural communities in the United States.¹

POHs first arose in the early 1980s in response to the rise of managed care and the corporatization of medical practice, as physicians sought to acquire control and ownership over their practice environment. Early health care services research highlighted concerns regarding physician self-referral in multiple markets, including physical therapy and radiological services. These findings, along with work of the General Accounting Office (GAO), led to the passage of the series of statutory reforms known as the "Stark Laws." These legislative provisions regulated and restricted physician self-referral in Medicare – and later Medicaid – for a variety of services in which physicians have a financial interest. Physician self-referral laws prohibit physicians from making referrals for certain services payable by Medicare to an entity with which the physician has a financial relationship. However, under the "whole hospital exception" a physician could refer a patient to a facility in which the physician was authorized to perform services only if he or she had an interest in the whole hospital, as opposed to a specific department.²

IMPACT OF THE AFFORDABLE CARE ACT

The Affordable Care Act (ACA) was passed in 2010 with a focus on expanding insurance coverage, creating robust competition in state insurance markets, and reducing both health insurance costs and health care costs. Section 6001 of the ACA placed new restrictions on the expansion of existing POHs and the creation of new ones; however, POHs established prior to the ACA being signed into law were given an exception and allowed to continue operations.³ Section

6001 of the ACA amended section 1877 of the Social Security Act to impose additional requirements for POHs to qualify for the whole hospital and rural provider exceptions. After its passage, POHs were prohibited from expanding facility capacity. However, a POH that qualified as an applicable hospital or high Medicaid facility could request an exception to the prohibition from the Secretary of the Department of Health and Human Services.⁴ As a result, the consequences of the ACA's virtual statutory ban on POHs were significant. More than \$275 million of planned economic activity spread across 45 hospital expansion projects ceased. More than 75 new hospitals either planned or under development were prematurely terminated, representing more than \$2.2 billion in economic losses. Non-financial losses include the loss of the "physician entrepreneur" and innovation in the face of increasing corporatization of medical practice, both likely contributing to the increase in physician professional dissatisfaction.⁵

Of the more than 250 POHs across 33 states, few, if any, could survive without Medicare or Medicaid funds. By contrast, there are approximately 5,000 public or for-profit hospitals in the United States.⁶ According to the AMA's Physician Practice Benchmark Survey, the share of practicing physicians who owned their practices dropped below 50 percent for the first time in 2016.⁷ The most recent data from the AMA's Physician Practice Benchmark Survey show that in 2022, 44 percent of physicians were owners of their practices, compared to 53.2 percent in 2012, and approximately 76 percent in the early 1980s. This shift represents more physicians opting to become employees at a hospital or practice instead of going into business themselves.⁸

As the federal government reviewed clinical information in the years following the passage of the ACA, it was clear that POHs were high-performing facilities. Nine of the top 10 performing hospitals were physician-owned, as were 48 of the top 100. This information was released by the Centers for Medicare & Medicaid Services (CMS) nearly three years after the ACA effectively banned these facilities from expanding and prohibited new majority physician-owned facilities from opening their doors. To date, efforts to lift the 2010 restrictions have proven unsuccessful. A lawsuit challenging that portion of the ACA was dismissed by the 5th U.S. Circuit Court of Appeals in August 2012, citing a lack of jurisdiction. Efforts to have Congress repeal Section 6001 of the ACA also have been unsuccessful.⁹

CONSOLIDATION AND MARKET IMPACT

Hospital consolidation results in the loss of both price and non-price competition. Hospital acquisition of physician practices can lead to higher prices without improvements in quality. Well-documented, specific harms of provider consolidation are many, including a lack of quality improvement and a decrease in patient satisfaction, physician burnout due to a loss of control over the practice environment, and higher hospital prices driving rising insurance premiums and ultimately rising costs to consumers.¹⁰ A September 2022 review of the Health Care Cost Institute Hospital Concentration Index, which measured market concentration in 182 metro areas across the U.S., summarized its findings as follows:

"...areas with physician-led hospitals have higher competition and lower market concentration. Only four percent of areas with physician-led hospitals were classified as very highly concentrated markets (compared to 13 percent without physician-led hospitals)."¹¹

Current market entry requirements are strict: ACA Section 6001 prohibits participation in Medicare for both new or expanded pre-existing POHs unless they meet pre-specified exceptions as a rural facility or a "high Medicaid" facility. Nonprofit and for-profit hospitals do not face this restriction. Since the passage of the ACA in 2010, only seven hospitals nationwide have been granted an exception.¹²

It is also important to note the impact of consolidation on prices. Allowing POH entrants into a market would increase competition and as a result would likely have a positive impact on price. From a competition perspective, the potential entry of additional POHs reduces the ability of incumbents to exercise market power and applies competitive pressure on price, quality, and innovation. Even the threat of such entry can improve market outcomes as incumbent hospitals keep prices and quality more competitive to avoid inviting a new entrant.¹³

COST AND QUALITY IMPLICATIONS

CMS studied physician-owned specialty hospitals and found a number of factors account for their high performance, including specialization, improved nursing staff ratios and expertise, patient amenities, patient communication and education, emphasis on quality monitoring, and clinical staff perspectives on physician ownership. Additionally, CMS found that perhaps the most essential POH efficiency is created by physician ownership itself:

“In our site visits, staff at specialty hospitals described the physician owners as being very involved in every aspect of patient care. The physicians monitored patient satisfaction data, established a culture that focused on patient satisfaction and were viewed by the staff as being very approachable and amenable to suggestions that would improve care processes.”¹⁴

Regarding costs, opponents of POHs claim that physician-owned facilities both “cherry-pick” only the healthiest patients and over-order on tests and treatments to drive up costs and increase profits. Neither of these claims have been proven to be true. Either a cherry-picking theory or a provider-induced demand theory presumes that physician owners have perverse incentives that nonprofit and investor-owned hospitals lack. Several reviews have found the claim of cherry-picking lacks consistent support in research. One review found that after controlling for a variety of factors, such as case mix, disease severity, and volume of procedures, research results on quality metrics were highly favorable for specialty POHs and neutral for general acute care POHs. In contrast, cost evidence was neutral to favorable, suggesting that specialty POHs tended to have lower or similar costs, while general acute care POHs tended to be similar in costs.¹⁵

AMA POLICY AND ADVOCACY

Policy H-215.960, established by [Council on Medical Service Report 7-A-19](#), states that the AMA will continue to support actions that promote competition and choice including repealing the ban on physician-owned hospitals, and the AMA has been active in implementing this policy. Policy H-215.960 also states that the AMA strongly supports and encourages competition in all health care markets.

In June 2023, the AMA [sent a letter to the U.S. House of Representatives](#) and [U.S. Senate](#) in support of H.R. 977 and S. 470 – The Patient Access to Higher Quality Health Care Act of 2023. This bipartisan legislation would repeal limits to the whole hospital exception of the Stark physician self-referral law, which essentially bans physician ownership of hospitals and places restrictions on expansion of already existing POHs.^{16,17}

The AMA also [submitted comments](#) in June 2023 on the 2024 Inpatient Prospective Payment System proposed rules. CMS proposes to reinstate restrictions on POHs that both qualify as high Medicaid facilities and are seeking exceptions to the prohibition on expanding facility capacity. In addition, the agency proposed to expand its authority regarding approval of exceptions to the prohibition on expanding facility capacity and to increase the type of relevant community input, as well as to double the length of the community input period. The AMA strongly opposes the

1 proposals to revoke the flexibilities for POHs that service greater numbers of Medicaid patients, to
2 increase the agency's regulatory authority to grant or deny exceptions to expansion, and to expand
3 the scope of community input. The AMA believes these proposals limit the capacity of POHs to
4 increase competition and choice in communities throughout the country and more significantly,
5 limit patients' access to high-quality care. The AMA believes that in the proposed rule, CMS
6 provides a one-sided rationale to support its proposals restricting POHs. CMS' own study in 2003
7 found a number of factors that account for the high performance of POHs, including specialization,
8 improved nursing staff ratios and expertise, patient amenities, patient communication and
9 education, an emphasis on quality monitoring, and clinical staff perspectives on physician
10 ownership.¹⁸ Unfortunately, CMS published the Final Rule in August 2023 and moved forward
11 with enacting restrictions on POHs. An excerpt from the Final Rule states:

12
13 "As we have stated in previous rulemakings, we are concerned that, when physicians have a
14 financial incentive to refer a patient to a particular entity, that incentive can affect utilization,
15 patient choice and competition. Physicians can overutilize by ordering items and services for
16 patients that absent a profit motive, they would not have ordered. A patient's choice is
17 diminished when physicians steer patients to less convenient, lower quality, or more expensive
18 providers of health care just because the physicians are sharing profits with, or receiving
19 remuneration from, the quality, service, or price." (80 FR 41926 and 81 FR 80533)¹⁹

20
21 The AMA has recently [provided comments to the U.S. Senate Finance Committee](#),²⁰ the [U.S.](#)
22 [House Committee on Ways and Means](#),²¹ and the [U.S. House Committee on Energy and](#)
23 [Commerce](#)²² all in support of physician-owned hospitals and repealing the existing ban.
24 Additionally, in July 2023, the AMA [supported a sign-on letter to Congress](#) in support of the
25 Patient Access to Higher Quality Health Care Act (S. 470/H.R. 977) which supports repealing the
26 ban on physician-owned hospitals.²³

27 28 CONCLUSION

29
30 Longstanding AMA policy supports the repeal of the ban on POHs, and the AMA has been actively
31 advocating for the repeal as recently as 2023. The AMA's June 2023 letter of support for the
32 Patient Access to Higher Quality Health Care Act of 2023 underscores that POHs have been shown to
33 provide high-quality care to the patients they serve. The Council believes that not only does
34 limiting the viability of the POHs reduce access to quality medical care, but it also reduces
35 competition in hospital markets to the detriment of the communities these hospitals serve.

36
37 One of the strongest opponents of POHs is the American Hospital Association (AHA). In a
38 [comment letter to Congress on H.R. 977/S.470](#), the AHA claims that POHs "provide limited or no
39 emergency services, relying instead on publicly funded 911 services when their patients need
40 emergency care." However, the majority of POHs are generally equipped with several hundred
41 beds and large emergency departments similar to community hospitals. A report by CMS in 2005
42 found that physician-owned cardiac hospitals resembled full-service hospitals with emergency
43 departments, whereas orthopedic hospitals and general surgical specialty hospitals more closely
44 resemble Ambulatory Surgery Centers (ASCs) which focus on outpatient services or cases with a
45 reasonable expectation of limited hospitalizations. For example, POHs with specialty care, like
46 cardiac care, closely resemble full-service hospitals with emergency departments, while POHs that
47 specialize in orthopedic care closely resemble other outpatient facilities or ASCs. The differences
48 are driven by services provided to patients and are not driven by the ownership structure of the
49 hospital.²⁴

1 Additionally, in their comment letter, the AHA claims that “physician self-referral also leads to
2 greater utilization of services and higher costs.” The Council believes that this is also a
3 misrepresentation. CMS studied referral patterns associated with specialty hospitals among
4 physician owners relative to their peers and ultimately stated: “We are unable to conclude that
5 referrals were driven primarily based on incentives for financial gain.” Several studies looking at
6 the effect of hospital ownership on health care utilization have concluded that physician ownership
7 does not lead to an increased volume of surgeries being performed, suggesting that any evidence of
8 increased utilization is at best mixed.²⁵

9
10 Finally, the AHA claims that “physician-owned hospitals tend to cherry-pick the most profitable
11 patients, jeopardizing communities’ access to full-service care.” To the contrary, evidence indicates
12 that physician-owned hospitals do not “cherry-pick” patients. For example, CMS studied referral
13 patterns associated with specialty hospitals among physician owners relative to their peers and
14 were unable to conclude that referrals were driven primarily based on incentives for financial gain.
15 Importantly, new economic research also finds strong evidence against “cherry-picking” in
16 POHs.²⁶

17
18 While the Council recognizes the challenges of a partnership with POHs, we believe there are
19 potential benefits to collaborating with interested stakeholders to promote the benefits that POHs
20 can provide to a community.

21
22 The IPPS Final Rule issued by CMS in August 2023 will make it more difficult for existing POHs
23 to expand and will not allow for new POHs to open. Even facilities deemed high Medicaid
24 facilities will not be able to expand beyond 200 percent of their baseline facility capacity, must
25 locate all approved expansion facility capacity on their main campus, and may not request an
26 expansion exception earlier than two calendar years from the date of the most recent decision by
27 CMS approving or denying the hospital’s most recent expansion request. The Final Rule changes
28 the process for community input when considering a POH’s request to expand, including doubling
29 the length of time for initial community input, as well as doubling the length of time for hospital
30 rebuttal if a request is denied.²⁷

31
32 The AMA believes that POHs provide high-quality care to patients and needed competition in
33 hospital markets. The AMA supports competition between health care providers and facilities as a
34 means of promoting the delivery of high-quality, cost-effective health care. Providing patients with
35 more choices for health care services stimulates innovation and incentivizes improved care, lower
36 costs, and expanded access.

37
38 The CMS Final Rule mischaracterizes physicians and POHs by incorrectly assuming that
39 physicians misuse resources and steer patients to use excess services and are solely driven by profit
40 motives. In contrast, POHs would increase competition and provide valuable resources to many
41 communities, including those in rural areas. CMS’ own study of physician referral patterns found
42 no evidence of “cherry-picking” or steering patients. Lifting the ban on POHs could allow
43 physicians to acquire hospitals and better enable them to implement alternative delivery and
44 payment models in an effort to control hospital costs and supervise the overall health care product.

45
46 The Council believes the AMA has clear policy to advocate for the repeal of the ban on physician-
47 owned hospitals as evidenced by recent AMA advocacy activities. The Council presents this report
48 for the information of the House and will continue to monitor this issue.

Fiscal Note: Less than \$500.

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Policy Appendix

Hospital Consolidation H-215.960

Our AMA: (1) affirms that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority; (2) will continue to support actions that promote competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency; and (3) will work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices.
(CMS Report 7, A-19; Reaffirmation: I-22)

REPORT OF THE SPEAKERS

Speakers' Report 01-I-23

Subject: Report of the Resolution Modernization Task Force Update

Presented by: Lisa Bohman Egbert, MD, Speaker; and John H. Armstrong, MD, Vice Speaker

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 Kylo, 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.

1 Pulling items off the reaffirmation consent calendar

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

10
11 Alternative Pathways

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

23
24 **Topic #3**

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

32
33 *Topic #4 Reference Committee Process*

34
35 The task force noted several concerns with the process by which resolutions move through
36 reference committees. These can be broadly separated into two main topics: Online Member
37 Forums and In-person Hearings.

38
39 Online Member Forum

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

44
45 [Policy D-600.956](#) *Increasing the Effectiveness of Online Reference Committee Testimony* initiated
46 a two-year trial of the production of a preliminary reference committee document, based on

1 testimony in the Online Member Forum during a prescribed 14 day period, which is then intended
2 to be used to inform the discussion at the in-person reference committee hearing. I-23 marks the
3 conclusion of this trial. For I-23, your Speakers established an expedited deadline system to enable
4 all items, minus the exempted items, to be included in the handbook and the forum. No addendum
5 was produced. Multiple communications were sent to the House to encourage more robust use of
6 the Forum, and the reference committees were directed to enhance their preliminary documents. As
7 of the writing of this report, the effects of these changes are unknown but are hoped to stimulate
8 better utilization of the Online Forum and that the improved preliminary documents will expedite
9 the in-person hearings.

10
11 **Topic #4**

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

15
16 **Topic #5 Reference Committee Hearings**

17
18 Your Speakers have heard several concerns regarding reference committee hearings at our recent
19 in-person meetings. Despite the earlier meeting start which allowed for more time for deliberation,
20 the volume of business before the reference committee hearings caused several to run over their
21 allotted time. Concerns have been raised that items at the end of the agenda do not receive adequate
22 discussion due to lack of attendance and significant restrictions on debate, in one instance down to
23 30 seconds. This often results in more items at the end of reference committees being extracted
24 from the consent calendar for full House deliberation. Reference committee members and
25 particularly the chairs spend significant time following the hearings in executive session and report
26 review. In addition, reference committee members and staff work, often without sleep, for
27 prolonged periods in order to complete their reports. It may be that this has become such a
28 significant time commitment that it is a reason for your Speakers having difficulty obtaining
29 enough volunteers for the reference committees at recent meetings.

30
31 **Topic #5**

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

35
36 **CONCLUSION**

37
38 The RMTF is looking forward to hearing your comments regarding the above topics at the Open
39 Forum to be held on Sunday, November 12 at 10 am. Note that this list is not meant to be all
40 inclusive but rather a guide to frame the discussion. The task force is open to hearing all comments
41 or suggestions from our House regarding improving this process.

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

The following reports, 1–4, were presented by Michael M. Deren, MD, Chair, Council on Constitution and Bylaws, and Richard M. Peer, MD, Chair, Council on Long Range Planning and Development:

1. MODIFICATIONS TO EXISTING AMA POLICIES TO BETTER GUIDE AMA POLICY DEVELOPMENT, CONSOLIDATION, SUNSET AND IMPLEMENTATION

Reference committee hearing: see report of [Reference Committee F](#).

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

As reported in Council on Constitution and Bylaws (CCB) Report 3-I-11, “AMA Policy Development, Reconciliation, Consolidation, Revision, Implementation, and Sunset,” which was adopted at the 2011 Interim Meeting of the American Medical Association (AMA) House of Delegates (HOD), the Council on Constitution and Bylaws (CCB) and the Council on Long Range Planning and Development (CLRPD) have committed to developing a methodology to consolidate AMA policies and to devise new mechanisms to guide the development of future policies and directives.

Since the 2011 Interim Meeting, both councils have reviewed existing AMA policies, and the processes and procedures that guide policy development, implementation, sunset and consolidation. Several overarching principles have guided the councils’ work in developing modifications to existing policies that are inconsistent at times and which offer no guidance to councils or the HOD in determining when to sunset or amend a policy:

- The rules, the goals, and the processes for establishing policy, revising policy, reconciling disparate policy, consolidating policies, and sunseting policy should be transparent.
- Guidelines will help the AMA councils, sections, the HOD and others be consistent in determining when a policy should be sunset rather than reaffirmed.
- Policy consolidation and revisions should occur on an accelerated schedule. The goal is to ensure that our AMA policies are accurate and comprehensive, but fewer in number.
- Policies should be sunset as soon as they are accomplished. Ten years for all policies is too long.
- All policies that have been sunset are retained in the AMA’s historical records.

In this report, the CCB and the CLRPD present recommendations for amending and consolidating these existing House policies. The councils have worked closely with the Office of House of Delegates Affairs and the Speakers, to minimize the burden on delegates and protect the democratic policymaking process. The purposes for these changes to existing policies are multi-factorial: 1) editorial changes to clarify existing policies; 2) deletion of various policy statements that have been accomplished or embodied elsewhere; 3) expansion of the policies where warranted; and 4) consolidation of several similar policies. The councils believe that adoption of these policies will greatly aid in sunseting policies that are no longer relevant or which were accomplished, as well as operationalize how policy amendments and consolidation can be accomplished.

The councils’ rationale for their recommendations are presented in Appendix A to this report. Where consolidation of like policies is being recommended, Appendix B presents the new consolidated policy. Appendix C presents the original text of all policies.

RECOMMENDATIONS

The Council on Constitution and Bylaws and Council on Long Range Planning and Development recommend that the policies listed below be acted upon in the manner indicated and that the remainder of this report be filed.

1. That Policy G-600.111 be amended by addition and deletion:

G-600.111 Consolidation of AMA Policy

Our AMA House of Delegates endorses the concept of consolidating its policies in order to make information on existing AMA policy more accessible and to increase the readability of our AMA Policy Database and our AMA PolicyFinder Program. (1) The policy consolidation process allows for ~~shall consist of two steps~~: (a) rescinding outmoded and duplicative policies, and (b) combining policies that relate to the same topic. ~~These two steps may be completed in a single report or in two separate reports to the House.~~ (2) Our AMA House requests that each AMA council, AMA section, and Board of Trustees advisory committee accept ongoing responsibility for developing recommendations on how to consolidate the policies in specific sections of our AMA Policy Database. In developing policy consolidation recommendations, our AMA councils should seek input from all relevant AMA bodies and units. Other groups represented in the House of Delegates also are encouraged to submit consolidation recommendations to the Speakers. (3) The House encourages each AMA council to develop at least one two or more policy consolidation reports each year, recommending changes that will result in significant improvements in the readability of our AMA Policy Database. (4) ~~To ensure that the policy consolidation process is limited to achieving the objective of making existing policy more accessible and readable, the recommendations in policy consolidation reports cannot be amended and must be voted upon in their entirety. The consolidation process permits editorial amendments for the sake of clarity, so long as the proposed changes are transparent to the House and do not change the meaning.~~

2. That Policy G-600.110 be amended by addition and deletion:

G-600.110 Sunset Mechanism for AMA Policy

(1) ~~As the House of Delegates adopts policies, A sunset mechanism with a maximum ten-year time horizon shall exist for all AMA policy positions established by our AMA House of Delegates. Under this sunset mechanism, A policy will typically sunset cease to be viable after ten years unless action is taken by the House of Delegates to reestablish retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years from the date of its reaffirmation. Further, any action of the House that modifies amends existing policies shall reset the sunset "clock," making the modified policy viable for 10 years from the date of its adoption.~~ (2) In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers ~~and/or the CLRPD~~ shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA Councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a ~~separate report to the House of Delegates identifying policies that are scheduled to sunset; that presents recommendations on how the policies assigned to it should be handled.~~ (d) For each policy under review, the reviewing council ~~shall~~ can recommend one of the following ~~alternatives~~ actions: (i) Retain the policy; (ii) ~~Rescind Sunset~~ the policy; ~~or~~ (iii) Retain part of the policy; or (iv) Reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing Council shall provide a succinct, but cogent justification ~~for the recommendation. For recommendations to retain a policy in part, the reviewing council should indicate how the policy should be changed by using strike through marks to indicate text that should be deleted.~~ (f) The Speakers shall determine assign the best way for the House of Delegates to handle the policy-sunset reports. for consideration by the appropriate Reference Committees. (3) Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished. (4) The AMA Councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices. (5) The most recent policy shall be deemed to supersede contradictory past AMA policies. (6) Sunset policies will be retained in the AMA historical archives.

3. That Policies G-600.071, G-600.120, and G-605.070 be amended by addition and deletion, and consolidated into a single policy statement:

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

AMA policy on House actions and decisions includes the following: (1) Other than CEJA reports and some CSAPH reports, the procedures of our AMA House allow for: (a) correcting factual errors in AMA reports, (b) rewording portions of a report that are objectionable, and (c) rewriting portions that could be misinterpreted or

misconstrued, so that the “revised” or “corrected” report can be presented for House action at the same meeting whenever possible. (2) A negative vote by the House of Delegates on resolutions which restate AMA policy does not change the existing policy. AMA policy can only be ~~changed~~ amended by means of a positive action of the House specifically intended to change that policy; (3) ~~Our AMA will adopt the electronic method of tabulating voting as soon as technically and economically feasible, not only for the election process, but also for contested or close voting of resolutions; and (4) Our AMA House of Delegates will continue its current method of voting, and not institute proxy or weighted voting.~~ Minor editorial changes to existing policies are allowed for accuracy, so long as such changes are reported to the House of Delegates so as to be transparent. Editorially amended policies, however, do not reset the sunset clock.

~~G-600.120 Implementation of House Policy~~

AMA policy on implementation of ~~resolutions~~ policy includes the following: (1) Our AMA House of Delegates shall be apprised of the status of adopted or referred resolutions and report recommendations ~~in reports~~ and ~~what specific actions that~~ have been taken on them over a one-year period. When situations preclude successful implementation of specific resolutions, the House and authors should be advised of such situations so that further or alternative actions can be taken if warranted. (2) Our AMA shall inform and afford an opportunity for each delegation to send a representative for any resolution introduced that is referred to a council or other body to the meeting at which that resolution will be considered. Our AMA shall incur no expense as a result of inviting the sponsors of resolutions to discuss their resolutions. (3) Any resolution which is adopted by our AMA House remains the ~~standing~~ policy of the Association until ~~modified~~ amended, or rescinded or sunset by the House.

~~G-605.070 Board Activities and House Policy~~

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

4. That Policies G-600.060 and G-600.005 be amended by insertion and deletion, and consolidated into a single policy statement:

G-600.060 Introducing Business to the AMA House

AMA policy on introducing business to our AMA House includes the following:

~~G-600.005 Improving Processes of the House of Delegates~~

1. Delegates submitting resolutions have a responsibility to review the Resolution checklist and verify that the resolution is in compliance. The Resolution checklist shall be distributed to all delegates and organizations in the HOD prior to each meeting, as well as be posted on the HOD website. A resolution format and a format for “information statements” (see #2) will be designed that will make them easier to prepare (e.g., a checklist approach). This new format will also provide a more specific explanation of the intended impact and rationale for resolutions that call for action in a resolved clause.

2. An new type of business item will be established, called an “Information sStatement,” can be used to bring an issue to the awareness of the HOD or the public, draw attention to existing policy for purposes of emphasis, or simply make a statement. Such items of business will be included in the section of the HOD Handbook for informational items and include appropriate attribution but will not go through the reference committee process, be voted on in the HOD or be incorporated into the Proceedings. An information statement is intended to require no action and will simply be brought to the attention of the HOD. If an information statement is

extracted, however, it will be managed by the Speaker in an appropriate manner, which may include a simple editorial correction up to and including withdrawal of the information statement.

~~3. Virtual reference committees will be pilot tested in the House of Delegates.~~

~~4. All AMA sections are encouraged to explore and/or pilot the use of virtual reference committees.~~

~~5. Required information on the budget will be provided to the HOD at a time and format more relevant to the AMA budget process.~~

~~6. The Speaker will appoint a task force regarding the Interim Meeting to address the following items, and report back to the House of Delegates at the 2009 Interim Meeting: (a) The structure and function of a replacement meeting to the Interim Meeting as currently structured (b) The role and function of the members of the HOD at the replacement meeting (c) The timing and location of the replacement meeting (d) The timing of the Annual Meeting (e) How and when the AMA should transition to the replacement meeting (f) How to maximize the value and minimize the cost of the replacement meeting (g) How to address the concerns of the various AMA Councils, Sections, and Special Groups regarding how the timing and nature of the replacement meeting will affect their work~~

~~7. A broad based virtual forum for HOD members and other AMA members will be created, to be convened and moderated by the Speakers of the HOD, for the purpose of discussing issues of importance to physicians and the health of the public.~~

~~8. Our AMA will provide infrastructure and support for setting up virtual communities within and between HOD participants that can be used to comment on issues, form coalitions, conduct caucuses, or address other needs that groups might have.~~

~~9. Our AMA will continue to monitor the needs of the Community Based, Private Practice Physicians and other caucuses of individual physicians who meet during the HOD meetings. 10. As an alternative to the formal Proceedings of the HOD, a searchable database of the original items of business, annotated reference committee reports, and the policy database (and transcripts if necessary) will be used as "collective documentation" of HOD meetings.~~

~~4. (1)~~ At the time the resolution is submitted, delegates introducing an item of business for consideration of the House of Delegates must declare any commercial or financial conflict of interest they have as individuals and any such conflict of interest must be noted on the resolution at the time of its distribution.

~~5. (2)~~ The submission of resolutions calling for similar action to what is already existing AMA policy is discouraged. State and specialty societies have the Organizations represented in the House of Delegates are responsible responsibility 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 state and specialty societies organizations represented in the House which he or she considers significant or when requested to do so by the state or specialty society organization, and the actions taken in response to such contacts.

~~6. (3)~~ Our AMA will continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates; ~~especially during its efforts to streamline the business of our AMA.~~

~~7. (4)~~ Our AMA encourages organizations and Sections of the House of Delegates to exercise restraint in submitting items on the day preceding the opening of the House.

~~8. (5)~~ Resolutions will be placed on the Reaffirmation Consent Calendar ~~only if~~ when they are identical or substantially identical to existing AMA policy. For resolutions placed on the Reaffirmation Consent Calendar, the pertinent existing policy will be clearly identified by reference to the Policy Database identification number. When practical, the Reaffirmation Consent Calendar should also include a listing of the actions that have been taken on the current AMA policies that are equivalent to the resolutions listed. For resolutions on the Reaffirmation Consent Calendar which are not extracted, the existing, pertinent AMA policy will be deemed to be reaffirmed in lieu of the submitted resolution which resets the sunset clock for ten years.

~~9. (6)~~ The practice of submitting status reports for House action Updates on referred resolutions is discontinued; this information will be included in the chart entitled "Implementation of Resolutions," which is made available to the House.

5. That Policy G-600.062, Guidelines for Drafting a Report, be sunset.
6. That Policy G-600.061 be amended by addition and deletion.

G-600.061 Guidelines for Drafting a Resolution or Report

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

(1) When proposing new AMA policy or modification of existing policy, the resolution should meet the following criteria: (a) The proposed policy should be stated as a broad guiding principle that sets forth the general philosophy of the Association on specific issues of concern to the medical profession; (b) The proposed policy should be clearly identified at the end of the resolution; (c) Recommendations for new or modified policy should include existing policy related to the subject as an appendix provided by the sponsor and supplemented as necessary by AMA Staff. If a modification of existing policy is being proposed, the resolution should set out the pertinent text of the existing policy, citing the policy number from the AMA Policy Database, and clearly identify the proposed modification. Modifications should be indicated by underlining proposed new text and lining through any proposed text deletions. If adoption of the new or modified policy would render obsolete or supersede one or more existing policies, those existing policies as set out in the AMA Policy Database should be identified and recommended for rescission. Reminders of this requirement should be sent ~~by the AMA to the state, county and specialty societies~~ all organizations represented in the House prior to the resolution submission deadline; (d) A fiscal note setting forth the estimated resource implications (expense increase, expense reduction, or change in revenue) of the proposed policy, program, or action shall be generated by AMA staff in consultation with the sponsor. Estimated changes in expenses will include direct outlays by the AMA as well as the value of the time of AMA's elected leaders and staff. A succinct description of the assumptions used to estimate the resource implications must be included in each fiscal note. When the resolution is estimated to have a resource implication of \$50,000 or more, the AMA shall publish and distribute a document explaining the major financial components or cost centers (such as travel, consulting fees, meeting costs, or mailing). No resolution that proposes policies, programs, or actions that require financial support by the AMA shall be considered without a fiscal note that meets the criteria set forth in this policy.

(2) When proposing to reaffirm existing policy, the resolution or report should contain a clear restatement of existing policy, citing the policy number from the AMA Policy Database.

(3) When proposing to establish a directive, the resolution or report should include all elements required for establishing new policy as well as a clear statement of existing policy, citing the policy number from the AMA Policy Database, underlying the directive.

(4) Reports responding to a referred resolution should include the resolves of that resolution in its original form or as last amended prior to the referral. Such reports should include a recommendation specific to the referred resolution. When a report is written in response to a directive, the report should sunset the directive calling for the report.

(5) The House's action is limited to recommendations, conclusions, and policy statements at the end of report. While the supporting text of reports is filed and does not become policy, the House may correct factual errors in AMA reports, reword portions of a report that are objectionable, and rewrite portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible. The supporting texts of reports are filed.

~~(46)~~ All resolutions and reports should ~~will~~ be written to include both "MD and DO," unless specifically applicable to one or the other.

~~(57)~~ ~~House of Delegates~~ Reports or resolutions should include, whenever possible or applicable, appropriate reference citations to facilitate independent review by delegates prior to policy development.

~~(68)~~ Each resolution resolve clause or report ~~in a~~ recommendation must be followed by a phrase, in parentheses, that indicates the nature and purpose of the resolve. These phrases are the following: (a) New HOD Policy; (b) Modify Current HOD Policy; (c) Consolidate Existing HOD Policy; ~~(ed)~~ Modify Bylaws; ~~(de)~~ Rescind HOD Policy; ~~(ef)~~ Reaffirm HOD Policy; or (g) Directive to Take Action.

~~(79)~~ Our AMA's Board of Trustees, AMA councils, House of Delegates reference committees, and sponsors of resolutions will ~~carefully consider Policies G-600.061, "Guidelines for Drafting a Resolution," and G-600.062, "Guidelines for Drafting a Report," and try, whenever possible, to make adjustments, additions, or elaborations of AMA policy positions by recommending modifications to existing AMA policy statements rather than creating new policy.~~

APPENDIX A - Existing Policies and Rationale for Changes

Policy Number	Title	Recommended Action & Rationale
G-600.111	Consolidation of AMA Policy	Amended for clarity; sunset of language no longer relevant or necessary. Establishes policy on the role and responsibility of all organizations in the HOD with respect to policy consolidation.
G-600.110	Sunset Mechanism for AMA Policy	Amended/expanded for clarity; sunset where policy is no longer relevant. Establishes guidelines for when a policy should be sunset.
G-600.071	Actions and Decisions by the AMA House	Amended for accuracy. Sunset of two policies that have been accomplished; consolidated with G-600.120 and G-605.070 into a single comprehensive policy statement, "Actions and Decisions by the AMA House and Policy Implementation."
G-600.120	Implementation of House Policy	Amended for accuracy. Consolidated with G-600.071 and G-605.070 into a single comprehensive policy statement, "Actions and Decisions by the AMA House and Policy Implementation."
G-605.070	Board Activities and House Policy	Amended for accuracy. Consolidated with G-600.071 and G-605.070 into a single comprehensive policy statement, "Actions and Decisions by the AMA House and Policy Implementation."
G-600.060	Introducing Business to the AMA House	Amended for clarity. Sunset of eight policies that have been accomplished or no longer relevant. Consolidated with G-600.005 into a single comprehensive policy statement, "Introducing Business to the AMA House."
G-600.005	Improving Processes of the House of Delegates	Amended for clarity and to reflect current practice. Consolidated with G-600.060 into a single comprehensive policy statement, "Introducing Business to the AMA House."
G-600.061	Guidelines for Drafting a Resolution	Expanded to provide guidelines for reports; retitled to "Guidelines for Drafting a Resolution or Report."
G-600.062	Guidelines for Drafting a Report	Sunset: Policy duplicative of G-600.061, which has been expanded to also address reports, with elements of this policy specific to reports included in updated G-600.061.

APPENDIX B - Consolidated Statements (as Proposed)

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

AMA policy on House actions and decisions includes the following: (1) Other than CEJA reports and some CSAPH reports, the procedures of our AMA House allow for: (a) correcting factual errors in AMA reports, (b) rewording portions of a report that are objectionable, and (c) rewriting portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible. (2) A negative vote by the House of Delegates on resolutions which restate AMA policy does not change the existing policy. AMA policy can only be amended by means of a positive action of the House specifically intended to change that policy. (3) Minor editorial changes to existing policies are allowed for accuracy, so long as such changes are reported to the House of Delegates so as to be transparent. Editorially amended policies, however, do not reset the sunset clock.

AMA policy on implementation of policy includes the following: (1) Our AMA House of Delegates shall be apprised of the status of adopted or referred resolutions and report recommendations and specific actions that have been taken on them over a one-year period. When situations preclude successful implementation of specific resolutions, the House and authors should be advised of such situations so that further or alternative actions can be taken if warranted. (2) Our AMA shall inform and afford an opportunity for each delegation to send a representative for any resolution introduced that is referred to a council or other body to the meeting at which that resolution will be considered. Our AMA shall incur no expense as a result of inviting the sponsors of resolutions to discuss their resolutions. (3) Any resolution which is adopted by our AMA House remains the policy of the Association until amended, rescinded or sunset by the House.

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

G-600.060 Introducing Business to the AMA House

AMA policy on introducing business to our AMA House includes the following: 1. Delegates submitting resolutions have a responsibility to review the Resolution checklist and verify that the resolution is in compliance. The Resolution checklist shall be distributed to all delegates and organizations in the HOD prior to each meeting, as well as be posted on the HOD website. 2. An Information Statement can be used to bring an issue to the awareness of the HOD or the public, draw attention to existing policy for purposes of emphasis, or simply make a statement. Such items will be included in the section of the HOD Handbook for informational items and include appropriate attribution but will not go through the reference committee process, be voted on in the HOD or be incorporated into the Proceedings. If an information statement is extracted, however, it will be managed by the Speaker in an appropriate manner, which may include a simple editorial correction up to and including withdrawal of the information statement. 3. Required information on the budget will be provided to the HOD at a time and format more relevant to the AMA budget process. 4. At the time the resolution is submitted, delegates introducing an item of business for consideration of the House of Delegates must declare any commercial or financial conflict of interest they have as individuals and any such conflict of interest must be noted on the resolution at the time of its distribution. 5. 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. 6. Our AMA will continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates. 7. Our AMA encourages organizations and Sections of the House of Delegates to exercise restraint in submitting items on the day preceding the opening of the House. 8. Resolutions will be placed on the Reaffirmation Consent Calendar when they are identical or substantially identical to existing AMA policy. For resolutions placed on the Reaffirmation Consent Calendar, the pertinent existing policy will be clearly identified by reference to the Policy Database identification number. When practical, the Reaffirmation Consent Calendar should also include a listing of the actions that have been taken on the current AMA policies that are equivalent to the resolutions listed. For resolutions on the Reaffirmation Consent Calendar which are not extracted, the existing, pertinent AMA policy will be deemed to be reaffirmed in lieu of the submitted resolution which resets the sunset clock for ten years. 9. Updates on referred resolutions are included in the chart entitled "Implementation of Resolutions," which is distributed to the House.

APPENDIX C – ORIGINAL TEXT OF ALL EXISTING POLICIES

G-600.111 Consolidation of AMA Policy

Our AMA House of Delegates endorses the concept of consolidating its policies in order to make information on existing AMA policy more accessible and to increase the readability of our AMA Policy Database and our AMA PolicyFinder Program. (1) The policy consolidation process shall consist of two steps: (a) rescinding outmoded and duplicative policies, and (b) combining policies that relate to the same topic. These two steps may be completed in a single report or in two separate reports to the House. (2) Our AMA House requests that each AMA council accept ongoing responsibility for developing recommendations on how to consolidate the policies in specific sections of our AMA Policy Database. In developing policy consolidation recommendations, our AMA councils should seek input from all relevant AMA bodies and units. (3) The House encourages each AMA council to develop at least one policy consolidation report each year, recommending changes that will result in significant improvements in the readability of our AMA Policy Database. (4) To ensure that the policy consolidation process is limited to achieving the objective of making existing policy more accessible and readable, the recommendations in policy consolidation reports cannot be amended and must be voted upon in their entirety. (CLRPD Rep. 1-A-94; Modified by CLRPD Rep. 4, I-95; Consolidated: CLRPD Rep. 3, I-01; Reaffirmed: CC&B Rep. 2, A-11)

G-600.110 Sunset Mechanism for AMA Policy

(1) A sunset mechanism with a ten-year time horizon shall exist for all AMA policy positions established by our AMA House of Delegates. Under this sunset mechanism, a policy will cease to be viable after ten years unless action is taken by the House of Delegates to reestablish it. Any action of our AMA House that reaffirms an existing policy position shall reset the sunset "clock," making the reaffirmed policy viable for 10 years from the date of its reaffirmation. Further, any action of the House that modifies existing policies shall reset the sunset "clock," making the modified policy viable for 10 years from the date of its adoption. (2) In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers and/or the CLRPD shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA Councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a separate report to the House of Delegates that presents recommendations on how the policies assigned to it should be handled. (d) For each policy under review, the reviewing council shall recommend one of the following alternatives: (i) Retain the policy; (ii) Rescind the policy; or (iii) Retain part of the policy. (e) For each recommendation that it makes, the reviewing Council shall provide a succinct, but cogent justification for the recommendation. For recommendations to retain a policy in part, the reviewing council should indicate how the policy should be changed by using strike-through marks to indicate text that should be deleted. (f) The Speakers shall assign the policy sunset reports for consideration by the appropriate Reference Committees. (BOT Rep. PP, I-84; CLRPD Rep. A, A-89; Reaffirmed: CLRPD Rep. 3 - I-94; Reaffirmed: CLRPD Rep. 2 and 5, I-95; Reaffirmed: Sunset Report, A-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CLRPD Rep. 1, A-02; Modified: CLRPD Rep. 5, A-03)

G-600.071 Actions and Decisions by the AMA House

AMA policy on House actions and decisions includes the following: (1) Other than CEJA reports and some CSAPH reports, the procedures of our AMA House allow for: (a) correcting factual errors in AMA reports, (b) rewording portions of a report that are objectionable, and (c) rewriting portions that could be misinterpreted or misconstrued, so that the “revised” or “corrected” report can be presented for House action at the same meeting whenever possible; (2) A negative vote by the House of Delegates on resolutions which restate AMA policy does not change the existing policy. AMA policy can only be changed by means of a positive action of the House specifically intended to change that policy; (3) Our AMA will adopt the electronic method of tabulating voting as soon as technically and economically feasible, not only for the election process, but also for contested or close voting of resolutions; and (4) Our AMA House of Delegates will continue its current method of voting, and not institute proxy or weighted voting. (Res. 45, I-89; Res. 609, I-95; Res. 605, I-98; Reaffirmed: Sunset Report and Modified: BOT Rep. 15, A-00; Consolidated: CLRPD Rep. 3, I-01; Appended: BOT Rep. 19, A-04)

G-605.070 Board Activities and House Policy

Except as noted herein, the Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates. Further, the Board of Trustees has the authority in urgent situations to take those policy actions that the Board deems best represent the interests of patients, physicians, and the AMA. In representing AMA policy in critical situations, the Board will take into consideration existing policy. The Board will immediately inform the Speaker of the House of Delegates and direct the Speaker to promptly inform the members of the House of Delegates when the Board has taken actions which differ from existing policy. Any action taken by the Board which is not consistent with existing policy requires a 2/3 vote of the Board. When the Board takes action which differs from existing policy, such action must be placed before the House of Delegates at its next meeting for deliberation (BOT Rep. FF, A-79; Reaffirmed: CLRPD Rep. B, I-89; Amended: CLRPD Rep. 2, I-93; Consolidated: CLRPD Rep. 3, I-01; Reaffirmed: CC&B Rep. 2, A-11)

G-600.120 Implementation of House Policy

AMA policy on implementation of resolutions includes the following: (1) Our AMA House of Delegates shall be apprised of the status of adopted or referred resolutions and recommendations in reports and what actions have been taken on them over a one-year period. When situations preclude successful implementation of specific resolutions, the House and authors should be advised of such situations so that further or alternative actions can be taken if warranted. (2) Our AMA shall inform and afford an opportunity for each delegation to send a representative for any resolution introduced that is referred to a council or other body to the meeting at which that resolution will be considered. Our AMA shall incur no expense as a result of inviting the sponsors of resolutions to discuss their resolutions. (3) Any resolution which is adopted by our AMA House remains the standing policy of the Association until modified or rescinded by the House. (Res. 52, I-86; Reaffirmed: Sunset Report, I-96; Consolidated: CLRPD Rep. 3, I-01; Modified: CLRPD Rep. 3, A-03)

G-600.060 Introducing Business to the AMA House

AMA policy on introducing business to our AMA House includes the following: (1) At the time the resolution is submitted, delegates introducing an item of business for consideration of the House of Delegates must declare any commercial or financial conflict of interest they have as individuals and any such conflict of interest must be noted on the resolution at the time of its distribution. (2) State and specialty societies have the responsibility to search for 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 state and specialty societies which he or she considers significant or when requested by the state or specialty society, and the actions taken in response to such contacts. (3) Our AMA will continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates, especially during its efforts to streamline the business of our AMA. (4) Our AMA encourages organizations and Sections of the House of Delegates to exercise restraint in submitting items on the day preceding the opening of the House. (5) Resolutions will be placed on the Reaffirmation Consent Calendar only if they are identical or substantially identical to existing AMA policy. For resolutions placed on the Reaffirmation Consent Calendar, the pertinent existing policy will be clearly identified by reference to the Policy Database identification number. When practical, the Reaffirmation Consent Calendar should also include a listing of the actions that have been taken on the current AMA policies that are equivalent to the resolutions listed. For resolutions on the Reaffirmation Consent Calendar which are not extracted, the existing, pertinent AMA policy will be deemed to be reaffirmed in lieu of the submitted resolution which resets the sunset clock for ten years. (6) The practice of submitting status reports for House action on referred resolutions is discontinued; this information will be included in the chart entitled “Implementation of Resolutions.” (Sub. Res. 120, A-84; BOT Rep. D and CLRPD Rep. C, I-91; CLRPD Rep. 3 - I-94; CLRPD Rep. 5, I-95; Res. 614, and Special Advisory Committee to the Speaker of the House of Delegates, I-99; Res. 604, I-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CLRPD Rep. 2, A-03; Reaffirmed: BOT Rep. 19, A-04; CC&B Rep. 3, I-08)

G-600.005 Improving Processes of the House of Delegates

1. A resolution format and a format for “information statements” (see #2) will be designed that will make them easier to prepare (e.g., a checklist approach). This new format will also provide a more specific explanation of the intended impact and rationale

for resolutions that call for action in a resolved clause. 2. A new type of business item will be established, called an “information statement,” to bring an issue to the awareness of the HOD or the public, draw attention to existing policy for purposes of emphasis, or simply make a statement. Such items of business will be included in the section of the HOD Handbook for informational items and include appropriate attribution but will not go through the reference committee process, be voted on in the HOD or be incorporated into the Proceedings. An information statement is intended to require no action and will simply be brought to the attention of the HOD. If an information statement is extracted, however, it will be managed by the Speaker in an appropriate manner, which may include a simple editorial correction up to and including withdrawal of the information statement. 3. Virtual reference committees will be pilot tested in the House of Delegates. 4. All AMA sections are encouraged to explore and/or pilot the use of virtual reference committees. 5. Required information on the budget will be provided to the HOD at a time and format more relevant to the AMA budget process. 6. The Speaker will appoint a task force regarding the Interim Meeting to address the following items, and report back to the House of Delegates at the 2009 Interim Meeting: (a) The structure and function of a replacement meeting to the Interim Meeting as currently structured (b) The role and function of the members of the HOD at the replacement meeting (c) The timing and location of the replacement meeting (d) The timing of the Annual Meeting (e) How and when the AMA should transition to the replacement meeting (f) How to maximize the value and minimize the cost of the replacement meeting (g) How to address the concerns of the various AMA Councils, Sections, and Special Groups regarding how the timing and nature of the replacement meeting will affect their work 7. A broad-based virtual forum for HOD members and other AMA members will be created, to be convened and moderated by the Speakers of the HOD, for the purpose of discussing issues of importance to physicians and the health of the public. 8. Our AMA will provide infrastructure and support for setting up virtual communities within and between HOD participants that can be used to comment on issues, form coalitions, conduct caucuses, or address other needs that groups might have. 9. Our AMA will continue to monitor the needs of the Community-Based, Private Practice Physicians and other caucuses of individual physicians who meet during the HOD meetings. 10. As an alternative to the formal Proceedings of the HOD, a searchable database of the original items of business, annotated reference committee reports, and the policy database (and transcripts if necessary) will be used as “collective documentation” of HOD meetings. (Rep. of the Speakers Special Advisory Committee on the House of Delegates, A-09; Appended: CLRPD Rep. 1, I-10)

G-600.061 Guidelines for Drafting a Resolution

Resolutions to the AMA House of Delegates shall meet the following guidelines: (1) When proposing new AMA policy or modification of existing policy, the resolution should meet the following criteria: (a) The proposed policy should be stated as a broad guiding principle that sets forth the general philosophy of the Association on specific issues of concern to the medical profession; (b) The proposed policy should be clearly identified at the end of the resolution; (c) Recommendations for new or modified policy should include existing policy related to the subject as an appendix provided by the sponsor and supplemented as necessary by AMA Staff. If a modification of existing policy is being proposed, the resolution should set out the pertinent text of the existing policy, citing the policy number from the AMA Policy Database, and clearly identify the proposed modification. Modifications should be indicated by underlining proposed new text and lining through any proposed text deletions. If adoption of the new or modified policy would render obsolete or supersede one or more existing policies, those existing policies as set out in the AMA Policy Database should be identified and recommended for rescission. Reminders of this requirement should be sent by the AMA to the state, county, and specialty societies represented in the House prior to the resolution submission deadline; (d) A fiscal note setting forth the estimated resource implications (expense increase, expense reduction, or change in revenue) of the proposed policy, program, or action shall be generated by AMA staff in consultation with the sponsor. Estimated changes in expenses will include direct outlays by the AMA as well as the value of the time of AMA’s elected leaders and staff. A succinct description of the assumptions used to estimate the resource implications must be included in each fiscal note. When the resolution is estimated to have a resource implication of \$50,000 or more, the AMA shall publish and distribute a document explaining the major financial components or cost centers (such as travel, consulting fees, meeting costs, or mailing). No resolution that proposes policies, programs, or actions that require financial support by the AMA shall be considered without a fiscal note that meets the criteria set forth in this policy. (2) When proposing to reaffirm existing policy, the resolution should contain a clear restatement of existing policy, citing the policy number from the AMA Policy Database. (3) When proposing to establish a directive, the resolution should include all elements required for establishing new policy as well as a clear statement of existing policy, citing the policy number from the AMA Policy Database, underlying the directive. (4) All resolutions will be written to include both “MD and DO,” unless specifically applicable to one or the other. (5) House of Delegates resolutions should include, whenever possible or applicable, appropriate reference citations to facilitate independent review by delegates prior to policy development. (6) Each resolve clause in a recommendation must be followed by a phrase, in parentheses, that indicates the nature and purpose of the resolve. These phrases are the following: (a) New HOD Policy; (b) Modify Current HOD Policy; (c) Modify Bylaws; (d) Rescind HOD Policy; (e) Reaffirm HOD Policy; or (f) Directive to Take Action. (7) Our AMA’s Board of Trustees, AMA councils, House of Delegates reference committees, and sponsors of resolutions will carefully consider Policies G-600.061, “Guidelines for Drafting a Resolution,” and G-600.062, “Guidelines for Drafting a Report,” and try, whenever possible, to make adjustments, additions, or elaborations of AMA policy positions by recommending modifications to existing AMA policy statements rather than creating new policy. (CLRPD Rep. 4, A-99; Modified by BOT Rep. 15, A-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CLRPD Rep. 2, A-02; Modified: CLRPD Rep. 6, A-03; Reaffirmed: BOT Rep. 19, A-04; Appended: Res. 606, A-05; Appended: Res. 611, A-07)

G-600.062 Guidelines for Drafting a Report

Reports to our AMA House of Delegates shall meet the following guidelines: (1) When a report to the House is responding to a referred resolution, the resolves of that resolution should be included in the report in the original form or last amended form prior

to the referral; (2) Policy statements in reports should be written as broad guiding principles that set forth the general philosophy of the Association on specific issues of concern to the medical profession; (3) When the report is proposing new or modified policy, it should include existing policy related to the subject as an appendix. Reports should clearly indicate whether the recommendations would result in modification of existing policy or in an addition of new policy to our AMA policy base. If a modification of existing policy is being proposed, the report shall set out the pertinent text of the existing policy, citing the policy number from our AMA Policy Database, and clearly identify the proposed modification. This should be done by underlining proposed new text and lining through any proposed text deletions. If adoption of the new or modified policy would render obsolete or supersede one or more existing policies, those existing policies as set out in our AMA Policy Database should be identified and recommended for rescission; (4) When a report contains a recommendation that present AMA policy should be reaffirmed, there should be a clear restatement of existing policy; (5) Where the recommendation in a report is in the nature of a directive, there should be a clear statement of existing or proposed policy underlying the directive; (6) Proposed statements of AMA policy should be clearly identified as policy recommendations at the end of report. The House's action is limited to recommendations, conclusions, and policy statements at the end of report. While the supporting text of reports is filed and does not become policy, the House may correct factual errors in AMA reports, reword portions of a report that are objectionable, and rewrite portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible. The supporting texts of reports are filed; (7) Each recommendation in a Board or Council report must be followed by a phrase, in parentheses, that indicates the nature and purpose of the recommendation. These phrases include the following: (a) New House Policy; (b) Modify Current House Policy; (c) Modify Bylaws; (d) Rescind House Policy; (e) Reaffirm House Policy; or (f) Directive to Take Action; (8) Reports exceeding six pages shall be preceded by an Executive Summary; and (9) Every report to the House that contains recommendations shall include a fiscal note that provides an estimate of the resource implications (expense increase, expense reduction, or change in revenue) of the proposed policy, program, or action. Estimated changes in expenses will include direct outlays by the AMA as well as the value of the time of AMA's elected leaders and staff. A succinct description of the assumptions used to estimate the resource implications must be included in each fiscal note. When the recommendations in the report are estimated to have a resource implication of \$50,000 or more, the AMA shall publish and distribute a document explaining the major financial components or cost centers (such as travel, consulting fees, meeting costs, or mailing). No report that proposes policies, programs, or actions that require financial support by the AMA shall be considered without a fiscal note that meets the criteria set forth in this policy. (10) Our AMA's Board of Trustees, AMA councils, House of Delegates reference committees, and sponsors of resolutions will carefully consider Policies H-600.061, "Guidelines for Drafting a Resolution," and H-600.062, "Guidelines for Drafting a Report," and try, whenever possible, to make adjustments, additions, or elaborations of AMA policy positions by recommending modifications to existing AMA policy statements rather than creating new policy. (CLRPD Rep. 4, A-99; CLRPD Rep. 6, A-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CLRPD Rep. 6, A-03; Reaffirmed: BOT Rep. 19, A-04)

REPORT OF THE SPEAKERS

The following report was presented by Susan R. Bailey, MD, Speaker; and Bruce A. Scott, MD, Vice Speaker.

1. RECOMMENDATIONS FOR POLICY RECONCILIATION

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

RECOMMENDED ACTIONS ACCOMPLISHED

Policy G-600.111, "Consolidation and Reconciliation of AMA Policy," calls on your Speakers to "present one or more reconciliation reports for action by the House of Delegates relating to newly passed policies from recent meetings that caused one or more existing policies to be redundant and/or obsolete."

Your Speakers present this report to deal with policies, or portions of policies, that are no longer relevant or that were affected by actions taken in 2017. Suggestions on other policy statements that your Speakers might address should be sent to hod@ama-assn.org for possible action. Where changes to language will be made, additions are shown with underscore and deletions are shown with red strikethrough.

RECOMMENDED RECONCILIATIONS

Policy to be modified in light of later House of Delegates action

I. G-600.027, "Designation of Specialty Societies for Representation in the House of Delegates"

This policy requires a minor change in the first paragraph given that the House amended the bylaws and adopted policy to implement the new procedure for apportioning delegates to national medical specialty societies. The change is a modest deletion from the policy and includes an appropriate capitalization in the first sentence. No other change to the policy is necessary.

1. ~~The current specialty society delegation allocation system (using a formula that incorporates the ballot) will be discontinued; and~~ Specialty society delegate allocation in the House of Delegates will be determined so that the total number of national specialty society delegates shall be equal to the total number of delegates apportioned to constituent societies under section 2.1.1 (and subsections thereof) of AMA bylaws, and will be distributed based on the latest available membership data for each society, which is generally from the society's most recent five year review, but may be determined annually at the society's request....

Policy to be modified for clarification and consistency with practice

II. G-600.061, "Guidelines for Drafting a Resolution or Report"

The title of Policy G-600.061, "Guidelines for Drafting a Resolution or Report," suggests that it applies to both resolutions and reports, and in fact several parts of the policy refer specifically to both resolutions and reports. However, some subparagraphs of Paragraph 1 do not reference reports, despite the fact that practice has enforced the guidelines with respect to all reports submitted to the House, and the House of Delegates Reference Manual plainly states (page 30) that a fiscal note "indicating the financial implications of the report's recommendations" will be included. To ensure correspondence between the policy title and actual practice, the policy should explicitly address reports in Paragraphs 1, 1b, 1c and 1d.

G-600.061, Guidelines for Drafting a Resolution or Report

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

1. When proposing new AMA policy or modification of existing policy, the resolution or report should meet the following criteria:

- a. The proposed policy should be stated as a broad guiding principle that sets forth the general philosophy of the Association on specific issues of concern to the medical profession;
 - b. The proposed policy should be clearly identified at the end of the resolution [or report](#);
 - c. Recommendations for new or modified policy should include existing policy related to the subject as an appendix provided by the sponsor and supplemented as necessary by AMA staff. If a modification of existing policy is being proposed, the resolution [or report](#) should set out the pertinent text of the existing policy, citing the policy number from the AMA policy database, and clearly identify the proposed modification. Modifications should be indicated by underlining proposed new text and lining through any proposed text deletions. If adoption of the new or modified policy would render obsolete or supersede one or more existing policies, those existing policies as set out in the AMA policy database should be identified and recommended for rescission. Reminders of this requirement should be sent to all organizations represented in the House prior to the resolution submission deadline;
 - d. A fiscal note setting forth the estimated resource implications (expense increase, expense reduction, or change in revenue) of the proposed policy, program, or action shall be generated by AMA staff in consultation with the sponsor. Estimated changes in expenses will include direct outlays by the AMA as well as the value of the time of AMA's elected leaders and staff. A succinct description of the assumptions used to estimate the resource implications must be included in each fiscal note. When the resolution [or report](#) is estimated to have a resource implication of \$50,000 or more, the AMA shall publish and distribute a document explaining the major financial components or cost centers (such as travel, consulting fees, meeting costs, or mailing). No resolution [or report](#) that proposes policies, programs, or actions that require financial support by the AMA shall be considered without a fiscal note that meets the criteria set forth in this policy.
2. When proposing to reaffirm existing policy, the resolution or report should contain a clear restatement of existing policy, citing the policy number from the AMA policy database.
 3. When proposing to establish a directive, the resolution or report should include all elements required for establishing new policy as well as a clear statement of existing policy, citing the policy number from the AMA policy database, underlying the directive.
 4. Reports responding to a referred resolution should include the resolves of that resolution in its original form or as last amended prior to the referral. Such reports should include a recommendation specific to the referred resolution. When a report is written in response to a directive, the report should sunset the directive calling for the report.
 5. The House's action is limited to recommendations, conclusions, and policy statements at the end of report. While the supporting text of reports is filed and does not become policy, the House may correct factual errors in AMA reports, reword portions of a report that are objectionable, and rewrite portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible. The supporting texts of reports are filed.
 6. All resolutions and reports should be written to include both "MD and DO," unless specifically applicable to one or the other.
 7. Reports or resolutions should include, whenever possible or applicable, appropriate reference citations to facilitate independent review by delegates prior to policy development.
 8. Each resolution resolve clause or report recommendation must be followed by a phrase, in parentheses, that indicates the nature and purpose of the resolve. These phrases are the following:
 - a. New HOD Policy;
 - b. Modify Current HOD Policy;
 - c. Consolidate Existing HOD Policy;
 - d. Modify Bylaws;
 - e. Rescind HOD Policy;

- f. Reaffirm HOD Policy; or
 - g. Directive to Take Action.
9. Our AMA's Board of Trustees, AMA councils, House of Delegates reference committees, and sponsors of resolutions will try, whenever possible, to make adjustments, additions, or elaborations of AMA policy positions by recommending modifications to existing AMA policy statements rather than creating new policy.

References to completed reports to be deleted from policies

The following policies will be modified by deleting references to requested reports that have been sent to and considered by the House of Delegates. Other, substantive portions of these directives are unchanged.

III. H-95.990, "Drug Abuse Related to Prescribing Practices"

The policy includes a request for a study that has been completed, so that section of the policy will be stricken. The remainder of the policy remains intact.

1. Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices:
 - A. institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the prescription drug abuse problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students.
 - B. placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard, emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms.
2. Our AMA:
 - A. promotes physician training and competence on the proper use of controlled substances;
 - B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients;
 - C. will provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and
 - D. encourages physicians to query a state's controlled substances databases for information on their patients on controlled substances.
3. ~~The Council on Science and Public Health will report at the 2012 Annual Meeting on the effectiveness of current drug policies, ways to prevent fraudulent prescriptions, and additional reporting requirements for state-based prescription drug monitoring programs for veterinarians, hospitals, opioid treatment programs, and Department of Veterans Affairs facilities.~~
4. ~~Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances.~~

Council on Science and Public Health Report 2-I-13, "A Contemporary View of National Drug Control Policy," reviewed the material and addressed the elements of paragraph 3 within the Council's expertise. For that reason, paragraph 3 will be deleted.

IV. D-160.927, "Risk Adjustment Refinement in ACO Settings and Medicare Shared Savings Programs"

Our AMA will continue seeking the even application of risk-adjustment in ACO settings to allow Hierarchical Condition Category risk scores to increase year-over-year within an agreement period for the continuously assigned Medicare Shared Savings Program beneficiaries ~~and report progress back to this House at the 2017 Annual Meeting.~~

At the 2017 Annual Meeting, the Board of Trustees offered Report 21, "Risk Adjustment Refinement in Accountable Care Organization (ACO) Settings and Medicare Shared Savings Programs (MSSP)," which described efforts that had been undertaken to address the CMS policies and noted that our AMA would continue to urge CMS to improve risk adjustment methodology in ACOs.

V. D-165.935, "Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care"

~~1-~~ Our AMA will: (a) actively engage the new Administration and Congress in discussions about the future of health care reform, in collaboration with state and specialty medical societies, emphasizing our AMA's extensive body of policy on health system reform; and (b) craft a strong public statement for immediate and broad release, articulating the priorities and firm commitment to our current AMA policies and our dedication in the development of comprehensive health care reform that continues and improves access to care for all patients.

~~2-Our AMA Board of Trustees will report back to our AMA House of Delegates at the 2017 Annual Meeting.~~

BOT Report 24-A-17, "Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care," characterized the efforts that had been undertaken to that point, including engagement with the Federation, collaborations with various patient advocacy groups and letters to congressional leadership as well as the White House.

VI. D-478.970, Physician-Patient Text Messaging and Non-HIPAA Compliant Electronic Messaging

Our AMA: ~~(1) will study the medicolegal implications of text messaging and other non-HIPAA-compliant electronic messaging between physicians, patients, and members of the health care team, with report back at the 2017 Annual Meeting; and 2) will develop patient-oriented educational materials about text messaging and other non-HIPAA-compliant electronic messaging communication between physicians, patients, and members of the health care team.~~

The report requested in part 1 of the policy was fulfilled by Board of Trustees Report 11-A-17, "Physician-Patient Text Messaging and Non-HIPAA Compliant Electronic Messaging," which modified Policy H-478.997, "Guidelines for Patient-Physician Electronic Mail and Text Messaging," which remains current policy.

Policy with a title change

VII. D-478.964, "High Cost to Authors for Open Source Peer Reviewed Publications"

Following usual practice, Board of Trustees Report 10-I-17 took its title from the underlying referred resolution. While the body of the report correctly referred to open access journals, the title, taken directly from the resolution, employed the term "open source." As "open access" is the preferred terminology, the title of Policy D-478.964 will be changed to "High Cost to Authors for Open Access ~~Source~~ Peer Reviewed Publications."

Directives to be rescinded in full

The following directives will be rescinded in full, as the requested studies have been completed, with reports presented to the House of Delegates several years ago.

VIII. D-160.930, "Studying Physician Access to ACO Participation"

Our AMA will study: (a) the criteria and processes by which various types of accountable care organizations (ACOs) determine which physicians will be selected to join vs. excluded from the ACO; (b) the criteria and processes by which physicians can be de-selected once they are members of an ACO; (c) the implications of such criteria and processes for patient access to care outside the ACO; and (d) the effect of evolving system alignments and integration on physician recruitment and retention. The results of this study will be reported back to the HOD and to our AMA membership at large by the 2015 Annual Meeting.

The directive was fulfilled by Council on Medical Service Report 7-A-15, "Physician Access to ACO Participation," which noted that efforts to identify and support current and emerging payment and care delivery models that work best for physicians across a variety of practice settings are ongoing.

IX. D-165.940, "Monitoring the Affordable Care Act"

Our AMA will assess the progress of implementation of the Patient Protection and Affordable Care Act based on AMA policy, as well as the estimated budgetary, coverage and physician-practice impacts of the law, and report back to the House of Delegates at the 2013 Interim Meeting.

Council on Medical Service Report 5-I-13, "Monitoring the Affordable Care Act," was prepared in response to this directive.

The changes outlined above do not reset the sunset clock and will be implemented when this report is filed.

606. INCREASING THE EFFECTIVENESS OF ONLINE REFERENCE COMMITTEE TESTIMONY
Introduced by Texas

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-600.956

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, That the preliminary reference committee document will be used to inform the discussion at the in-person reference committee; and be it further

RESOLVED, That there be an evaluation to determine if this procedure should continue; and be it further

RESOLVED, That AMA pursue any bylaw changes that might be necessary to allow this trial; and be it further

RESOLVED, That the period for online testimony be no longer than 14 days.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(A-23)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: Speakers Task Force to Review and Modernize the Resolution Process

Referred to: Reference Committee F

1 Whereas, Our American Medical Association House of Delegates recently reviewed and revised
2 the election process for officers and councils through a Speakers Task Force; and
3

4 Whereas, The process of submitting, reviewing, evaluating, reporting, and voting on resolutions
5 in our HOD has not changed in many years; and
6

7 Whereas, For the past two years, all delegations and sections have met virtually and have been
8 able to work asynchronously to discuss and vote on potential resolutions to submit to the AMA
9 HOD; and
10

11 Whereas, The Saturday/Sunday tote contains a significant amount of new resolutions each
12 year; and
13

14 Whereas, The resolutions in the Saturday/Sunday tote cannot be adequately reviewed and
15 vetted by all delegations and delegation staff and reference committee members prior to the
16 start of the reference committee hearings; and
17

18 Whereas, According to Bylaws 2.11.3.1.3, "Late resolutions may be presented by a delegate
19 prior to the recess of the opening session of the House of Delegates, and will be accepted as
20 business of the House of Delegates only upon two-thirds vote of delegates present and voting";
21 and
22

23 Whereas, According to Bylaws 2.11.3.1.4 Emergency Resolutions, "resolutions of an
24 emergency nature may be presented by a delegate any time after the opening session of the
25 House of Delegates is recessed. Emergency resolutions will be accepted as business only upon
26 a three-fourths vote of delegates present and voting, and if accepted shall be presented to the
27 House of Delegates without consideration by a reference committee. A simple majority vote of
28 the delegates present, and voting shall be required for adoption"; and
29

30 Whereas, The ability to meet virtually and work asynchronously was enhanced during the
31 pandemic to the point where it is potentially more efficient and convenient for Delegations and
32 Sections; therefore be it
33

34 RESOLVED, That our American Medical Association form a Speakers Task Force on the
35 Resolution Process to review the entire process of handling resolutions for our AMA House of
36 Delegates, including but not limited to definitions of on time resolutions, emergency resolutions,
37 and late resolutions, deadlines for submission of resolutions by all sections, processing and
38 review of reference committee reports, and use of virtual meetings so that all on time resolutions
39 can be submitted by the same deadline (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA Speakers Task Force on the Resolution Process report back to our
- 2 AMA House of Delegates by the 2024 Annual Meeting with recommendations regarding the
- 3 resolution process. (Directive to Take Action)

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

Received: 5/2/23

RELEVANT AMA POLICY

Procedure B-2.11

2.11.3.1.3 Late Resolutions. Late resolutions may be presented by a delegate prior to the recess of the opening session of the House of Delegates, and will be accepted as business of the House of Delegates only upon two-thirds vote of delegates present and voting.

2.11.3.1.4 Emergency Resolutions. Resolutions of an emergency nature may be presented by a delegate any time after the opening session of the House of Delegates is recessed. Emergency resolutions will be accepted as business only upon a three-fourths vote of delegates present and voting, and if accepted shall be presented to the House of Delegates without consideration by a reference committee. A simple majority vote of the delegates present and voting shall be required for adoption.

Procedure. B-2.11

Topic: House of Delegates **Policy Subtopic:** NA
Meeting Type: NA **Year Last Modified:** 2017
Action: NA **Type:** Constitution & Bylaws
Council & Committees: NA

2.11.1 Order of Business. The Order of Business will be proposed by the Speaker and approved by the House of Delegates.

At any meeting, the House of Delegates, by majority vote, may change the order of business.

2.11.2 Privilege of the Floor. The House of Delegates, by a two-thirds vote of delegates present and voting, may extend to any person an invitation to address the House.

2.11.3 Introduction of Business.

2.11.3.1 Resolutions. To be considered as regular business, each **resolution** must be introduced by a delegate or organization represented in the House of Delegates and must have been submitted to the AMA not later than 30 days prior to the commencement of the meeting at which it is to be considered, with the following exceptions.

2.11.3.1.1 Exempted Resolutions. If any member organization's house of delegates or primary policy making body, as defined by the organization, adjourns during the 5-week period preceding commencement of an AMA House of Delegates meeting, the organization is allowed 7 days after the close of its meeting to submit resolutions to the AMA. All such resolutions must be received by noon of the day before the commencement of the AMA House of Delegates meeting. The presiding officer of the organization shall certify that the resolution was adopted at its just concluded meeting and that the body directed that the resolution be submitted to the AMA House of Delegates.

2.11.3.1.2 AMA Sections. Resolutions presented from the business meetings of the AMA Sections may be presented for consideration by the House of Delegates no later than the recess of the House of Delegates opening session to be accepted as regular business. Resolutions presented after the recess of the opening session of the House of Delegates will be accepted in accordance with Bylaw 2.11.3.1.4.

2.11.3.1.3 Late Resolutions. Late resolutions may be presented by a delegate prior to the recess of the opening session of the House of Delegates, and will be accepted as business of the House of Delegates only upon two-thirds vote of delegates present and voting.

2.11.3.1.4 Emergency Resolutions. Resolutions of an emergency nature may be presented by a delegate any time after the opening session of the House of Delegates is recessed. Emergency resolutions will be accepted as business only upon a three-fourths vote of delegates present and

voting, and if accepted shall be presented to the House of Delegates without consideration by a reference committee. A simple majority vote of the delegates present and voting shall be required for adoption.

2.11.3.1.5 Withdrawal of Resolutions. A resolution may be withdrawn by its sponsor at any time prior to its acceptance as business by the House of Delegates.

2.11.3.1.6 Resolutions not Accepted. Late resolutions and emergency resolutions not accepted as business by the House of Delegates may be submitted for consideration at a future meeting in accordance with the procedure in Bylaw 2.11.3.

2.11.3.2 Business from the Board of Trustees. Reports, recommendations, resolutions or other new business, may be presented by the Board of Trustees at any time during a meeting. Items of business presented before the recess of the opening session of the House of Delegates will be accepted as regular business. Items of business presented after the recess of the opening session of the House of Delegates will be accepted as emergency business and shall be presented to the House of Delegates without consideration by a reference committee. A two-thirds vote of the delegates present and voting shall be required for adoption.

2.11.3.3 Business from the Councils. Reports, opinions or recommendations from a council of the AMA or a special committee of the House of Delegates may be presented at any time during a meeting. Items of business presented before the recess of the opening session of the House of Delegates will be accepted as regular business. Items of business presented after the recess of the opening session of the House of Delegates will be accepted as emergency business and shall be presented to the House of Delegates without consideration by a reference committee. A two-thirds vote of the delegates present and voting shall be required for adoption.

2.11.3.4 Informational Reports of Sections. Informational reports may be presented by the AMA Sections on an annual basis.

2.11.4 Referral to Reference Committee. Reports, recommendations, resolutions or other new business presented prior to the recess of the opening session of the House of Delegates shall be referred to an appropriate reference committee for hearings and report, subject to acceptance as business of the House of Delegates. Items of business presented after the recess of the opening session are not referred to reference committee, but rather heard by the House of Delegates as a whole, subject to acceptance as business of the House of Delegates. Informational items are not referred to a reference committee.

2.11.6 Quorum. A majority of the voting members of the House of Delegates Official Call shall constitute a quorum.

Resolution Committee. B-2.13.3

Topic: House of Delegates **Policy Subtopic:** NA

Meeting Type: **Year Last Modified:**

Action: NA **Type:** Constitution & Bylaws

Council & Committees:

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

2.13.3.1 Appointment. The Speaker shall appoint the members of the committee. Membership on this committee is restricted to delegates.

2.13.3.2 Size. The committee shall consist of a maximum of 31 members.

2.13.3.3 Term. The committee shall serve only during the meeting at which it is appointed, unless otherwise directed by the House of Delegates.

2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum.

2.13.3.5 Meetings. The committee shall not be required to hold meetings. Action may be taken by written or electronic communications.

2.13.3.6 Procedure. A **resolution** shall be accepted for consideration at an Interim Meeting upon majority vote of committee members voting. The Speaker shall only vote in the case of a tie. If a **resolution** is not accepted, it may be submitted for consideration at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1.

2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee shall be presented to the House of Delegates at the call of the Speaker.

Introducing Business to the AMA House G-600.060

AMA policy on introducing business to our AMA House includes the following:

1. Delegates submitting resolutions have a responsibility to review the Resolution checklist and verify that the resolution is in compliance. The Resolution checklist shall be distributed to all delegates and organizations in the HOD prior to each meeting, as well as be posted on the HOD website.
2. An Information Statement can be used to bring an issue to the awareness of the HOD or the public, draw attention to existing policy for purposes of emphasis, or simply make a statement. Such items will be included in the section of the HOD Handbook for informational items and include appropriate attribution but will not go through the reference committee process, be voted on in the HOD or be incorporated into the Proceedings. If an information statement is extracted, however, it will be managed by the Speaker in an appropriate manner, which may include a simple editorial correction up to and including withdrawal of the information statement.
3. Required information on the budget will be provided to the HOD at a time and format more relevant to the AMA budget process.
4. At the time the resolution is submitted, delegates introducing an item of business for consideration of the House of Delegates must declare any commercial or financial conflict of interest they have as individuals and any such conflict of interest must be noted on the resolution at the time of its distribution.
5. 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.
6. Our AMA will continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates.
7. Our AMA encourages organizations and Sections of the House of Delegates to exercise restraint in submitting items on the day preceding the opening of the House.
8. Resolutions will be placed on the Reaffirmation Consent Calendar when they are identical or substantially identical to existing AMA policy. For resolutions placed on the Reaffirmation Consent Calendar, the pertinent existing policy will be clearly identified by reference to the Policy Database identification number. When practical, the Reaffirmation Consent Calendar should also include a listing of the actions that have been taken on the current AMA policies that are equivalent to the resolutions listed. For resolutions on the Reaffirmation Consent Calendar which are not extracted, the existing, pertinent AMA policy will be deemed to be reaffirmed in lieu of the submitted resolution which resets the sunset clock for ten years.
9. Updates on referred resolutions are included in the chart entitled "Implementation of Resolutions," which is made available to the House.

Policy Timeline

Sub. Res. 120, A-84 BOT Rep. D and CLRPD Rep. C, I-91 CLRPD Rep. 3 - I-94 CLRPD Rep. 5, I-95 Res. 614, and Special Advisory Committee to the Speaker of the House of Delegates, I-99 Res. 604, I-00 Consolidated: CLRPD Rep. 3, I-01 Modified: CLRPD Rep. 2, A-03 Reaffirmed: BOT Rep. 19, A-04 CC&B Rep. 3, I-08 Modified: CCB/CLRPD Rep. 1, A-12 Reaffirmed: CCB/CLRPD Rep. 1, A-22

Guidelines for Drafting a Resolution or Report G-600.061

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

1. When proposing new AMA policy or modification of existing policy, the resolution or report should meet the following criteria:

(a) The proposed policy should be stated as a broad guiding principle that sets forth the general philosophy of the Association on specific issues of concern to the medical profession;

(b) The proposed policy should be clearly identified at the end of the resolution or report;

(c) Recommendations for new or modified policy should include existing policy related to the subject as an appendix provided by the sponsor and supplemented as necessary by AMA staff. If a modification of existing policy is being proposed, the resolution or report should set out the pertinent text of the existing policy, citing the policy number from the AMA policy database, and clearly identify the proposed modification. Modifications should be indicated by underlining proposed new text and lining through any proposed text deletions. If adoption of the new or modified policy would render obsolete or supersede one or more existing policies, those existing policies as set out in the AMA policy database should be identified and recommended for rescission. Reminders of this requirement should be sent to all organizations represented in the House prior to the resolution submission deadline;

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

2. When proposing to reaffirm existing policy, the resolution or report should contain a clear restatement of existing policy, citing the policy number from the AMA policy database.

3. When proposing to establish a directive, the resolution or report should include all elements required for establishing new policy as well as a clear statement of existing policy, citing the policy number from the AMA policy database, underlying the directive.

4. Reports responding to a referred resolution should include the resolves of that resolution in its original form or as last amended prior to the referral. Such reports should include a

recommendation specific to the referred resolution. When a report is written in response to a directive, the report should sunset the directive calling for the report.

5. The House's action is limited to recommendations, conclusions, and policy statements at the end of report. While the supporting text of reports is filed and does not become policy, the House may correct factual errors in AMA reports, reword portions of a report that are objectionable, and rewrite portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible. The supporting texts of reports are filed.

6. All resolutions and reports should be written to include both "MD and DO," unless specifically applicable to one or the other.

7. Reports or resolutions should include, whenever possible or applicable, appropriate reference citations to facilitate independent review by delegates prior to policy development.

8. Each resolution resolve clause or report recommendation must be followed by a phrase, in parentheses, that indicates the nature and purpose of the resolve. These phrases are the following:

- (a) New HOD Policy;
- (b) Modify Current HOD Policy;
- (c) Consolidate Existing HOD Policy;
- (d) Modify Bylaws;
- (e) Rescind HOD Policy;
- (f) Reaffirm HOD Policy; or
- (g) Directive to Take Action.

9. Our AMA's Board of Trustees, AMA councils, House of Delegates reference committees, and sponsors of resolutions will try, whenever possible, to make adjustments, additions, or elaborations of AMA policy positions by recommending modifications to existing AMA policy statements rather than creating new policy.

Policy Timeline

CLRPD Rep. 4, A-99 Modified by BOT Rep. 15, A-00 Consolidated: CLRPD Rep. 3, I-01 Modified: CLRPD Rep. 2, A-02 Modified: CLRPD Rep. 6, A-03 Reaffirmed: BOT Rep. 19, A-04 Appended: Res. 606, A-05 Appended: Res. 611, A-07 Modified: CCB/CLRPD Rep. 1, A-12 Modified: Speakers Rep., A-18 Reaffirmed: CCB/CLRPD Rep. 1, A-22

Legal Support for Decision-making by the AMA House G-600.070

The following procedure for providing legal advice on issues before the House shall be followed:

(1) All resolutions received by the AMA Office of House of Delegates Affairs also will be reviewed by the Office of the General Counsel. When a resolution poses serious legal problems, the Speaker, legal counsel, or other AMA staff will communicate with the sponsor or medical association; (2) If the text of the proposed resolution that poses serious legal problems is not changed or if the resolution is not withdrawn, the Chair or another member of the Board will be available to speak to the legal objections in open or executive sessions of the reference committee or before the House of Delegates; (3) In the case of late resolutions that pose serious legal problems, the Chair or another member of the Board will inform the House of Delegates of the legal objections prior to a vote to accept or reject the resolution; (4) In accordance with the current procedures, any reference committee may request the Office of the General Counsel to provide additional legal advice and other information during the committee's executive session; and (5) During HOD meetings, delegates may also seek legal advice regarding proposed resolutions and amendments on an individual basis from the Office of the General Counsel.

Policy Timeline

BOT Rep. Q, A-80 Reaffirmed: Rep. B, I-90 Reaffirmed: Sunset Report, I-00 Consolidated: CLRPD Rep. 3, I-01 CC&B Rep. 3, I-08 Modified: CCB/CLRPD Rep. 3, A-12 Reaffirmed: CCB/CLRPD Rep. 1, A-22