AMA
AMERICAN MEDICAL ASSOCIATION

AMA House of Delegates Handbook

2023 Interim Meeting
Gaylord National Resort & Convention Center
Nov. 10–14

Access the handbook online at ama-assn.org/hod-business.

#AMAmtg
@AmerMedicalAssn

INTERIM 23

MEMORANDUM FROM THE SPEAKER OF THE HOUSE OF DELEGATES

- **All Delegates, Alternate Delegates and others receiving this material are reminded that it refers only to items to be considered by the House.**

- **No action has been taken on anything herein contained, and it is informational only.**

- **Only those items that have been acted on finally by the House can be considered official.**

- **The Interim Meeting is focused on advocacy issues. A resolution committee (see AMA Bylaw 2.13.3) considers each resolution and recommends that the item be considered or not considered at the Interim Meeting. Items that meet the following definition of advocacy or that are considered urgent are recommended for acceptance:**

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

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

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

AMA
AMERICAN MEDICAL ASSOCIATION

UNDERSTANDING THE RECORDING OF AMERICAN MEDICAL ASSOCIATION POLICY

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

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

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

AMA policy can be accessed at ama-assn.org/go/policyfinder.

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

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

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

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

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

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

LIST OF MATERIALS INCLUDED IN THIS HANDBOOK (I-23)

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

The informational reports contain no recommendations and will be filed on Saturday, November 11, unless a request is received for referral and consideration by a Reference Committee (similar to the use of a consent calendar).

1. **Memorandum from the Speaker**

2. **Understanding the Recording of American Medical Association Policy**

3. **Declaration of Professional Responsibility - Medicine's Social Contract with Humanity**

4. **Delegate / Alternate Delegate Job Description, Roles, and Responsibilities**

5. **Seating Allocation and Seating Chart for the House of Delegates**

6. **Hotel Maps**

7. **Official Call to the Officers and Members of the AMA**
   Officials of the Association and AMA Councils
   Ex Officio Members of the HOD
   SSS Representatives
   Listing of Delegates and Alternate Delegates

8. **Reference Committee Schedule and Room Assignments**

9. **Note on Order of Business**

10. **Summary of Fiscal Notes**

11. **List of Resolutions by Sponsor**

FOLLOWING COLLATED BY REFERRAL

12. **Report(s) of the Board of Trustees - Willie Underwood, III, MD, MSc, MPH, Chair**
    01 Employed Physicians (Amendments to C&B)
    02 Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies (K)
    03 Update on Climate Change and Health – AMA Activities (Info. Report)
    04 Update on Firearm Injury Prevention Task Force (Info. Report)
    05 AMA Public Health Strategy: The Mental Health Crisis (K)

06 Universal Good Samaritan Statute (B)
07 Obtaining Professional Recognition for Medical Service Professionals (B)
08 AMA Efforts on Medicare Payment Reform (Info. Report)
09 Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted (Info. Report)
10 Medical Decision-Making Autonomy of the Attending Physician (Amendments to C&B)
11 Criminalization of Providing Medical Care (Info. Report)
12 American Medical Association Meeting Venues and Accessibility (F)
13 House of Delegates (HOD) Modernization (F)
14 Funding for Physicians to Provide Safe Storage Devices to Patients with Unsecured Firearms in the Home (K)

13. Report(s) of the Council on Ethical and Judicial Affairs - David A. Fleming, MD, Chair
01 Physicians' Use of Social Media for Product Promotion and Compensation (Amendments to C&B)
02 Research Handling of De-Identified Patient Data (Amendments to C&B)

14. Opinion(s) of the Council on Ethical and Judicial Affairs - David A. Fleming, MD, Chair
01 Responsibilities to Promote Equitable Care (Info. Report)

15. Report(s) of the Council on Long Range Planning and Development - Gary Thal, MD, Chair
01 Women Physicians Section Five-Year Review (F)
02 Generative AI in Medicine and Health Care (Info. Report)

16. Report(s) of the Council on Medical Education - Cynthia Jumper, MD, MPH, Chair
01 Leave Policies for Medical Students, Residents, Fellows, and Physicians (C)
02 Update on Continuing Board Certification (C)
03 Ensuring Equity in Interview Processes for Entry to Undergraduate and Graduate Medical Education (C)
04 Recognizing Specialty Certifications for Physicians (C)
05 Organizations to Represent the Interests of Resident and Fellow Physicians (C)

17. Report(s) of the Council on Medical Service - Sheila Rege, MD, Chair
01 ACO REACH (J)
02 Health Insurers and Collection of Patient Cost-Sharing (J)
03 Strengthening Network Adequacy (J)
04 Physician-Owned Hospitals (Info. Report)
05 Medicaid Unwinding Update (J)
06 Rural Hospital Payment Models (J)
07 Sustainable Payment for Community Practices (J)

18. Report(s) of the Council on Science and Public Health - David J. Welsh, MD, MBA, Chair
01 Drug Shortages: 2023 Update (K)
02 Precision Medicine and Health Equity (K)
03 HPV-Associated Cancer Prevention (K)
04 Supporting and Funding Sobering Centers (K)
05 Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room (K)
06 Marketing Guardrails for the "Over-Medicalization" of Cannabis Use (K)
07 Efficacy of Requirements for Metal Detection/Weapons Interdiction Systems in Health Care Facilities (K)

19. Report(s) of the HOD Committee on Compensation of the Officers - Claudette Dalton, MD, Chair

01 Report of the House of Delegates Committee on the Compensation of the Officers (F)

20. Report(s) of the Speakers - Lisa Bohman Egbert, MD, Speaker; John H. Armstrong, MD, Vice Speaker

01 Report of the Resolution Modernization Task Force Update (Info. Report)
02 Extending Online Forum Trial Through A-24 (F)
03 Report of the Election Task Force 2 (Amendments to C&B)

21. Resolutions

002 Support for International Aid for Reproductive Healthcare (Amendments to C&B)
004 Reconsideration of Medical Aid in Dying (MAID) (Amendments to C&B)
005 Adopting a Neutral Stance on Medical Aid in Dying (Amendments to C&B)
006 Inappropriate Use of Health Records in Criminal Proceedings (Amendments to C&B)
007 Improving Access to Forensic Medical Evaluations and Legal Representation for Asylum Seekers (Amendments to C&B)
009 Physicians arrested for Non-Violent Crimes While Engaged in Public Protests (Amendments to C&B)
201 Opposition to the Restriction and Criminalization of Appropriate Use of Psychotropics in Long Term Care (B)
202 Protecting the Health of Patients Incarcerated in For-Profit Prisons (B)
203 Anti-Discrimination Protections for Housing Vouchers (B)
204 Improving PrEP & PEP Access (B)
205 Cannabis Product Safety (B)
206 The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice (B)
207 On-Site Physician Requirement for Emergency Departments (B)
208 Non-Physician Practitioners Oversight and Training (B)
210 Immigration Status in Medicaid and CHIP (B)
213 Health Technology Accessibility for Aging Patients (B)
215 A Public Health-Centered Criminal Justice System (B)
216 Saving Traditional Medicare (B)
217 Addressing Work Requirements for J-1 Visa Waiver Physicians (B)
218 Youth Residential Treatment Program Regulation (B)
219 Improving Access to Post-Acute Medical Care for Patients with Substance Use Disorder (SUD) (B)
220 Merit-Based Process for the Selection of all Federal Administrative Law Judges (B)
222 Expansion of Remote Digital Laboratory Access Under CLIA (B)
223 Initial Consultation for Clinical Trials Under Medicare Advantage (B)
224 ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers (B)
301 Clarification of AMA Policy D-310-948 “Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure” (C)
302 Medical Student Reports of Disability-Related Mistreatment (C)
304 Health Insurance Options for Medical Students (C)
305 Addressing Burnout and Physician Shortages for Public Health (C)
306 Increasing Practice Viability for Female Physicians through Increased Employer and Employee Awareness of Protected Leave Policies (C)
601 Carbon Pricing to Address Climate Change (F)
606 Prevention of Healthcare-Related Scams (F)
608 Confronting Ageism in Medicine (F)

801 Improving Pharmaceutical Access and Affordability (J)
802 Improving Nonprofit Hospital Charity Care Policies (J)
803 Improving Medicaid and CHIP Access and Affordability (J)
804 Required Clinical Qualifications in Determining Medical Diagnoses and Medical Necessity (J)
805 Medication Reconciliation Education (J)
806 Evidence-Based Anti-Obesity Medication as a Covered Benefit (J)
807 Any Willing Provider (J)
808 Prosthodontic Coverage after Oncologic Reconstruction (J)
809 Outsourcing of Administrative and Clinical Work to Different Time Zones – An Issue of Equity, Diversity, and Inclusion (J)
811 Expanding the Use of Medical Interpreters (J)
812 Indian Health Service Improvements (J)
813 Strengthening Efforts Against Horizontal & Vertical Consolidation (J)
814 Providing Parity for Medicare Facility Fees (J)
815 Long-Term Care and Support Services for Seniors (J)
817 Expanding AMA Payment Reform Work and Advocacy to Medicaid and other non-Medicare payment modules for Pediatric Healthcare and Specialty Populations (J)
818 Amendment to AMA policy on healthcare system reform proposals (J)
819 Amend Virtual Credit Card Policy (J)
820 Affordability and Accessibility of Treatment of Overweight and Obesity (J)
901 Silicosis from Work with Engineered Stone (K)
902 Post Market Research Trials (K)
903 Supporting Emergency Anti-Seizure Interventions (K)
904 Universal Return-to-Play Protocols (K)
905 Support for Research on the Relationship Between Estrogen and Migraine (K)
906 Online Content Promoting LGBTQ+ Inclusive Safe Sex Practices (K)
909 High Risk HPV Subtypes in Minoritized Populations (K)
910 Sickle Cell Disease Workforce (K)
913 Public Health Impacts of Industrialized Farms (K)
914 Adverse Childhood Experiences (K)
915 Social Media Impact on Youth Mental Health (K)
916 Elimination of Buprenorphine Dose Limits (K)
917 Advocating for Education and Action Regarding the Health Hazards of PFAS Chemicals (K)
918 Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals (K)
919 Lithium Battery Safety (K)
920 Antipsychotic Medication Use for Hospice Patients (K)
921 Addressing Disparities and Lack of Research for Endometriosis (K)
922 Prescription Drug Shortages and Pharmacy Inventories (K)

22. Resolutions – Consideration not yet determined

The following resolutions have not yet been reviewed by the Resolution Committee at the time of the HOD Handbook posting:

306 Increasing Practice Viability for Female Physicians through Increased Employer and Employee Awareness of Protected Leave Policies (C if considered)
608 Confronting Ageism in Medicine (F if considered)
818 Amendment to AMA policy on healthcare system reform proposals (J if considered)
917 Advocating for Education and Action Regarding the Health Hazards of PFAS Chemicals (K if considered)
918 Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals (K if considered)
919 Lithium Battery Safety (K if considered)
920 Antipsychotic Medication Use for Hospice Patients (K if considered)

921 Addressing Disparities and Lack of Research for Endometriosis (K if considered)

23. Not for Consideration

001 Physician-Patient Communications in the Digital Era
003 Guardianship and Conservatorship Reform
008 AMA Executive Vice President
209 Opposing Pay-to-Stay Incarceration Fees
211 Indian Water Rights
212 Medical-Legal Partnerships & Legal Aid Services
214 Humanitarian Efforts to Resettle Refugees
221 Support for Physicians Pursuing Collective Bargaining and Unionization
303 Fairness for International Medical Students
602 Inclusive Language for Immigrants in Relevant Past and Future AMA Policies
603 Improving the Efficiency of the House of Delegates Resolution Process
604 Updating Language Regarding Families and Pregnant Persons
605 Ranked Choice Voting
607 Equity-Focused Person-First Language in AMA Reports and Policies
810 Racial Misclassification
816 Reducing Barriers to Gender-Affirming Care through Improved Payment and Reimbursement
907 Occupational Screenings for Lung Disease
908 Sexuality and Reproductive Health Education
911 Support for Research on the Nutritional and Other Impacts of Plant-Based Meat
912 Fragrance Regulation

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

Preamble

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

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

Declaration

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

1. Respect human life and the dignity of every individual.

2. Refrain from supporting or committing crimes against humanity and condemn all such acts.

3. Treat the sick and injured with competence and compassion and without prejudice.

4. Apply our knowledge and skills when needed, though doing so may put us at risk.

5. Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.

6. Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.

7. Educate the public and polity about present and future threats to the health of humanity.

8. Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.

9. Teach and mentor those who follow us for they are the future of our caring profession.

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

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

Delegate/Alternate Delegate Job Description, Roles and Responsibilities

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

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

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

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

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

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

SEATING ALLOCATION – 2023 INTERIM MEETING

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

AMDA – 2
AMDA – The Society for Post-Acute and Long-Term Care Medicine (AMDA) – 2

AMGA - 1
American Medical Group Association (AMGA) - 1

ANESTHESIOLOGY - 11
American Society of Anesthesiologists (ASA) - 9
Former Board Chair (Patchin) – 1
Delegates – 8
American Society of Regional Anesthesia and Pain Medicine (ASRAPM) - 2

ARS – 1
American Rhinologic Society (ARS) - 1

CARDIOLOGY - 17
American College of Cardiology (ACC) - 7
American Society of Echocardiography (ASE) - 2
American Society of Nuclear Cardiology (ASNC) – 2
Heart Rhythm Society (HRS) - 2
Society for Cardiovascular Angiography and Interventions (SCAI) – 2
Society for Cardiovascular Magnetic Resonance (SCMR) - 1
Society of Cardiovascular Computed Tomography (SCCT) – 1

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

CRITICAL CARE MEDICINE- 3
Society of Critical Care Medicine (SCCM) - 3
Delegates - 2
Resident and Fellow Section Delegate - 1

DERMATOLOGY - 11
American Academy of Dermatology Assoc. (AAD) – 4
American College of Mohs Surgery (ACMS) – 1
American Contact Dermatitis Society (ACDS) - 1
American Society for Dermatologic Surgery Assoc (ASDSA) - 3
American Society of Dermatopathology (ASD) - 1
Society for Investigative Dermatology (SID) - 1

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

ENDOCRINOLOGY - 3
American Association of Clinical Endocrinology (AACE) - 1
The Endocrine Society (ES) - 2

FAMILY PHYSICIANS - 18
American Academy of Family Physicians (AAFP) - 18
Former Board Chair (Langston) - 1
Delegates - 16
Resident and Fellow Section Delegate - 1

GASTROENTEROLOGY - 7
American College of Gastroenterology (ACG) - 2
American Gastroenterological Association (AGA) - 2
American Society for Gastrointestinal Endoscopy (ASGE) - 3

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

GREAT LAKES - 65
Illinois - 17
Delegates - 12
Resident and Fellow Section Delegates - 2
American College of Legal Medicine (ACLM) - 1
American Med Women's Association (AMWA) - 1
Society of Nuclear Medicine and Molecular Imaging (SNMMI) - 1
Indiana - 6
Delegates – 5
Medical Student Regional Delegate- 1
Michigan – 18
Trustee (Mukkamala) - 1
Delegates - 14
Medical Student Regional Delegate – 1
Resident and Fellow Section Delegates - 2
Ohio - 15
Delegates (minus Speaker) - 13
Resident and Fellow Section Delegates – 2
Amer Assn of Neuromuscular & Electrodiagnostic Med (AANEM)- 1
Wisconsin - 9
Delegates - 5
Medical Student Regional Delegate – 1
Resident and Fellow Section Delegates - 2
Undersea & Hyperbaric Medical Society (UHMS) – 1

HEART OF AMERICA - 12
Kansas – 4
Delegates - 3
Medical Student Regional Delegate- 1
Missouri – 8
Delegates - 6
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate – 1

HEMATOLOGY - 2
American Society of Hematology (ASH) - 2

HOSPITAL MEDICINE - 3
Society of Hospital Medicine (SHM) – 3

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

INTERNAL MEDICINE - 36
American College of Physicians (ACP) – 35
Trustee (Fryhofer) – 1
Delegates – 34
Former President (Wilson)
Renal Physicians Association (RPA) - 1

MOBILITY CAUCUS - 14
American Acad of Orthopaedic Surgeons (AAOS) – 5
Delegates – 5
Former President (Gurman)
American Association for Hand Surgery (AAHS) - 1
American Orthopaedic Association (AOrA) - 1
American Orthopaedic Foot and Ankle Society (AOFAS) - 1
American Society for Surgery of the Hand (ASSH) - 1
American Society of Interventional Pain Physicians (ASIPP) - 2
International Society for the Advancement of Spine Surgery (ISASS) – 1
North American Spine Society (NASS) - 2

NEUROSCIENCES – 33
American Academy of Addiction Psychiatry (AAAP) - 1
American Academy of Child and Adolescent Psychiatry (AACAP) - 2
American Academy of Hospice and Palliative Medicine (AAHPM) - 2
American Academy of Neurology (AAN) – 5
Delegates – 4
Resident and Fellow Section Delegate - 1
American Academy of Pain Medicine (AAPM) - 1
American Acad of Psychiatry and the Law (AAPL) - 1
American Assoc for Geriatric Psychiatry (AAGP) - 1
American Association of Neurological Surgeons (AANS) - 4
Former President (Carmel) - 1
Delegates – 2
Resident and Fellow Section Delegate – 1
American Psychiatric Association (APA) - 10
Former President (Harris) – 1
Delegates - 8
Resident and Fellow Section Delegate – 1
American Society of Neuroimaging (ASNI) - 1
Congress of Neurological Surgeons (CNS) - 2
GLMA : Health Professionals Advancing LGBTQ Equality – 1
North American Neuromodulation Society (NANS) - 1
International Pain and Spine Intervention Society (IPSIS) - 1

NEW ENGLAND - 30
Connecticut – 8
Trustee (Koirala) - 1
Delegates - 4
Medical Student Regional Delegates- 2
Resident and Fellow Section Delegate - 1
Maine - 3
Delegates – 2
Medical Student Regional Delegate - 1
Massachusetts - 15
Delegates - 13
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
New Hampshire - 1
Rhode Island - 2
Vermont – 1

NEW YORK - 28
Former President (Nielsen) – 1
Trustee (Madejski) – 1
Delegates - 22
Medical Student Regional Delegate - 1
American College of Nuclear Medicine (ACNM) - 1
American Society of Neuroradiology (ASN) - 2

NORTH CENTRAL - 17
Iowa – 5
Delegates – 4
Outpatient Endovascular and Interventional Society (OEIS) - 1
Minnesota – 6
Delegates - 5
Medical Student Regional Delegate- 1
Nebraska – 3
Delegates – 2
Resident and Fellow Section Delegate - 1
North Dakota - 1
South Dakota - 2

OBSTETRICIANS AND GYNECOLOGISTS - 19
American Association of Gynecologic Laparoscopists (AAGL) - 3
American College of Medical Genetics and Genomics (ACMGG) - 1
American College of Obstetricians and Gynecologists (ACOG) – 14
Delegates – 14
Former President (Wah)
American Soc for Reproductive Medicine (ASRM) - 1

ONCOLOGY - 5
Association for Clinical Oncology (ACO) – 5
Delegates – 5
Former President (McAneny)

PACWEST CONFERENCE – 86
Alaska - 1
Arizona - 8
Delegates – 5
American Coll of Radiation Oncology (ACRO) - 1
American Institute of Ultrasound in Medicine (AIUM) – 2
California - 43
Former Presidents (Corlin) – 1
Trustee (Ding) - 1
Delegates - 33
Medical Student Regional Delegates - 2
Resident and Fellow Section Delegates - 2
American Clinical Neurophysiology Soc (ACNS) – 1
American Soc for Radiation Oncology (ASRO) – 2
North American Neuro-Ophthalmology Society (NANOS) – 1
Colorado - 7
Delegates - 6
Obesity Medicine Association (OMA) - 1
Hawaii - 2
Idaho - 1
Montana - 1

PACWEST CONFERENCE (cont'd)
Nevada – 4
Delegates - 2
Resident and Fellow Section Delegates – 2
New Mexico – 4
Delegates – 2
Resident and Fellow Section Delegate - 1
American Academy of Allergy, Asthma & Immunology (AAAAI) – 1
Oregon – 5
Delegates - 4
Medical Student Regional Delegate- 1
Utah – 2
Washington – 7
Delegates – 6
Medical Student Regional Delegate - 1
Wyoming – 1

PATHOLOGY - 9
American Society for Clinical Pathology (ASCP) – 3
American Society of Cytopathology (ASC) - 1
College of American Pathologists (CAP) – 4
National Association of Medical Examiners (NAME) - 1

PEDIATRICS - 7
American Academy of Pediatrics (AAP) – 7
Trustee (Ajayi) - 1
Delegates - 5
Resident and Fellow Section Delegate - 1

PENNSYLVANIA - 19
Trustee (Heine) - 1
Delegates - 13
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate – 1
American Association of Physicians of Indian Origin (AAPIO) – 1
American Hernia Society (AHS) - 1
National Medical Association (NMA) - 1

PHYSICAL MEDICINE AND REHABILITATION - 2
American Academy of Physical Med & Rehabilitation (AAPMR) – 2

PREVENTIVE MEDICINE - 8
Aerospace Medical Association (AsMA) - 1
American Academy of Insurance Medicine (AAIM) - 1
American Association of Public Health Physicians (AAPHP) – 2
Delegate - 1
Resident and Fellow Section Delegate - 1
American College of Medical Quality (ACMQ) - 1
American College of Occupational & Environmental Med (ACOEM) - 2
American College of Preventive Medicine (ACPM) - 1

RADIOLOGY - 17
American College of Radiology (ACR) – 8
Delegates – 8
Former President (Johnson)
American Roentgen Ray Society (ARRS) – 3
Association of University Radiologists (AUR) - 1
Radiological Society of North America (RSNA) – 3
Society of Interventional Radiology (SIR) - 2

RHEUMATOLOGY - 2
American College of Rheumatology (ACRh) - 2

SECTIONS - 12
Academic Physicians Section (APS) - 1
Integrated Physician Practice Section (IPPS) - 1
International Medical Graduates Section (IMG) - 1
Medical Student Section (MSS) - 2
Trustee (Siddiqui) - 1
Delegate – 1
Minority Affairs Section (MAS) - 1
Organized Medical Staff Section (OMSS) – 1
Private Practice Physician Section (PPPS) - 1
Resident and Fellow Section (RFS) – 1
Senior Physicians Section (SPS) - 1
Women Physicians Section (WPS) -1
Young Physicians Section (YPS) - 1

SERVICES - 6
Air Force - 1
Army - 1
AMSUS - Society of Federal Health Professionals - 1
Navy - 1
Public Health Service - 1
Veterans Affairs - 1

SLEEP MEDICINE – 2
American Academy of Sleep Medicine (AASM) - 2

SOUTHEASTERN - 122
Alabama – 5
Delegates - 4
Medical Student Regional Delegate- 1
Arkansas – 4
Trustee (Ferguson) – 1
Delegates - 3
Delaware - 2
Former Board Chair (Permut) – 1
Delegate - 1
District of Columbia - 5
Former Board Chair (Scalettar) - 1
Delegates - 3
Resident and Fellow Section Delegate - 1
Florida – 21
Former President (Coble) – 1
Trustee (Butler) - 1
Delegates – 17
Medical Student Regional Delegate- 1
The Triological Society (TS) - 1
Georgia – 7
Delegates – 6
Medical Student Regional Delegate- 1
Kentucky - 6
Delegates – 4
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
Louisiana - 7
Delegates - 6
Medical Student Regional Delegate- 1

SOUTHEASTERN (cont'd)
Maryland - 9
Trustee (Edwards) - 1
Delegates – 6
Medical Student Regional Delegate - 1
Acad of Physicians in Clinical Research (APCR) - 1
Mississippi – 4
Delegates – 3
Resident and Fellow Section Delegate - 1
New Jersey - 11
Delegates - 8
Medical Student Regional Delegate- 1
American Acad of Facial Plastic and Reconstructive Surgery (AAFPRS) – 1
American Osteopathic Association (AOA) – 1
North Carolina – 7
Delegates - 6
Medical Student Regional Delegate- 1
Oklahoma – 5
Delegates - 4
Medical Student Regional Delegate- 1
Puerto Rico - 2
South Carolina – 8
Former Presidents (Harmon, Smoak) – 2
Trustee (Pastides) - 1
Delegates - 5
Tennessee – 7
Delegates – 6
American Vein and Lymphatic Society (AVLS) - 1
Virginia – 10
Former President (Wootton) – 1
Delegates - 8
Medical Student Regional Delegate- 1
West Virginia – 2

SURGEONS - 43
American Academy of Cosmetic Surgery (AACS) - 1
American Academy of Ophthalmology (AAO) – 4
American Academy of Otolaryngic Allergy (AAOA) - 1
Amer Acad of Otolaryngology - Head & Neck Surgery (AAOHNS) - 3
American Association for Thoracic Surgery (AATS) - 1
American Association of Plastic Surgeons (AAPS) - 1
American College of Surgeons (ACS) (minus Vice Speaker) – 8
American Society for Aesthetic Plastic Surgery (ASAPS) – 1
American Society for Metabolic and Bariatric Surgery (ASMBS) - 1
American Society for Reconstructive Microsurgery (ASRMS) - 1
American Society of Breast Surgeons (ASBS) - 2
American Society of Cataract and Refractive Surgery (ASCTRS) - 2
American Society of Colon and Rectal Surgeons (ASCRS) - 2
American Soc of Maxillofacial Surgeons (ASMS) - 1
Amer Soc of Ophthalmic Plastic & Reconstructive Surg (ASOPRS) - 1
American Society of Plastic Surgeons (ASPS) – 3
American Society of Retina Specialists (ASRS) - 2
American Society of Transplant Surgeons (ASTS) - 1
International Coll of Surgeons-US Section (ICS-US) - 1
Society for Vascular Surgery (SVS) - 1
Society of Amer Gastrointestinal Endoscopic Surgeons (SAGES) - 2
Society of Laparoscopic and Robotic Surgeons (SLRS) - 2
Society of Thoracic Surgeons (STS) - 2

TERRITORIES - 2
Guam - 1
Virgin Islands - 1

TEXAS - 28
Former Presidents (Dickey, Rohack) - 2
Former Board Chair (Kridel) – 1
Delegates - 20
Medical Student Regional Delegate – 1
Resident and Fellow Section Delegates – 2
American College of Allergy, Asthma & Immunology (ACAAI) – 1
International Society of Hair Restoration Surgery (ISHRS) – 1

THORACIC MEDICINE - 2
American Thoracic Society (ATS) - 2

UROLOGY - 4
American Assoc of Clinical Urologists (AACU) - 1
American Urological Association (AUA) – 3
Delegates -2
Resident and Fellow Section Delegate – 1

OFFICIAL OBSERVERS - 28
Accreditation Association for Ambulatory Health Care
Alliance for Continuing Education in the Health Professions
Alliance for Regenerative Medicine
Ambulatory Surgery Center Association
American Academy of Physician Associates
American Association of Medical Assistants
American Board of Medical Specialties
American Dental Association
American Health Quality Association
American Hospital Association
American Nurses Association
American Podiatric Medical Association
American Public Health Association
Association of periOperative Registered Nurses
Association of State and Territorial Health Officials
Commission on Graduates of Foreign Nursing Schools
Council of Medical Specialty Societies
Educational Commission for Foreign Medical Graduates
Federation of State Medical Boards
Federation of State Physician Health Programs
Medical Group Management Association
Medical Professional Liability Association
National Association of County and City Health Officials
National Commission on Correctional Health Care
National Council of State Boards of Nursing
National Indian Health Board
Society for Academic Continuing Medical Education
US Pharmacopeia

TELLERS - 4

HOUSE OF DELEGATES · GAYLORD NATIONAL RESORT & CONVENTION CENTER, NATIONAL HARBOR, MARYLAND (I-23)

Audience Left — STAGE — Audience Right

SPEAKER — VICE SPEAKER

SEAT / ROW	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	CARDIOLOGY - 17								PENNSYLVANIA - 19							
1	HRS	HRS	ASNC	ASNC	SCCT	ACC	ACC	ACC	NMA			STUDENT	RESIDENT			
	CARDIOLOGY								PENNSYLVANIA							
2	ASE	ASE	SCMR	SCAI	SCAI	ACC	ACC	ACC	ACC	AAPIO	AHS					
	CALIFORNIA - 43								NEW YORK - 28				PENNSYLVANIA			
3								DING			STUDENT		HEINE			
	CALIFORNIA								NEW YORK							
4				STUDENT				NANOS								
	CALIFORNIA								NEW YORK							
5						STUDENT			NIELSEN							
	HAWAII - 2	CALIFORNIA							NEW YORK							
6								ACNS	MADEJSKI					ASN	ASN	ACNM
	WY - 1	CAIFORNIA							SURGEONS - 43							
7					RESIDENT				SVS	ACS	ACS	ACS	ACS	ACS	ACS	ACS
	UTAH - 2	CALIFORNIA							SURGEONS							
8					RESIDENT	ASRO	ASRO	CORLIN	ASBS	ASBS	ASCRS	ASCRS	ASMS	ICSUS	SAGES	SAGES
	NEW MEXICO - 4				ARIZONA - 8				SURGEONS							
9		RESIDENT		AAAAI				AIUM	ASCTRS	ASCTRS	AAO	AAO	AAO	AAO	SLR	SLR
	NEVADA - 4				ARIZONA				SURGEONS							
10		RESIDENT	RESIDENT					ACRO	ASAPS	ASRS	ASRS	ASOPRS	ASRMS	ASMBS	AAPS	AACS
	WASHINGTON - 7							AK - 1	SURGEONS							
11					STUDENT				AAOA	AATS	ASTS	STS	STS	ASPS	ASPS	ASPS
	COLORADO - 7							ID - 1	SURGEONS			ARS - 1	MOBILITY - 14			
12							OMA		AAOHNS	AAOHNS	AAOHNS		NASS	NASS	ASIPP	ASIPP
	RHODE ISLAND-2	MT - 1	OREGON - 5						ILLINOIS - 17			MOBILITY				
13						STUDENT			ACLM	SNMMI	AMWA	GURMAN	AAOS	AAOS	AAOS	AAOS
	MASSACHUSETTS - 15								ILLINOIS			MOBILITY				
14					STUDENT							ISASS	AORA	AOFAS	ASSH	AAHS
	NH - 1	MASSACHUSETTS							ILLINOIS							
15						RESIDENT						RESIDENT				
	VT - 1	MAINE - 3			CONNECTICUT - 8				MICHIGAN - 18					ILLINOIS		
16			STUDENT			STUDENT	RESIDENT		MUKKAMALA		STUDENT			RESIDENT		
	NEUROSCIENCES - 33				CONNECTICUT				MICHIGAN							
17	CARMEL	AANS	AANS/ RESIDENT	AANS		STUDENT		KOIRALA					RESIDENT			
	NEUROSCIENCES								MICHIGAN					OHIO - 15		
18	CNS	CNS	AAN	AAN	AAN/ RESIDENT	AAN	AAN	ASNI			RESIDENT					
	NEUROSCIENCES								OHIO							
19	AAPM	AAHPM	AAHPM	AACAP	AACAP	AAAP	IPSIS	NANS	AANEM				RESIDENT			
	NEUROSCIENCES								OHIO					WISCONSIN - 9		
20	GLMA	AAGP	AAPL	APA	APA	APA/ RESIDENT	APA	APA			RESIDENT			STUDENT	RESIDENT	
	ANESTHESIOLOGY - 11			NEUROSCIENCES					INDIANA - 6			WISCONSIN				
21	ASRAPM	ASRAPM	PATCHIN	APA	APA	APA	APA	HARRIS				UHMS		RESIDENT		
	ANESTHESIOLOGY				SERVICES - 6				INDIANA			EMERGENCY MEDICINE - 11				
22	ASA	ASA	ASA	ASA	ASA	VA	ARMY	AF		STUDENT		STACK	ACEP	ACEP/ RESIDENT		
	ANESTHESIOLOGY			SERVICES				HOSPITAL MED - 3	EMERGENCY MEDICINE							
23	ASA	ASA	ASA	PHS	NAVY	AMSUS									ACEP/ RESIDENT	

SEAT / ROW	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
			PATHOLOGY - 9					IOWA - 5						ADDICTION MEDICINE- 3		
1	T	T	CAP	CAP	CAP	CAP	NAME	ASC	OEIS					LEVIN	ASAM	ASAM
	TENNESSEE - 7							PATHOLOGY						MINNESOTA - 6		
2				AVLS				ASCP	ASCP	ASCP				STUDENT		
	DISTRICT OF COLUMBIA - 5					INTERNAL MEDICINE - 36						SD - 2	ND - 1	NEBRASKA - 3		
3			RESIDENT	SCALETTAR		FRYHOFER								RESIDENT		
	OKLAHOMA - 5					WV - 2		INTERNAL MEDICINE								
4				STUDENT												
	LOUISIANA - 7							INTERNAL MEDICINE								
5				STUDENT												
	NORTH CAROLINA - 7							INTERNAL MEDICINE								
6				STUDENT				WILSON								
	KENTUCKY - 6					RHEUM - 2		INTERNAL MEDICINE				FAMILY PHYSICIANS - 18				
7				STUDENT	RESIDENT				RPA							
	MARYLAND - 9							FAMILY PHYSICIANS								
8			EDWARDS	STUDENT		APCR	LANGSTON					RESIDENT				
	ALABAMA - 5					MARYLAND		PEDIATRICS - 7				FAMILY PHYSICIANS				
9			STUDENT						RESIDENT							
	VIRGINIA - 10							PEDIATRICS				PREVENTIVE MEDICINE - 8				
10			STUDENT	WOOTTON					AJAYI			AAPHP/ RESIDENT	AAPHP	ACMQ	ACOEM	ACOEM
	FLORIDA - 21					VIRGINIA	GASTROENTEROLOGY -		PREVENTIVE MEDICINE			RITICAL CARE MEDICINE -				
11			BUTLER	STUDENT	COBLE			ASGE	ASGE	ASGE	ACPM	AsMA	AAIM	RESIDENT		
	FLORIDA								GASTROENTEROLOGY			AMGA - 1	INFECTIOUS DISEASES - 3			
12									ACG	ACG	AGA	AGA		RESIDENT		
	FLORIDA								GERIATRICS - 3			ONCOLOGY - 5				
13										RESIDENT			MCANENY			
	SOUTH CAROLINA - 8								OBSTETRICIANS & GYNECOLOGISTS - 19					HEMATOLOGY - 2		
14				HARMON	SMOAK	PASTIDES			WAH	ACOG	ACOG	ACOG	ACOG	ACOG		
	GEORGIA - 7							OBSTETRICIANS & GYNECOLOGISTS								
15				STUDENT				ACOG	ACOG	ACOG	ACOG	ACOG	ACOG	ACOG	ACOG	ACMGG
	ARKANSAS - 4				DE - 2		PR - 2		OBSTETRICIANS & GYNECOLOGISTS					ENDOCRINOLOGY - 3		
16			FERGUSON			PERMUT				ASRM	AAGL	AAGL	AAGL	AACE	ES	ES
	NEW JERSEY - 11							SECTIONS - 12						THORACIC - 2		
17				STUDENT	AAFPRS				RFS	YPS	MAS	APS	IPPS	PPPS		
	MISSISSIPPI - 4			NEW JERSEY				SECTIONS						DERMATOLOGY - 11		
18			RESIDENT		AOA			SIDDIQUI	MSS	WPS	OMSS	IMG	SPS	ASDSA	ASDSA	ASDSA
	MISSOURI - 8			KANSAS - 4				CHEST PHYSICIANS - 3		PM&R - 2				DERMATOLOGY		
19			STUDENT		STUDENT			ACCP	ACCP	ACCP	AAPMR	AAPMR	ACMS	ACDS	ASD	SID
	MISSOURI			TERRITORIES -				TEXAS - 28				DERMATOLOGY				
20			RESIDENT					KRIDEL		RESIDENT			AAD	AAD	AAD	AAD
	RADIOLOGY - 17							TEXAS								
21	ACR	ACR	ACR	ACR	ARRS	ARRS	ARRS	DICKEY		STUDENT						
	RADIOLOGY - 17							TEXAS								
22	ACR	ACR	ACR	JOHNSON	AUR	SIR	SIR	ROHACK			RESIDENT					
	UROLOGY - 4				RADIOLOGY			TEXAS			AMDA - 2		SLEEP - 2			
23	AUA	AUA/ RESIDEN	AUA	AACU	RSNA	RSNA	RSNA	ACAAI	ISHRS							

Meeting Space Map

National Harbor Conference Rooms

- A National Harbor Conference Rooms

Ballroom Level

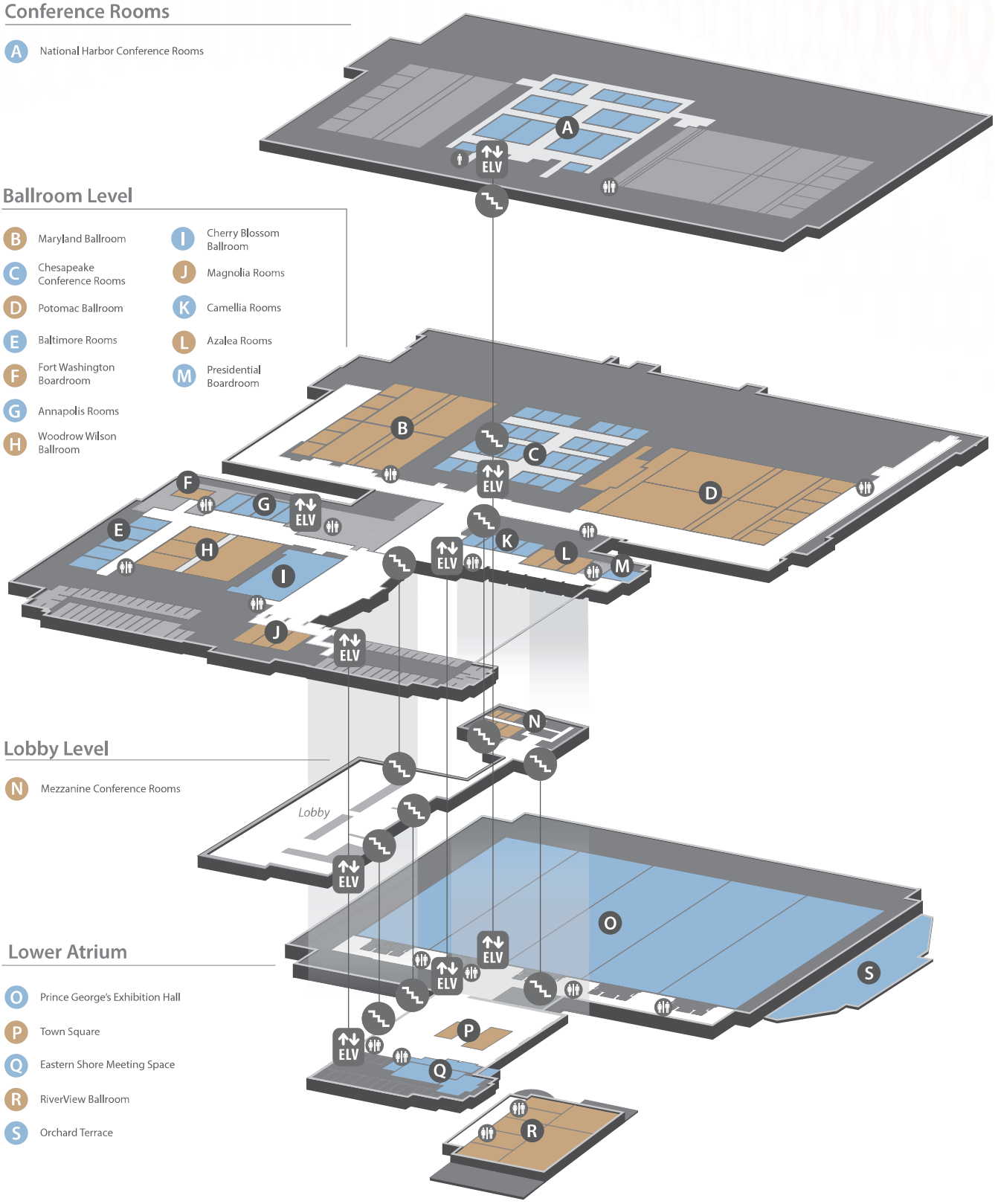
- B Maryland Ballroom
- C Chesapeake Conference Rooms
- D Potomac Ballroom
- E Baltimore Rooms
- F Fort Washington Boardroom
- G Annapolis Rooms
- H Woodrow Wilson Ballroom
- I Cherry Blossom Ballroom
- J Magnolia Rooms
- K Camellia Rooms
- L Azalea Rooms
- M Presidential Boardroom

Lobby Level

- N Mezzanine Conference Rooms

Lower Atrium

- O Prince George's Exhibition Hall
- P Town Square
- Q Eastern Shore Meeting Space
- R RiverView Ballroom
- S Orchard Terrace



2023 INTERIM MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Official Call to the Officers and Members of the American Medical Association to attend the November 2023 Interim Meeting of the House of Delegates in Chicago, Illinois, November 10 - 14, 2023.

The House of Delegates will convene at 6:00 p.m., on November 10 at the Gaylord National Resort & Convention Center.

STATE ASSOCIATION REPRESENTATION IN THE HOUSE OF DELEGATES

Alabama 4
Alaska 1
Arizona 5
Arkansas 3
California 33
Colorado 6
Connecticut 4
Delaware 1
District of Columbia 3
Florida 17
Georgia 6
Guam 1
Hawaii 2
Idaho 1
Illinois 12
Indiana 5
Iowa 4
Kansas 3
Kentucky 5
Louisiana 6
Maine 2
Maryland 6
Massachusetts 13
Michigan 14
Minnesota 5
Mississippi 3
Missouri 6
Montana 1
Nebraska 2
Nevada 2
New Hampshire 1
New Jersey 8
New Mexico 2
New York 22
North Carolina 6
North Dakota 1
Ohio 13
Oklahoma 4
Oregon 4
Pennsylvania 13
Puerto Rico 2
Rhode Island 2
South Carolina 5
South Dakota 2
Tennessee 6
Texas 20
Utah 2
Vermont 1
Virgin Islands 1
Virginia 8
Washington 6
West Virginia 2
Wisconsin 5
Wyoming 1

SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

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

Remaining eligible national medical specialty societies (63) are entitled to one delegate each.

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

State Medical Associations	312
National Medical Specialty Societies	309
Professional Interest Medical Associations	3
Other National Societies (AMWA, AOA, NMA)	3
Medical Student Regional Delegates	27
Resident and Fellow Delegate Representatives	35
Sections	11
Services	5
Total Delegates	**705**

Registration facilities will be maintained at the Gaylord National Resort & Convention Center Foyer.

Jesse M. Ehrenfeld, MD, MPH
President

Lisa Bohman Egbert, MD
Speaker, House of Delegates

David H. Aizuss, MD
Secretary

2023 - 2024

OFFICIALS OF THE ASSOCIATION

BOARD OF TRUSTEES (OFFICERS)

President – Jesse M. Ehrenfeld ..... Milwaukee, Wisconsin
President-Elect - Bruce A. Scott ..... Louisville, Kentucky
Immediate Past President – Jack Resneck ..... San Rafael, California
Secretary – David H. Aizuss ..... Encino, California
Speaker, House of Delegates - Lisa Bohman Egbert ..... Kettering, Ohio
Vice Speaker, House of Delegates - John H. Armstrong ..... Ocala, Florida

Toluwalase A. Ajayi (2026) ..... San Diego, California
Madelyn E. Butler (2025) ..... Tampa, Florida
Alexander Ding (2026) ..... Louisville, Kentucky
Willarda V. Edwards (2024) ..... Baltimore, Maryland
Scott Ferguson (2026) ..... West Memphis, Arkansas
Sandra Adamson Fryhofer (2026) ..... Atlanta, Georgia
Marilyn J. Heine (2026) ..... Dresher, Pennsylvania
Pratistha Koirala (2024) ..... Danbury, Connecticut
Ilse R. Levin (2024) ..... Silver Spring, Maryland
Thomas J. Madejski (2024) ..... Medina, New York
Bobby Mukkamala (2025) ..... Flint, Michigan
Harris Pastides (2024) ..... Columbia, South Carolina
Aliya Siddiqui (2024) ..... Milwaukee, Wisconsin
Michael Suk (2024), *Chair-Elect* ..... Danville, Pennsylvania
Willie Underwood, III (2024), *Chair* ..... Buffalo, New York

COUNCILS OF THE AMA

COUNCIL ON CONSTITUTION AND BYLAWS
Jerry P. Abraham, Los Angeles, California, Vice Chair (2025); John H. Armstrong, Ocala, Florida, Vice Speaker: Ex Officio (2024); Mark N. Bair, Highland, Utah, Chair, (2027); Druv Bhagavan, St. Louis, Missouri (Student) (2024); Pino D. Colone, Howell, Michigan (2024); Mary Ann Contogiannis, Greensboro, North Carolina (2025); Lisa Bohman Egbert, Kettering, Ohio, Speaker: Ex Officio (2027); Daniel O. Pfeifle, Indianapolis, Indiana (Resident) (2025); Kevin C. Reilly, Sr., Grovetown, Georgia (2026); Steven C. Thornquist, Bethany, Connecticut (2026).
Secretary: Janice Robertson, Chicago, Illinois.

COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
Rebecca W. Brendel, Boston, Massachusetts (2026); Arthur R. Derse, Shorewood, Wisconsin (2030); Sophia A. Doerr, Madison, Wisonsin (Student) (2025); David A. Fleming, Columbia, Missouri, Chair (2024); Michael G. Knight, Washington, District of Columbia (2029); Jeremy A. Lazarus, Greenwood Village, Colorado, Vice Chair (2025); Larry E. Reaves, Fort Worth, Texas (2027); Daniel P. Sulmasy, Washington, District of Columbia (2028); Danish M. Zaidi, New Haven, Connecticut (Resident) (2024).
Secretary: Amber Comer, Chicago, Illinois.

COUNCIL ON LEGISLATION
Vijaya L. Appareddy, Chattanooga, Tennessee (2024); Maryanne C. Bombaugh, Falmouth, Massachusetts (2024); Claude D. Brunson, Ridgeland, Mississippi (2024); Michael D. Chafty, Kalamazoo, Michigan (2024); Gary W. Floyd, Corpus Christi, Texas, Chair, (2024); Benjamin Z. Galper, McLean, Virginia (AMPAC Liaison) (2024); Merrilee Aynes Gober, Atlanta, Georgia (Alliance Rep) (2029); Ross F. Goldberg, Scottsdale, Arizona (2024); Tracy L. Henry, Lithonia, Georgia (2024); Tripti C. Kataria, Chicago, Illinois (2024); Sarah Mae Smith, Anaheim, California (Student) (2024); Sophia E. Spadafore, New York, New York (Resident) (2024); Ann Rosemarie Stroink, Bloomington, Illinois (2024); Marta J. Van Beek, Iowa City, Iowa, Vice Chair (2024).
Secretary: George Cox, Washington, District of Columbia.

COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT
Edmond B. Cabbabe, St. Louis, Missouri (2025); Clarence P. Chou, Milwaukee, Wisconsin (2024); Renato A. Guerrieri, Houston, Texas (Student) (2024); G. Sealy Massingill, Fort Worth, Texas (2027); Gary D. Thal, Chicago, Illinois, Chair (2025); Michelle A. Berger, Austin, Texas, Vice Chair (2026); Jan M. Kief, Merritt Island, Florida (2027); Shannon P. Pryor, Chevy Chase, Maryland (2024); Stephanie M. Strohbeen, Whitefish Bay, Wisconsin (Resident) (2024).
Secretary: Susan Close, Chicago, Illinois.

COUNCIL ON MEDICAL EDUCATION
Suja M. Matthew, Hinsdale, Illinois (2026); Sherri S. Baker, Edmond, Oklahoma (2025); Kelly J. Caverzagie, Omaha, Nebraska (2027); Ricardo R. Correa Marquez, Phoenix, AZ (2027); Louito C. Edje, Cincinnati, Ohio (2025); Robert B. Goldberg, Morristown, New York (2025); Revati Gummaluri, Flemington, New Jersey (Student) (2024); Cynthia A. Jumper, Lubbock, Texas, Chair (2024); Shannon M. Kilgore, Palo Alto, California (2027); Daniel C. Lee, Mobile, Alabama (Resident) (2025); Krystal L. Tomei, Lyndhurst, Ohio, Chair-Elect (2025); Daniel M. Young, Vestal, New York (2027).
Secretary: Tanya Lopez, Chicago, Illinois.

COUNCIL ON MEDICAL SERVICE
A. Patrice Burgess, Boise, Idaho (2027); Alain A. Chaoui, Peabody, Massachusetts (2025); Steven L. Chen, San Diego, California (2024); Betty S. Chu, Detroit, Michigan (At-Large) (2026); Alice Coombs, Richmond, Virginia (2027); Erick A. Eiting, New York, New York (2024); Stephen K. Epstein, Needham, Massachusetts, Chair-Elect (2026); Ravi Goel, Cherry Hill, New Jersey (2026); Hari S. Iyer Detroit, Michigan (Resident) (2025); Lynn L. C. Jeffers, Camarillo, California, Chair (2024); Justin W. Magrath New Orleans, Louisiana (Student) (2024); Sheila Rege, Pasco, Washington, Chair (2026).
Secretary: Val Carpenter, Chicago, Illinois.

COUNCIL ON SCIENCE AND PUBLIC HEALTH
Ankush K. Bansal, Loxahatchee, Florida (2027); Joanna Bisgrove, Evanston, Illinois (2026); John T. Carlo, Dallas, Texas, Chair-Elect (2025); Joshua M. Cohen, New York, New York (2026); David R. Cundiff, Ilwaco, Washington (2026); Karen Dionesotes, Baltimore, Maryland (Resident) (2024); Mary E. LaPlante, Broadview Heights, OH (2025); Marc Mendelsohn, St. Louis, MO (2027); Tamaan K. Osbourne-Roberts, Denver, Colorado (2027); Padmini D. Ranasinghe, Baltimore, Maryland (2026); David J. Welsh, Batesville, Indiana, Chair (2024); Kirsten C. Woodyard De Brit, Covington, KY (Student) (2024).
Secretary: Andrea Garcia, Chicago, Illinois.

AMERICAN MEDICAL ASSOCIATION POLITICAL ACTION COMMITTEE
Elie C. Azrak, St. Louis, Missouri; Brooke M. Buckley, Bloomfield Hills, Michigan, Chair; Paul J. Carniol, Summit, New Jersey; Juliana Cobb, Lousiville, Kentucky (Student); Benjamin Z. Galper, McLean, Virginia (COL Liaison); Victoria Gordon, Houston, Texas (Resident); Bruce A. MacLeod, Pittsburgh, Pennsylvania; L. Elizabeth Peterson, Spokane, Washington, Secretary; Stephen J. Rockower, Bethesda, Maryland; Sion Roy, Malibu, California; Janice E. Tildon-Burton, Wilmington, Delaware.
Executive Director and Treasurer: Kevin Walker, Washington, District of Columbia.

EX OFFICIO MEMBERS OF THE HOUSE OF DELEGATES

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

FORMER PRESIDENTS

Susan R. Bailey	2020-2021	Patrice A. Harris	2019-2020	Nancy H. Nielsen	2008-2009
David O. Barbe	2017-2018	J. Edward Hill	2005-2006	William G. Plested, III	2006-2007
Lonnie R. Bristow	1995-1996	Ardis D. Hoven	2013-2014	J. James Rohack	2009-2010
Peter W. Carmel	2011-2012	Daniel H. Johnson, Jr.	1996-1997	Randolph D. Smoak, Jr.	2000-2001
Yank D. Coble, Jr.	2002-2003	Jeremy A. Lazarus	2012-2013	Steven J. Stack	2015-2016
Richard F. Corlin	2001-2002	Robert E. McAfee	1994-1995	Robert M. Wah	2014-2015
Nancy W. Dickey	1998-1999	Barbara L. McAneny	2018-2019	Cecil B. Wilson	2010-2011
Andrew W. Gurman	2016-2017	Alan R. Nelson	1989-1990	Percy Wootton	1997-1998
Gerald E. Harmon	2021-2022	John C. Nelson	2004-2005		

FORMER TRUSTEES

Herman I. Abromowitz	1997-2005	Alan C. Hartford	1989-1990	Rebecca J. Patchin	1988-1989
Susan Hershberg Adelman	1998-2002	Drayton Charles Harvey	2020-2023	Rebecca J. Patchin	2003-2011
Kendall S. Allred	2008-2009	William A. Hazel, Jr	2004-2009	Stephen R. Permut	2010-2018
Raj S. Ambay	2009-2011	Cyril M. Hetsko	2003-2011	Pamela Petersen-Crair	1996-1998
Joseph P. Annis	2006-2014	J. Edward Hill	1996-2004	Dina Marie Pitta	2015-2016
Grayson W. Armstrong	2019-2021	Ardis D. Hoven	2005-2012	William G. Plested, III	1998-2005
John H. Armstrong	2002-2006	William E. Jacott	1989-1998	Stephen Pool	1995-1996
Maya A. Babu	2013-2017	Hillary D. Johnson	2001-2002	Liana Puscas	1999-2001
Susan R. Bailey	2011-2018	Matthew D. Kagan	1999-2000	Kevin C. Reilly	2003-2005
Timothy E. Baldwin	1987-1989	Christopher K. Kay	2008-2012	Ryan J. Ribeira	2013-2014
David O. Barbe	2009-2016	William E. Kobler	2012-2020	J. James Rohack	2001-2008
Regina M. Benjamin	1995-1998	Russell W.H. Kridel	2014-2022	David A. Rosman	2002-2004
Scott L. Bernstein	1991-1992	Edward L. Langston	2003-2011	Samantha L. Rosman	2005-2009
Stefano M. Bertozzi	1986-1988	Matthew C. Lawyer	2004-2005	Raymond Scalettar	1985-1994
David J. Brailer	1985-1986	Jeremy A. Lazarus	2005-2011	Bruce A. Scott	1998-2002
Lonnie R. Bristow	1985-1994	W. J. Lewis	1979-1984	Carl A. Sirio	2010-2018
Peter Carmel	2002-2010	Audrey J. Ludwig	1990-1991	Sarah Mae Smith	2019-2020
Alice A. Chenault	1984-1985	Justin B. Mahida	2009-2010	Randolph D. Smoak, Jr.	1992-1999
Yank D. Coble	1994-2001	Omar Z. Maniya	2016-2017	Steven J. Stack	2006-2014
David S. Cockrum	1993-1994	Robert E. McAfee	1984-1993	Michael Suk	1994-1995
MaryAnn Contogiannis	1989-1993	Barbara L. McAneny	2010-2017	Andrew M. Thomas	1997-1999
Malini Daniel	2012-2013	William A. McDade	2016-2020	Jeffrey A. Towson	1998-1999
Christopher M. DeRienzo	2006-2008	Mary Anne McCaffree	2008-2016	Georgia A. Tuttle	2011-2019
Nancy W. Dickey	1989-1997	Joe T. McDonald	2005-2006	Jordan M. VanLare	2011-2012
Alexander Ding	2011-2013	Samuel J. Mackenzie	2014-2015	Robert M. Wah	2005-2013
William A. Dolan	2007-2011	Sandeep “Sunny” Mistry	2000-2001	Peter Y. Watson	2001-2003
Timothy T. Flaherty	1994-2003	Mario Motta	2018-2022	Monica C. Wehby	2011-2013
Melissa J. Garretson	1992-1993	Elizabeth Blake Murphy	2020-2021	Kevin W. Williams	2016-2020
Michael S. Goldrich	1993-1997	Alan R. Nelson	1980-1988	Meredith C. Williams	2010-2011
Julie K. Goonewardene	2012-2016	John C. Nelson	1994-2003	Cecil B. Wilson	2002-2009
Andrew W. Gurman	2007-2015	Nancy H. Nielsen	2005-2007	Percy Wootton	1991-1996
Patrice A. Harris	2011-2018	Albert J. Osbahr, III	2011-2019		

SPECIALTY AND SERVICE SOCIETY REPRESENTATIVES
2023 Interim Meeting of the AMA House of Delegates

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

Academy of Consultation Liaison Psychiatry	Lee Tynes, MD
American Academy of Emergency Medicine	Joseph Wood, MD, JD
American Association of Endocrine Surgeons	Dina Elaraj, MD
American Association of Hip and Knee Surgeons	Beau Kildow, MD
American College of Correctional Physicians	Charles Lee, MD
American College of Lifestyle Medicine	Cate Collings, MD
American Dermatological Association	Murad Alam, MD
American Epilepsy Society	David M. Labiner, MD
American Society for Laser Medicine and Surgery	George Hruza, MD
American Society of General Surgeons	Albert Kwan, MD
American Society of Nephrology	Jeffrey S. Berns, MD
American Venous Forum	Eleftherios Xenos, MD; Greg Snyder, MD
Association of Academic Physiatrists	Prakash Jayabalan, MD, PhD
Association of Professors of Dermatology	Christopher R. Shea, MD
International Academy of Independent Medical Evaluators	Diana Kraemer, MD
Korean American Medical Association	John Yun, MD
Society for Pediatric Dermatology	Dawn Davis, MD
United States and Canadian Academy of Pathology	Nicole Riddle, MD; Daniel Zedek

MEMBERS OF THE HOUSE OF DELEGATES SPECIAL MEETING - NOVEMBER 2023
The following is a list of delegates and alternate delegates to the House of Delegates as reported to the Executive Vice President

Medical Association of the State of Alabama

Delegate(s)

B Jerry Harrison, Haleyville AL

John Meigs Jr, Brent AL

William Schneider, Huntsville AL

George C. Smith, Lineville AL

Alternate Delegate(s)

Alexis Mason, Tuscaloosa AL

Jane Weida, Tuscaloosa AL

Tom Weida, Tuscaloosa AL

Regional Medical Student Delegate(s)

Amber Shirley, New Tazewell TN

Regional Medical Student Alternate Delegate(s)

Joshua Collingwood, Dothan AL

Arizona Medical Association

Delegate(s)

Veronica K. Dowling, Lakeside AZ

Gary R. Figge, Tucson AZ

Michael Hamant, Tucson AZ

M Zuhdi Jasser, Phoenix AZ

Marc Leib, Phoenix AZ

Alternate Delegate(s)

Ilana Addis, Tucson AZ

Adam Brodsky, Phoenix AZ

Timothy Fagan, Tucson AZ

Jacquelyn Hoffman, Tucson AZ

Nadeem Kazi, Casa Grande AZ

Arkansas Medical Society

Delegate(s)

Amy Cahill, White Hall AR

Arkansas Medical Society

Delegate(s)

Eugene Shelby, Little Rock AR

Alan Wilson, Monticello AR

Alternate Delegate(s)

Stephen Magie, Conway AR

Danny Wilkerson, Little Rock AR

California Medical Association

Delegate(s)

Jerry P Abraham, Los Angeles CA

Barbara J. Arnold, Sacramento CA

Patricia L. Austin, Alamo CA

Dirk Stephen Baumann, Burlingame CA

David Bazzo, San Diego CA

Jeffrey Brackett, Ventura CA

Peter N. Bretan, Novato CA

J Brennan Cassidy, Newport Beach CA

Kyle P. Edmonds, San Diego CA

Rachel Ekaireb, Sacramento CA

George Fouras, Los Angeles CA

Dev A. GnanaDev, Upland CA

Catherine Gutfreund, Santa Rosa CA

Robert Hertzka, Rancho Santa Fe CA

Samuel Huang, Los Angeles CA

Kermit Jones, Vacaville CA

Jessica Kim, San Jose CA

Jeff Klingman, Orinda CA

Edward Lee, Sacramento CA

Man Kit Leung, San Francisco CA

Arthur N. Lurvey, Los Angeles CA

California Medical Association

Delegate(s)

Michael Luszczak, Carmichael CA

Ramin Manshadi, Stockton CA

Theodore Mazer, Fort Myers FL

Kelly McCue, Davis CA

Mihir Parikh, La Jolla CA

Stephen Parodi, Oakland CA

Albert Ray, San Diego CA

Ryan J. Ribeira, Mountain View CA

Tatiana W. Spirtos, Redwood City CA

James J. Strebig, Irvine CA

Raymond Tsai, Lost Hills CA

Holly Yang, San Diego CA

Alternate Delegate(s)

Alan Anzai, Sacramento CA

Jacob Burns, Sacramento CA

Jack Chou, Baldwin Park CA

James Cotter, Napa CA

Suparna Dutta, Oakland CA

Sergio Flores, San Diego CA

David Friscia, San Diego CA

Anjalee Galion, Santa Ana CA

Raminder Gill, Sacramento CA

Brian Grady, San Francisco CA

Scott Richard Karlan, West Hollywood CA

Nikan Khatibi, Laguna Niguel CA

Mark H. Kogan, San Pablo CA

Sudeep Kukreja, Orange CA

Stacey Ludwig, Los Angeles CA

Debbie Lupeika, Redding CA

Chang Na, Bakersfield CA

California Medical Association

Alternate Delegate(s)

Kimberly Newell, San Francisco CA

Bing Pao, Rcho Santa Fe CA

Sion Roy, Malibu CA

Lorin Scher, Sacramento CA

Ellen Shank, Sacramento CA

Seema Sidhu, Fremont CA

William Tseng, San Diego CA

Shannon Udovic-Constant, San Francisco CA

Valencia Walker, Los Angeles CA

Patricia Wang, Antioch CA

Barbara Weissman, Pacifica CA

Anna Yap, Carmichael CA

Frank Zhou, Los Angeles CA

Resident and Fellow Sectional Delegate(s)

Jacob Hoerter, Oakland CA

Pauline Huynh, Oakland CA

Resident and Fellow Sectional Alternate Delegate(s)

Dayna Isaacs, El Dorado Hills CA

Regional Medical Student Delegate(s)

Rana Andary, Irvine CA

Sarah Mae Smith, Irvine CA

Regional Medical Student Alternate Delegate(s)

Kylee Borger, Riverside CA

Joely Hannan, Snoqualmie WA

Elisabeth McCallum, Irvine CA

Jacob Schlossman, Irvine CA

Colorado Medical Society

Delegate(s)

David Downs, Denver CO

Jan Kief, Merritt Island FL

Current as of: 10/12/2023

Colorado Medical Society

Delegate(s)

A. "Lee" Morgan, Denver CO

Tamaan Osbourne-Roberts, Denver CO

Lynn Parry, Littleton CO

Alternate Delegate(s)

Carolynn Francavilla, Lakewood CO

Rachelle M. Klammer, Denver CO

Patrick Pevoto, Fruita CO

Brigitta J. Robinson, Centennial CO

Michael Volz, Englewood CO

Connecticut State Medical Society

Delegate(s)

Katherine L. Harvey, Canton CT

Kathleen A. LaVorgna, Norwalk CT

Bollepalli Subbarao, Middletown CT

Steven C. Thornquist, Bethany CT

Alternate Delegate(s)

M. Natalie Achong, Unionville CT

Raymond Lorenzoni, Woodbridge CT

Stacy Taylor, New Hartford CT

Michael Virata, Woodbridge CT

Resident and Fellow Sectional Delegate(s)

Daniel Kerekes, New Hyde Park NY

Regional Medical Student Delegate(s)

Krishna Channa, Farmington CT

Julia Silverman, Farmington CT

Regional Medical Student Alternate Delegate(s)

Catriona Hong, Glastonbury CT

Vedika Karandikar, Farmington CT

Lizzie Suschana, Farmington CT

Medical Society of Delaware

Delegate(s)

Janice Tildon-Burton, Newark DE

Alternate Delegate(s)

Matthew Burday, Wilmington DE

Medical Society of the District of Columbia

Delegate(s)

Neal D Barnard, Washington DC

Peter E. Lavine, Washington DC

Raymond K. Tu, Washington DC

Alternate Delegate(s)

Susanne Bathgate, Arlington VA

Matthew Lecuyer, Washington DC

Meghan Schott, Washington DC

Resident and Fellow Sectional Delegate(s)

Angela Wu, Washington DC

Florida Medical Association

Delegate(s)

Ankush Bansal, Westlake FL

Rebekah Bernard, Fort Myers FL

Andrew Cooke, Mount Dora FL

Lisa Cosgrove, Jacksonville FL

Eva Crooke, Tampa FL

Mark Dobbertien, Orange Park FL

Michelle Falcone, Miami FL

Ronald Frederic Giffler, Davie FL

Jason Goldman, Coral Springs FL

Rebecca Lynn Johnson, Tampa FL

Tra'Chella Johnson Foy, Jacksonville FL

John Montgomery, Fleming Island FL

Douglas Murphy, Ocala FL

Ralph Jacinto Nobo, Bartow FL

Michael L. Patete, Venice FL

Florida Medical Association

Delegate(s)

Alan B. Pillersdorf, Lake Worth FL

Michael Andrew Zimmer, St Petersburg FL

Alternate Delegate(s)

Shawn Baca, Boca Raton FL

Michael Cromer, Tampa FL

Aaron Elkin, Hollywood FL

Vania Fernandez, Miami FL

Shelley C. Glover, Clermont FL

Raphael C. Haciski, Naples FL

Ryan Hall, Lake Mary FL

Lawrence S. Halperin, Altamonte Spg FL

Karen Harris, Gainesville FL

Kacey Montgomery, Gulf Breeze FL

Vicki Norton, Boca Raton FL

Arthur E. Palamara, Hollywood FL

Thomas G. Peters, Jacksonville FL

Sergio B. Seoane, Lakeland FL

Regional Medical Student Delegate(s)

Neva Lundy, Miami FL

Regional Medical Student Alternate Delegate(s)

Alex Tolbert, Tallahassee FL

Medical Association of Georgia

Delegate(s)

John S. Antalis, Dalton GA

S William Clark III, Waycross GA

Billie Luke Jackson, Macon GA

Ali R Rahimi, Atlanta GA

Sandra B. Reed, Atlanta GA

Charles Wilmer, Atlanta GA

Medical Association of Georgia

Alternate Delegate(s)

Keisha Callins, Macon GA

Shamie Das, Atlanta GA

Zachary Lopater, Macon GA

Chris McAdams, Atlanta GA

Fonda A. Mitchell, Atlanta GA

Regional Medical Student Delegate(s)

Aditi Dave, Macon GA

Hawaii Medical Association

Delegate(s)

Bernard Robinson, Aiea HI

Jerry Van Meter, Honolulu HI

Alternate Delegate(s)

Angela Pratt, Honolulu HI

Idaho Medical Association

Delegate(s)

A. Patrice Burgess, Boise ID

Alternate Delegate(s)

Zachary Warnock, Pocatello ID

Illinois State Medical Society

Delegate(s)

Rodney Alford, Watseka IL

Thomas M. Anderson, Chicago IL

Howard Axe, Grayslake IL

Christine Bishof, Elmhurst IL

Howard Chodash, Springfield IL

Niva Lubin-Johnson, Chicago IL

James L. Milam, Grayslake IL

Robert Panton, Elmwood Park IL

Ammu Susheela, Chicago IL

Shastri Swaminathan, Westmont IL

Piyush Vyas, Lake Forest IL

Illinois State Medical Society

Delegate(s)

Steven D. Williams, Bourbonnais IL

Alternate Delegate(s)

Smitha Arekapudi, Chicago IL

Scott A. Cooper, Chicago IL

Richard A. Geline, Glenview IL

Vikram B. Patel, South Barrington IL

Holly Rosencranz, Champaign IL

Judith G Savage, Tinley Park IL

Kayla Tran, North Chicago IL

Resident and Fellow Sectional Delegate(s)

Moudi Hubeishy, Chicago IL

Adam Roussas, Chicago IL

Resident and Fellow Sectional Alternate Delegate(s)

Oluwasegun Paul Emenogu, Chicago IL

Indiana State Medical Association

Delegate(s)

Michael Hoover, Evansville IN

Vidya S. Kora, Michigan City IN

William Mohr, Kokomo IN

Rhonda Sharp, Lagrange IN

David Welsh, Batesville IN

Alternate Delegate(s)

Deepak Azad, Floyds Knobs IN

Roberto Darroca, Muncie IN

Heidi Dunniway, Evansville IN

Lisa Hatcher, Columbia City IN

Stacie Wenk, Evansville IN

Regional Medical Student Delegate(s)

Sydney Clark, W Lafayette IN

Iowa Medical Society

Delegate(s)

Robert Lee, Johnston IA

Douglas Martin, Sioux City IA

Douglas Peters, W Burlington IA

Victoria Sharp, Iowa City IA

Alternate Delegate(s)

Brian Privett, Cedar Rapids IA

Jessica Zuzga-Reed, Waukee IA

Kansas Medical Society

Delegate(s)

Mark Brady, Shawnee Mission KS

Robert Gibbs, Parsons KS

Arthur D. Snow, Shawnee Mission KS

Alternate Delegate(s)

Debra Doubek, Manhattan KS

LaDona Schmidt, Holton KS

Benjamin Stone, Overland Park KS

Regional Medical Student Delegate(s)

Maddy Mash, Kansas City KS

Kentucky Medical Association

Delegate(s)

David J. Bensema, Lexington KY

J Gregory Cooper, Cynthiana KY

John L. Roberts, Louisville KY

Donald J. Swikert, Edgewood KY

Alternate Delegate(s)

Shawn C. Jones, Paducah KY

Neal J. Moser, Taylor Mill KY

Monalisa Tailor, Louisville KY

R. Brent Wright, Glasgow KY

Resident and Fellow Sectional Delegate(s)

Elisa Quince, Visailia CA

Kentucky Medical Association

Regional Medical Student Delegate(s)
Abby Rawls, Bowling Green KY

Louisiana State Medical Society

Delegate(s)
Luis M. Alvarado, Mandeville LA
Kamel Brakta, Shreveport LA
George Ellis, New Orleans LA
William Freeman, Prairieville LA
Donald Posner, Shreverport LA

Alternate Delegate(s)
Deborah Fletcher, Shreveport LA
Clayton Runfalo, Prairieville LA

Regional Medical Student Delegate(s)
Laila Koduri, New Orleans LA

Maine Medical Association

Delegate(s)
Richard A. Evans, Dover Foxcroft ME
Maroulla S. Gleaton, Augusta ME

Alternate Delegate(s)
Dieter Kreckel, Rumford ME
Charles F. Pattavina, Bangor ME

Regional Medical Student Delegate(s)
Kaye Dandrea, Lakeville MA

MedChi: The Maryland State Medical Society

Delegate(s)
Harbhajan Ajrawat, Potomac MD
Loralie Dawn Ma, Fulton MD
Shannon Pryor, Chevy Chase MD
Gary Pushkin, Baltimore MD
Stephen J. Rockower, Bethesda MD
Bruce M. Smoller, Potomac MD

MedChi: The Maryland State Medical Society

Alternate Delegate(s)
Renee Bovelle, Silver Spring MD
Rohini Chakravarthy, Baltimore MD
Karen Qi, Baltimore MI
Padmini Ranasinghe, Baltimore MD
James J. York, Millersville MD

Regional Medical Student Delegate(s)
Preetham Bachina, Baltimore MD

Massachusetts Medical Society

Delegate(s)
Maryanne C. Bombaugh, Mashpee MA
Theodore A Calianos II, Mashpee MA
Alain A. Chaoui, Boxford MA
Emily Cleveland Manchanda, Andover MA
Dennis Dimitri, Worcester MA
Henry Dorkin, Newton MA
Ronald Dunlap, Weymouth MA
Christopher Garofalo, N Attleboro MA
Lee S. Perrin, Southborough MA
David A. Rosman, Stoneham MA
Spiro Spanakis, Shrewsbury MA
Ellana Stinson, Boston MA
Lynda M. Young, Worcester MA

Alternate Delegate(s)
Carole Allen, Arlington MA
Melody J. Eckardt, Milton MA
Eli Freiman, Watertown MA
Michael Medlock, Lexington MA
Maximilian J. Pany, Brookline MA
Kenath Shamir, Fall River MA
Barbara A. Spivak, Watertown MA

Massachusetts Medical Society

Resident and Fellow Sectional Delegate(s)

Celeste Peay, Boston MA

Resident and Fellow Sectional Alternate Delegate(s)

Hussein Antar, Salem MA

Regional Medical Student Delegate(s)

Priya Desai, Boston MA

Regional Medical Student Alternate Delegate(s)

Nimish Saxena, Boston MA

Michigan State Medical Society

Delegate(s)

Paul D. Bozyk, Beverly Hills MI

T. Jann Caison-Sorey, Bloomfield Heights MI

Michael D. Chafty, Kalamazoo MI

Betty S. Chu, Detroit MI

Pino D. Colone, Howell MI

Kaitlyn Dobesh, Detroit MI

Amit Ghose, Okemos MI

Mark C. Komorowski, Essexville MI

Christie L. Morgan, Grosse Pointe Woods MI

Rose M. Ramirez, Belmont MI

Michael A. Sandler, West Bloomfield MI

Krishna K. Sawhney, Bloomfield Hills MI

Richard E. Smith, W Bloomfield MI

David T. Walsworth, East Lansing MI

Alternate Delegate(s)

Brooke M. Buckley, Wyandotte MI

Edward Bush, Grosse Ile MI

Theodore Jones, Dearborn MI

Courtland Keteyian, Ann Arbor MI

Patricia Kolowich, Northville MI

Aarti Patel, Northville MI

Michigan State Medical Society

Alternate Delegate(s)

Michael J Redinger, Kalamazoo MI

M. Salim U Siddiqui, Canton MI

John A. Waters, Flint MI

David Whalen, Grand Rapids MI

Resident and Fellow Sectional Delegate(s)

Nicolas Fletcher, Grand Rapids MI

Mohammad Ibrahim, Dearborn MI

Regional Medical Student Delegate(s)

Sara Kazyak, Detroit MI

Regional Medical Student Alternate Delegate(s)

Alex Yorks, Detroit MI

Minnesota Medical Association

Delegate(s)

John Abenstein, Oronoco MN

Andrea Hillerud, Eagan MN

Dennis O'Hare, Minneapolis MN

Cindy F. Smith, Spicer MN

David Thorson, Mahtomedi MN

Alternate Delegate(s)

Lisa Mattson, Plymouth MN

George Morris, Saint Cloud MN

Ashok Patel, Rochester MN

Laurel Ries, Saint Paul MN

Regional Medical Student Delegate(s)

Adrine Kocharian, Minneapolis MN

Mississippi State Medical Association

Delegate(s)

Jennifer Bryan, Brandon MS

J Clay Hays, Jackson MS

Carlos Latorre, Vicksburg MS

Mississippi State Medical Association

Alternate Delegate(s)

Randy Easterling, Vicksburg MS

Katherine Pannel, Oxford MS

Lee Voulters, Pass Christian MS

Resident and Fellow Sectional Delegate(s)

Avani Patel, Jackson MS

Missouri State Medical Association

Delegate(s)

Elie Azrak, Bridgeton MO

Peggy Barjenbruch, Mexico MO

Edmond Cabbabe, St Louis MO

Joseph Corrado, Mexico MO

Betty Drees, Kansas City MO

Charles W. Van Way, Fairway KS

Alternate Delegate(s)

Charles Adams, Kansas City MO

George Hruza, Chesterfield MO

Ravi S Johar, Chesterfield MO

Joanne Loethen, Prairie Village KS

Kayce Morton, Springfield MO

Resident and Fellow Sectional Delegate(s)

Kelly Schmidt, Columbia MO

Regional Medical Student Delegate(s)

Druv Bhagavan, Saint Louis MO

Regional Medical Student Alternate Delegate(s)

Tanvi Karmarkar, Kansas City MO

Sham Manoranjithan, Columbia MO

Montana Medical Association

Delegate(s)

Nicole C. Clark, Helena MT

Montana Medical Association

Alternate Delegate(s)

Michael P Temporal, Billings MT

Nebraska Medical Association

Delegate(s)

Kelly J. Caverzagie, Omaha NE

Jordan Warchol, Omaha NE

Alternate Delegate(s)

Aman Mahal, Omaha NE

Robert Wergin, Seward NE

Resident and Fellow Sectional Delegate(s)

Michael Visenio, Omaha NE

Regional Medical Student Alternate Delegate(s)

Andrew Norton, Madison WI

Nevada State Medical Association

Delegate(s)

Wayne C. Hardwick, Reno NV

Florence Jameson, Boulder City NV

Alternate Delegate(s)

Joseph A. Adashek, Las Vegas NV

Peter R. Fenwick, Reno NV

Resident and Fellow Sectional Delegate(s)

Jacob Altholz, Las Vegas NV

Helene Nepomuceno, Las Vegas NV

Resident and Fellow Sectional Alternate Delegate(s)

Katrina Naik, Las Vegas NV

Medical Society of New Jersey

Delegate(s)

Mary Campagnolo, Bordentown NJ

Joseph P. Costabile, Marlton NJ

Christopher Gribbin, Princeton NJ

Charles Michael Moss, Ramsey NJ

Medical Society of New Jersey

Delegate(s)

Nancy L. Mueller, Englewood Cliffs NJ

John W. Poole, Ridgewood NJ

Niranjan V. Rao, Somerset NJ

David Swee, Bradley Beach NJ

Alternate Delegate(s)

Donald M. Chervenak, Florham Park NJ

Nicole A. Henry-Dindial, Westfield NJ

Alan L Kenwood, Morristown NJ

Shivam Mital, Somerset NJ

Myrian Mondestin-Sorrentino, Monroe Twp N

Steven Orland, Pennington NJ

Inga Robbins, Atlantic City NJ

Regional Medical Student Delegate(s)

Revati Gummaluri, Flemington NJ

Regional Medical Student Alternate Delegate(s)

Shad Yasin, Newark NJ

New Mexico Medical Society

Delegate(s)

Stephen P. Lucero, Taos NM

William Ritchie, Albuquerque NM

Alternate Delegate(s)

Angelina Villas-Admas, Albuquerque NM

Todd Williams, Farmington NM

Resident and Fellow Sectional Delegate(s)

Danielle Rivera, Albuquerque NM

Medical Society of the State of New York

Delegate(s)

Louis Auguste, Manhasset NY

Maria Basile, East Setauket NY

Michael Brisman, Old Westbury NY

Medical Society of the State of New York

Delegate(s)

Joshua M. Cohen, New York NY

Jerome C. Cohen, Loch Sheldrake NY

Frank G. Dowling, Islandia NY

Robert A. Frankel, Brooklyn NY

Daniel Gold, White Plains NY

Robert B. Goldberg, Morristown NJ

Howard Huang, Watertown NY

David Jakubowicz, Scarsdale NY

Thomas T Lee, Tarrytown NY

Bonnie L. Litvack, Mont Kisco NY

Joseph R. Maldonado, Westernville NY

Parag Mehta, New Hyde Park NY

Gregory L. Pinto, Saratoga Springs NY

Paul A. Pipia, Syosset NY

Bryan Redmond, Rochester NY

Malcolm D. Reid, Briarcliff Manor NY

Joseph Sellers, Cobleskill NY

Corliss Varnum, Oswego NY

Daniel M. Young, Vesta NY

Alternate Delegate(s)

Niraj Acharya, Brooklyn NY

Mark Adams, Fairport NY

Joseph DiPoala Jr, Victor NY

Janine Fogarty, Rochester NY

Henika Kaura, Johnson City NY

Andrew Y. Kleinman, Rye Brook NY

Daniel J. Koretz, Ontario NY

Adolph Meyer, Flushing NY

Brian Murray, Albany NY

Charles Rothberg, Patchogue NY

Current as of: 10/12/2023

Medical Society of the State of New York

Alternate Delegate(s)

Jocelyn Young, Vestal NY

L. Carlos Zapata, Plainview NY

Michael Ziegelbaum, Jericho NY

Resident and Fellow Sectional Alternate Delegate(s)

Leanna Knight, E Rochester NY

Regional Medical Student Delegate(s)

Elana Sitnik, Syracuse NY

Regional Medical Student Alternate Delegate(s)

Anjlee Panjwani, Syracuse NY

North Carolina Medical Society

Delegate(s)

Mary Ann Contogiannis, Greensboro NC

John A. Fagg, Winston-Salem NC

E. Rebecca Hayes, Charlotte NC

Darlyne Menscer, Charlotte NC

Karen Smith, Raeford NC

Royce Syracuse, Huntersville NC

Alternate Delegate(s)

Arthur Apolinario, Clinton NC

John Meier, Raleigh NC

Eileen Raynor, Durham NC

Michael Utecht, Durham NC

Regional Medical Student Delegate(s)

Alex Soltany, Winston Salem NC

North Dakota Medical Association

Delegate(s)

Fadel Nammour, Fargo ND

Alternate Delegate(s)

David Schmitz, Grand Forks ND

Ohio State Medical Association

Delegate(s)

Anthony Armstrong, Toledo OH

Tyler J. Campbell, Winchester OH

Robyn F Chatman, Cincinnati OH

John Corker, Cincinnati OH

Louito C Edje, Cincinnati OH

Lisa Bohman Egbert, Kettering OH

Richard R. Ellison, Fairlawn OH

Gary R. Katz, Dublin OH

Deepak Kumar, Dayton OH

Andrew Rudawsky, Lakewood OH

William C. Sternfeld, Sylvania OH

Shannon Trotter, Columbus OH

Colette R. Willins, Avon OH

Alternate Delegate(s)

John Bastulli, Shaker Hts OH

Christopher Brown, Columbus OH

Tani Malhotra, Parma OH

Elizabeth Muennich, Mason OH

Christopher Paprzycki, Cincinnati OH

Jennifer Wayland, Cincinnati OH

Christopher Wee, Shaker Hts OH

Resident and Fellow Sectional Delegate(s)

Brandon Francis, Cleveland OH

Michelle Knopp, Columbus OH

Regional Medical Student Alternate Delegate(s)

TJ Atchison, Columbus OH

Kaylee Scarnati, Toledo OH

Oklahoma State Medical Association

Delegate(s)

Sherri Baker, Edmond OK

Oklahoma State Medical Association

Delegate(s)

Jay A. Gregory, Muskogee OK

Woody Jenkins, Stillwater OK

Bruce Storms, Chickasha OK

Alternate Delegate(s)

Geoffrey Chow, Tulsa OK

Mary Clarke, Stillwater OK

Julie Hager, Oklahoma City OK

Jean Hausheer, Lawton OK

Regional Medical Student Delegate(s)

Will Maher, Tulsa OK

Oregon Medical Association

Delegate(s)

Peter A. Bernardo, Salem OR

Colin Cave, Lake Oswego OR

Robert Dannenhoffer, Roseburg OR

Kevin Ewanchyna, Corvallis OR

Alternate Delegate(s)

Reva Ricketts-Loriaux, Portland OR

Regional Medical Student Delegate(s)

Daniel Resnick, Pomona OR

Pennsylvania Medical Society

Delegate(s)

Theodore A. Christopher, Maple Glen PA

Michael A. DellaVecchia, Berwyn PA

Richard Eisenstaedt , Abington PA

Mark Friedlander, Narberth PA

F. Wilson Jackson, Camp Hill PA

Bindukumar Kansupada, Yardley PA

Bruce A. Mac Leod, Pittsburgh PA

Jill M. Owens, Bradford PA

Ralph Schmeltz, Pittsburgh PA

Pennsylvania Medical Society

Delegate(s)

Scott E. Shapiro, Lower Gwynedd PA

John W. Spurlock, Bethlehem PA

John Michael Vasudevan, Philadelphia PA

John P. Williams, Gibsonia PA

Alternate Delegate(s)

Domenick Bucci, Southampton PA

George William Fryhofer, Philadelphia PA

James A. Goodyear, North Wales PA

Kanupriya Gupta, Pittsburgh PA

Nathan Hoff, Honesdale PA

Chadd Kraus, Lewisburg PA

Peter S. Lund, Fairview PA

Andrew Lutzkanin, Elizabethtown PA

Dale M. Mandel, Paoli PA

Narayana Murali, Old Forge PA

Lorraine Rosamilia, Port Matilda PA

James W. Thomas, North Wales PA

Martin D. Trichtinger, Hatboro PA

Resident and Fellow Sectional Delegate(s)

Haidn Foster, Hummelstown PA

Regional Medical Student Delegate(s)

Rafay Nasir, Hershey PA

Regional Medical Student Alternate Delegate(s)

Anudeeta Gautam, Philadelphia PA

Rhode Island Medical Society

Delegate(s)

Sarah Fessler, Riverside RI

Peter A. Hollmann, Cranston RI

Current as of: 10/12/2023

South Carolina Medical Association

Delegate(s)

Gary A. Delaney, Orangeburg SC

Richard Osman, Myrtle Beach SC

Alexander Ramsay, Charleston SC

Bruce A. Snyder, Greenville SC

Greg Tarasidis, Greenwood SC

Alternate Delegate(s)

Wesley Frierson, Lexington SC

H Timberlake Pearce, Beaufort SC

Stefanie M. Putnam, Mauldin SC

Todd E Schlesinger, Charleston SC

Christopher A Yeakel, Elgin SC

Regional Medical Student Alternate Delegate(s)

Jared Buteau, Greenville SC

South Dakota State Medical Association

Delegate(s)

Robert L. Allison, Pierre SD

Mary Carpenter, Winner SD

Alternate Delegate(s)

Denise Hanisch, Centerville SD

Robert Summerer, Madison SD

Tennessee Medical Association

Delegate(s)

O. Lee Berkenstock, Cordova TN

Richard J. DePersio, Knoxville TN

John J. Ingram, Alcoa TN

Wiley T. Robinson, Memphis TN

Nita Shumaker, Hixson TN

Christopher E. Young, Signal Mtn TN

Alternate Delegate(s)

VijayaLakshmi Appareddy, Chattanooga TN

Tennessee Medical Association

Alternate Delegate(s)

Landon S. Combs, Gray TN

Regional Medical Student Alternate Delegate(s)

Fabiola Ramos-Guzman, San Juan PR

Texas Medical Association

Delegate(s)

Michelle A. Berger, Austin TX

Gerald Ray Callas, Beaumont TX

John T. Carlo, Dallas TX

Diana Fite, Magnolia TX

John G. Flores, Carrollton TX

Gary Floyd, Keller TX

Gregory M. Fuller, Keller TX

William S. Gilmer, Houston TX

Robert T. Gunby, Dallas TX

Steven R. Hays, Dallas TX

David N. Henkes, San Antonio TX

Cynthia Jumper, Lubbock TX

Kenneth L. Mattox, Houston TX

Kevin H. McKinney, Galveston TX

Jennifer Rushton, San Antonio TX

Leslie H. Secrest, Dallas TX

Jayesh Shah, San Antonio TX

Elizabeth Torres, Sugar Land TX

Roxanne Tyroch, El Paso TX

E. Linda Villarreal, Edinburg TX

Alternate Delegate(s)

Kimberly Avila Edwards, Austin TX

Mark A. Casanova, Dallas TX

Shanna Combs, Fort Worth TX

Robert H. Emmick, Austin TX

Texas Medical Association

Alternate Delegate(s)

William H Fleming, Houston TX

John T. Gill, Dallas TX

Bryan G. Johnson, Frisco TX

Matthew McGlennon, Houston TX

Eddie Lee Patton, Sugar Land TX

Vivek Rao, Odessa TX

Angela Self, Grapevine TX

Ezequiel "Zeke" Silva, San Antonio TX

Sherif Z. Zaafran, Houston TX

Yasser Zeid, Longview TX

Resident and Fellow Sectional Delegate(s)

Victoria Gordon, Houston TX

Subhan Tabba, Dallas TX

Resident and Fellow Sectional Alternate Delegate(s)

Whitney Stuard, Irving TX

Regional Medical Student Delegate(s)

Jooeun Jeong, Houston TX

Regional Medical Student Alternate Delegate(s)

Kimberly Ibarra, Conroe TX

Tyson Lumbreras, El Paso TX

Radhika Patel, Conroe TX

Ashwin Varma, San Antonio TX

Utah Medical Association

Delegate(s)

Mark Bair, Highland UT

Richard Labasky, Salt Lake City UT

Alternate Delegate(s)

Anne Lin, Salt Lake Cty UT

Brittany R. McColgan, Salt Lake Cty UT

Vermont Medical Society

Delegate(s)

Catherine Schneider, Windsor VT

Alternate Delegate(s)

Rebecca Bell, Burlington VT

Medical Society of Virginia

Delegate(s)

Joel Thomas Bundy, Virginia Beach VA

Alice Coombs-Tolbert, Richmond VA

Claudette E. Dalton, Nellysford VA

Clifford L Deal III, Richmond VA

Thomas W. Eppes, Forest VA

Michele A. Nedelka, Virginia Beach VA

Bhushan H. Pandya, Danville VA

Cynthia C. Romero, Virginia Beach VA

Alternate Delegate(s)

Joshua Lesko, Portsmouth VA

Mohit Nanda, Charlottesville VA

Josephine Nguyen, Burke VA

Lee Ouyang, Norfolk VA

Sterling N. Ransone, Deltaville VA

Regional Medical Student Delegate(s)

Shaylyn Fahey, Roanoke VA

Regional Medical Student Alternate Delegate(s)

Sneha Krish, Richmond VA

Lavinia Wainwright, Norfolk VA

Washington State Medical Association

Delegate(s)

Matthew Grierson, Bothell WA

Erin Harnish, Longview WA

Nariman Heshmati, Mukliteo WA

L Elizabeth Peterson, Spokane WA

Current as of: 10/12/2023

Washington State Medical Association

Delegate(s)

Sheila D. Rege, Tri-Cities WA

Rod Trytko, Spokane WA

Alternate Delegate(s)

Rachel Clement, Wenatchee WA

Amish Dave, Seattle WA

Colin Fields, Seattle WA

Teresa Girolami, Redmond WA

Rajneet Lamba, Kirkland WA

Elizabeth Parker, Seattle WA

Regional Medical Student Delegate(s)

Jade Cook, Los Angeles CA

West Virginia State Medical Association

Delegate(s)

Hoyt Burdick, Huntington WV

Joseph Barry Selby, Morgantown WV

Wisconsin Medical Society

Delegate(s)

Clarence P. Chou, Mequon WI

Barbara Hummel, Muskego WI

George Melvin Lange, River Hills WI

Don Lee, Franklin WI

Tosha Wetterneck, Madison WI

Alternate Delegate(s)

Keshni Ramnanan, Pewaukee WI

Resident and Fellow Sectional Delegate(s)

Bradley Pfeifer, Madison WI

Stephanie Strohbeen, Whitefish Bay WI

Regional Medical Student Delegate(s)

Nicholas Bohannon, Lincoln NE

Wyoming Medical Society

Delegate(s)

Stephen Brown, Casper WY

Alternate Delegate(s)

Paul Johnson, Cheyenne WY

Current as of: 10/12/2023

Academy of Physicians in Clinical Research

Delegate(s)
Peter Howard Rheinstein, Severna Park MD

Alternate Delegate(s)
Michael Ybarra, Bethesda MD

Aerospace Medical Association

Delegate(s)
Hernando J Ortega, San Antonio TX

Alternate Delegate(s)
Robert Orford, Fountain Hls AZ

AMDA-The Society for Post-Acute and Long-Term Care Medicine

Delegate(s)
Leslie Eber, Golden CO

Karl Steinberg, Oceanside CA

Alternate Delegate(s)
Rajeev Kumar, Oak Brook IL

American Academy of Addiction Psychiatry

Delegate(s)
Alëna Balasanova, Omaha NE

Alternate Delegate(s)
John J. Mariani, Brooklyn NY

American Academy of Allergy, Asthma & Immunology

Delegate(s)
Steven G. Tolber, Corrales NM

Alternate Delegate(s)
Lynda G. Kabbash, Chestnut Hill MA

American Academy of Child and Adolescent Psychiatry

Delegate(s)
Adrienne Adams, Chicago IL

Warren Ng, New York NY

American Academy of Child and Adolescent Psychiatry

Alternate Delegate(s)
Soo Lee, Chicago IL

Karen Pierce, Chicago IL

American Academy of Cosmetic Surgery

Delegate(s)
Anthony J. Geroulis, Northfield IL

Alternate Delegate(s)
Robert F. Jackson, Noblesville IN

American Academy of Dermatology Association

Delegate(s)
Hillary Johnson-Jahangir, Iowa City IA

Adam Rubin, Philadelphia PA

Marta Jane Van Beek, Iowa City IA

Cyndi J. Yag-Howard, Naples FL

Alternate Delegate(s)
Lindsay Ackerman, Phoenix AZ

Seemal Desai, Frisco TX

Jon "Klint" Peebles, Washington DC

Sabra Sullivan, Jackson MS

American Academy of Family Physicians

Delegate(s)
Joanna T. Bisgrove, Oregon WI

Steven P. Furr, Jackson AL

Michael Hanak, LaGrange IL

Tochi Iroku-Malize, Islip NY

Sabesan Karuppiah, Overland Park KS

Evelyn Lynnette Lewis, Newman GA

Anita Ravi, New York NY

Stephen Richards, Spirit Lakes IA

American Academy of Family Physicians

Delegate(s)

LaTasha Seliby Perkins, Alexandria VA

Hugh Taylor, Hamilton MA

Emma York, Lorton VA

Kim Yu, Novi MI

Alternate Delegate(s)

Emily Briggs, New Braunfels TX

Tate Hinkle, Auburn AL

Russell Kohl, Stilwell KS

Mary Krebs, Dayton OH

Janet West, Jacksonville FL

Julie K. Wood, Leawood KS

Resident and Fellow Sectional Delegate(s)

Melanie Biegler, Madison WI

American Academy of Hospice and Palliative Medicine

Delegate(s)

Chad D. Kollas, Orlando FL

Ruth M Thomson, Flat Rock NC

Alternate Delegate(s)

Ana Leech, Houston TX

American Academy of Insurance Medicine

Delegate(s)

Deborah Y. Smart, Gurnee IL

Alternate Delegate(s)

Susan Stegman, Franklin WI

American Academy of Neurology

Delegate(s)

Barry Czeisler, Brooklyn NY

Shannon Kilgore, Palo Alto CA

Mark Milstein, New York NY

Ann Murray, Morgantown WV

American Academy of Neurology

Alternate Delegate(s)

Eva Ritzl, Baltimore MD

Jeremy Toler, New Orleans LA

Resident and Fellow Sectional Delegate(s)

Daniel Lee, Mobile AL

American Academy of Ophthalmology

Delegate(s)

Ravi D. Goel, Cherry Hill NJ

Joe Nezgoda, N Palm Beach FL

Lisa Nijm, Warrenville IL

Mildred M G. Olivier, Arlington Heights IL

Alternate Delegate(s)

Grayson W. Armstrong, Boston MA

Donald J. Cinotti, Jersey City NJ

American Academy of Orthopaedic Surgeons

Delegate(s)

Andrew W. Gurman, Altoona PA

Heidi Hullinger, New York NY

Casey J. Humbyrd, Narberth PA

William R. Martin, Chicago IL

Kimberly Jo Templeton, Leawood KS

Alternate Delegate(s)

Adam John Bruggeman, San Antonio TX

Anna Noel Miller, Saint Louis MO

David Teuscher, Arlington TX

American Academy of Otolaryngic Allergy

Delegate(s)

Wesley Dean VanderArk, Camp Hill PA

Alternate Delegate(s)

Alpen A. Patel,

Current as of: 10/12/2023

American Academy of Otolaryngology-Head and Neck Surgery

Delegate(s)

Susan Dixon McCammon, Birmingham AL

Michael S. Goldrich, E Brunswick NJ

Douglas R. Myers, Vancouver WA

Alternate Delegate(s)

James C. Denneny, Alexandria VA

Resident and Fellow Sectional Alternate Delegate(s)

Benjamin Ostrander, San Diego CA

American Academy of Pain Medicine

Delegate(s)

Bob Wailes, Carlsbad CA

Alternate Delegate(s)

Charles Argoff, Albany NY

American Academy of Pediatrics

Delegate(s)

Carol Berkowitz, Rancho Palos Verdes CA

Melissa J. Garretson, Fort Worth TX

Zarah Iqbal, San Francisco CA

Sarah Marsicek, Windermere FL

Samantha Rosman, Stoneham MA

Alternate Delegate(s)

Ariel Carpenter, Louisville KY

Sandy Lee Chung, Fairfax VA

Benjamin Hoffman,

Pam Shaw, Kansas City KS

Resident and Fellow Sectional Delegate(s)

Rohan Khazanchi, Boston MA

American Academy of Physical Medicine and Rehabilitation

Delegate(s)

Stuart Glassman, Concord NH

American Academy of Physical Medicine and Rehabilitation

Delegate(s)

Susan L. Hubbell, Lima OH

Alternate Delegate(s)

Rosalynn Conic, Gainesville FL

Carlo Milani, Westport CT

American Academy of Sleep Medicine

Delegate(s)

Kelly Carden, Nashville TN

Patrick J. Strollo, Gibsonia PA

Alternate Delegate(s)

Belen Esparis, Bryn Mawr PA

Sam Fleishman, Fayetteville NC

American Association for Geriatric Psychiatry

Delegate(s)

Allan Anderson, Tucson AZ

Alternate Delegate(s)

Vanessa A. Stan, Chicago IL

American Association for Hand Surgery

Delegate(s)

Peter C. Amadio, Rochester MN

Alternate Delegate(s)

Nicholas B. Vedder, Seattle WA

American Association for Thoracic Surgery

Delegate(s)

Robert E Merritt, Columbus OH

American Association of Clinical Endocrinology

Delegate(s)

Jonathan D. Leffert, Dallas TX

Alternate Delegate(s)

Pavan Chava, New Orleans LA

American Association of Gynecologic Laparoscopists

Delegate(s)
Sheena Galhotra, Chicago IL

Joseph M. Maurice, Chicago IL

Alternate Delegate(s)
Asha McClurg, Durnham NC

American Association of Neurological Surgeons

Delegate(s)
Kenneth S. Blumenfeld, Los Angeles CA

Joshua Rosenow, Chicago IL

Alternate Delegate(s)
Krystal L Tomei, Lyndhurst OH

Resident and Fellow Sectional Delegate(s)
Laura Stone McGuire, Chicago IL

American Association of Neuromuscular & Electrodiagnostic Medicine

Delegate(s)
William Pease, Columbus OH

Alternate Delegate(s)
William S. David, Lincoln MA

American Association of Plastic Surgeons

Delegate(s)
Michele Manahan, Baltimore MD

American Association of Public Health Physicians

Delegate(s)
Arlene Seid, Grantham PA

Alternate Delegate(s)
Dave Cundiff, Ilwaco WA

Resident and Fellow Sectional Delegate(s)
Christina Wang, San Francisco CA

American Clinical Neurophysiology Society

Delegate(s)
Marc Nuwer, Los Angeles CA

Alternate Delegate(s)
Jaime Lopez, Stanford CA

American College of Allergy, Asthma and Immunology

Delegate(s)
Alnoor A. Malick, Houston TX

Alternate Delegate(s)
John M. Seyerle, Cincinnati OH

American College of Cardiology

Delegate(s)
Jerry D. Kennett, Columbia MO

Aaron Kithcart, New York NY

M Eugene Sherman, Englewood CO

Suma Thomas, Cleveland OH

L. Samuel Wann, Santa Fe NM

Kim Allan Williams, Louisville KY

David Winchester, Gainesville FL

Alternate Delegate(s)
Nihar R Desai, New Haven CT

Benjamin Galper, Potomac MD

Jana E Montgomery, Burlington MA

Rachita MD Navara,

Annabelle Santos Volgman,

American College of Chest Physicians (CHEST)

Delegate(s)
John Studdard, Jackson MS

American College of Emergency Physicians

Delegate(s)
Brooks F. Bock, Vail CO

American College of Emergency Physicians

Delegate(s)

Erick Eiting, New York NY

Stephen K Epstein, Needham MA

Hilary E. Fairbrother, Houston TX

Marc Mendelsohn, St. Louis MO

John C. Moorhead, Portland OR

Ashley Norse, Jacksonville FL

Debra Perina, Ruckersville VA

Alternate Delegate(s)

Reid Orth, Goldsboro NC

Scott Pasichow, Mahomet IL

Resident and Fellow Sectional Delegate(s)

Betsy Rojas, Jersey City NJ

Sophia Spadafore, New York NY

American College of Gastroenterology

Delegate(s)

R Bruce Cameron, Shaker Heights OH

March Seabrook, West Columbia SC

American College of Legal Medicine

Delegate(s)

Richard Wilbur, Lake Forest IL

Alternate Delegate(s)

Rey Gonzalez, Harlingen TX

American College of Medical Genetics and Genomics

Delegate(s)

Susan Debra Klugman, Bronx NY

Alternate Delegate(s)

Jerry Vockley, Pittsburgh PA

American College of Medical Quality

Resident and Fellow Sectional Alternate Delegate(s)

Sohayla Rostami, Flushing NY

American College of Mohs Surgery

Delegate(s)

Michel McDonald, Nashville TN

Alternate Delegate(s)

Divya Srivastava, Dallas TX

American College of Nuclear Medicine

Delegate(s)

Alan Klitzke, Buffalo NY

American College of Obstetricians and Gynecologists

Delegate(s)

Kavita Arora, Chapel Hill NC

Cee Ann Davis, Winchester VA

Marygrace Elson, Iowa City IA

Coy Flowers, Roncerverte WV

Laura Faye Gephart, McAllen TX

Cheryl Gibson Fountain, Grosse Pointe MI

Nita Kulkarni, Flint MI

Mary E. LaPlante, Broadview Heights OH

G. Sealy Massingill, Fort Worth TX

Diana Ramos, Laguna Beach CA

Brandi Ring, Houston TX

Kasandra Scales, Alexandria VA

Heather Smith, Newport RI

Robert Wah, Thornton CO

Alternate Delegate(s)

Veronica Alvarez-Galiana, Miami FL

Anthony Sciscione, Newark DE

American College of Obstetricians and Gynecologists

Alternate Delegate(s)

Ana Marie Tobiasz,

American College of Occupational and Environmental Medicine

Delegate(s)

Albert J Osbahr, Hickory NC

Kenji Saito, Augusta ME

Alternate Delegate(s)

Allison Jones, Urbana IL

Romero N. Santiago, New Haven CT

American College of Physicians

Delegate(s)

George Abraham, Worcester MA

Omar Atiq, Little Rock AR

Eileen Barrett, Albuquerque NM

Micah Beachy, Omaha NE

Sue Bornstein, Dallas TX

Adam Bumgardner, Rockville MD

Sarah G. Candler, Houston TX

Elisa Choi, Boston MA

Amanda Collar, Albuquerque NM

Thomas Cooney, Portland OR

Ricardo Correa, Westlake OH

Charles Cutler, Merion PA

Noel N. Deep, Antigo WI

Yul D. Ejnes, N Scituate RI

Jacqueline Fincher, Thomson GA

William E. Fox, Charlottesville VA

Richard S. Frankenstein, Tustin CA

William E. Golden, Little Rock AR

American College of Physicians

Delegate(s)

Renato Guerrieri, Houston TX

Tracey Henry, Powder Springs GA

Susan Hingle, Springfield IL

Katie Jobbins, East Longmeadow MA

Angela Johnson, Baton Rouge LA

Janet Jokela, Champaign IL

Lynne M. Kirk, Chicago IL

J Leonard Lichtenfeld, Atlanta GA

Suja M. Mathew, Chicago IL

Robert McLean, New Haven CT

Ryan Mire, Nashville TN

Marianne Parshley, Portland OR

Priya Radhakrishnan, Phoenix AZ

Stephen D. Sisson, Baltimore MD

Donna E. Sweet, Wichita KS

Cecil B. Wilson, Winter Park FL

Alternate Delegate(s)

Darilyn Moyer, Philadelphia PA

American College of Preventive Medicine

Delegate(s)

Robert Gilchick, Los Angeles CA

Alternate Delegate(s)

Andrew Karasick, Piscataway NJ

American College of Radiation Oncology

Delegate(s)

Mohamed Khan, Gilbert AZ

American College of Radiology

Delegate(s)

Naiim S. Ali, Winooski VT

Bibb Allen, Mountain Brk AL

American College of Radiology

Delegate(s)

Tilden L Childs, Fort Worth TX

Nancy Ellerbroek, Valencia CA

Steven Falcone, Coral Springs FL

Todd M. Hertzberg, Pittsburgh PA

Daniel H. Johnson, Metairie LA

Gunjan Malhotra, Ann Arbor MI

Alternate Delegate(s)

Jade Anderson, Fitchburg WI

Alan Matsumoto, Charlottesville VA

Benjamin Meyer, Seattle WA

Arl Van. Moore, Charlotte NC

William Thorwarth, Daniel Island SC

Resident and Fellow Sectional Alternate Delegate(s)

Anirudh Gautam, Burlington MA

American College of Rheumatology

Delegate(s)

Gary L. Bryant, New Castle DE

Eileen M. Moynihan, Hadden Heights NJ

Alternate Delegate(s)

Luke Barre, Dartmouth MA

American College of Surgeons

Delegate(s)

John Armstrong, Ocala FL

Daniel Dent, San Antonio TX

Ross F. Goldberg, Phoenix AZ

Jacob Moalem, Rochester NY

Lena M. Napolitano, Ann Arbor MI

Leigh A. Neumayer, Jacksonville FL

Naveen Sangji, Ann Arbor MI

American College of Surgeons

Delegate(s)

Kenneth Sharp, Nashville TN

Alternate Delegate(s)

Luke V Selby, Columbus OH

Patricia Turner, Chicago IL

American Contact Dermatitis Society

Delegate(s)

Bruce Brod, Downingtown PA

Alternate Delegate(s)

James Taylor, Pepper Pike OH

American Gastroenterological Association

Delegate(s)

Claudia Gruss, Redding CT

Lilani Perera, Grafton WI

American Geriatrics Society

Delegate(s)

Eugene Lammers, Fairhope AL

Craig Rubin, Dallas TX

Alternate Delegate(s)

Deborah Freeland, Dallas TX

Resident and Fellow Sectional Delegate(s)

Samantha Beck, Oklahoma City OK

American Hernia Society

Delegate(s)

John P Fischer, Villanova PA

American Institute of Ultrasound in Medicine

Delegate(s)

David P. Bahner, Columbus OH

Marilyn Laughead, New River AZ

American Medical Women's Association

Delegate(s)

Neelum Aggarwal, Chicago IL

Alternate Delegate(s)

Roberta Gebhard, Grand Island NY

American Orthopaedic Association

Delegate(s)

Kevin Plancher, New York NY

Alternate Delegate(s)

Frederick Flandry, Columbus GA

American Orthopaedic Foot and Ankle Society

Delegate(s)

Christopher Chiodo, Walpole MA

Alternate Delegate(s)

Mariam Hakim-Zargar, Avon CT

American Osteopathic Association

Delegate(s)

Ira Monka, Cedar Knolls NJ

Alternate Delegate(s)

Teresa A. Hubka, Chicago IL

American Psychiatric Association

Delegate(s)

Kenneth M. Certa, Plymouth Meeting PA

Frank Alexander Clark, Simpsonville SC

Sara Coffey, Tulsa OK

Laura Halpin, Los Angeles CA

Jerry L. Halverson, Oconomowoc WI

Dionne Hart, Rochester MN

Ray Hsiao, Bellevue WA

Cheryl Hurd, Fort Worth TX

Alternate Delegate(s)

Saul M. Levin, Washington DC

American Psychiatric Association

Alternate Delegate(s)

Theresa M. Miskimen, Millstone Twp NJ

Resident and Fellow Sectional Delegate(s)

Karen Dionesotes, Baltimore MD

American Roentgen Ray Society

Delegate(s)

Denise Collins, Detroit MI

Travis Meyer, Jacksonville FL

American Society for Aesthetic Plastic Surgery

Delegate(s)

Clark F. Schierle, Chicago IL

Alternate Delegate(s)

Lawrence Iteld,

American Society for Clinical Pathology

Delegate(s)

Edmund R. Donoghue, Paw Paw MI

William G. Finn, Ann Arbor MI

Jennifer Nicole Stall, Minneapolis MN

Alternate Delegate(s)

Peter DeRosa,

Steven H. Kroft, Mequion WI

H. Clifford Sullivan, Marietta GA

American Society for Dermatologic Surgery Association (ASDSA)

Delegate(s)

M. Laurin Council, St. Louis MO

Jessica Krant, New York NY

Rachel Kyllo, Saint Louis MO

American Society for Gastrointestinal Endoscopy

Delegate(s)

Robin Mendelsohn, New York NY

Walter G. Park, Los Altos CA

Gary Richter, Atlanta GA

American Society for Metabolic and Bariatric Surgery

Delegate(s)

John Scott, Greenville SC

Alternate Delegate(s)

Samer Mattar, Houston TX

American Society for Radiation Oncology

Delegate(s)

Shane Hopkins, Ames IA

Shilpen A. Patel, San Francisco CA

American Society for Surgery of the Hand

Delegate(s)

Robert C. Kramer, Beaumont TX

American Society of Addiction Medicine

Delegate(s)

Stuart Gitlow, New York NY

Stephen Taylor, Atlanta GA

Alternate Delegate(s)

Seth Flagg, Silver Spring MD

Elizabeth Salisbury-Afshar , Waunakee WI

American Society of Anesthesiologists

Delegate(s)

Randall M. Clark, Denver CO

James D. Grant, Bloomfield Hills MI

Tripti C. Kataria, Chicago IL

Candace E. Keller, Miramar Beach FL

American Society of Anesthesiologists

Delegate(s)

Edward Mariano, Palo Alto CA

Mary Dale Peterson, Corpus Christi TX

Michael B. Simon, Jacksonville FL

Gary D. Thal, Chicago IL

Alternate Delegate(s)

Ronald Harter, Dublin OH

Lucas Kasson,

Olivia Sonderman,

American Society of Breast Surgeons

Delegate(s)

David Rubin Brenin, Charlottesville VA

Steven Chen, San Diego CA

American Society of Colon and Rectal Surgeons

Delegate(s)

Anne Mongiu, New Haven CT

Alternate Delegate(s)

Sachin Vaid, Wilmington DE

American Society of Cytopathology

Delegate(s)

Swati Mehrotra, Schaumburg IL

Alternate Delegate(s)

Margaret Compton, Nashville TN

American Society of Dermatopathology

Delegate(s)

Melissa Piliang, Cleveland OH

Alternate Delegate(s)

Karl Napekoski, Naperville IL

American Society of Echocardiography

Delegate(s)

Kameswari Maganti, Chicago IL

Peter S. Rahko, Madison WI

American Society of Hematology

Delegate(s)

Chancellor Donald, New Orleans LA

Amar Kelkar, Roxbury Xing MA

Alternate Delegate(s)

Ellen Fraint,

Kelsey Martin, Westport CT

American Society of Interventional Pain Physicians

Delegate(s)

Sachin Jha, Tustin CA

Lee Snook, Sacramento CA

Alternate Delegate(s)

Michael C. Lubrano, Boston MA

Kunj Patel, Brookline MA

American Society of Maxillofacial Surgeons

Delegate(s)

Kant Lin, Milwaukee WI

American Society of Neuroradiology

Delegate(s)

Kyle Atcheson, Winston Salem NC

Jacqueline Anne Bello, New York NY

American Society of Ophthalmic Plastic and Reconstructive Surgery

Delegate(s)

Erin Shriver, Iowa City IA

Alternate Delegate(s)

Jamie Keen, Detroit MI

American Society of Ophthalmic Plastic and Reconstructive Surgery

Alternate Delegate(s)

Fatemeh Rajaii, Baltimore MD

American Society of Plastic Surgeons

Delegate(s)

C. Bob Basu, Cypress TX

Robert J. Havlik, Mequon WI

Lynn LC. Jeffers, Camarillo CA

Alternate Delegate(s)

Raj Ambay, Wesley Chapel FL

Maristella Evangelista, Birmingham MI

Danielle Rochlin, Palo Alto CA

Resident and Fellow Sectional Alternate Delegate(s)

Aaron Kearney, Chicago IL

Daniel Pfeifle, Rochester MN

American Society of Regional Anesthesia and Pain Medicine

Delegate(s)

Richard Chou, San Francisco CA

American Society of Retina Specialists

Delegate(s)

Michael J. Davis, Los Angeles CA

American Society of Transplant Surgeons

Delegate(s)

Stuart M. Greenstein, Bronx NY

Alternate Delegate(s)

Kenneth Andreoni, Philadelphia PA

American Thoracic Society

Delegate(s)

Ajanta Patel, Chicago IL

Chris Worsham, Charlestown MA

American Thoracic Society

Alternate Delegate(s)
Ai-Yui Maria Tan, Maywood IL

American Urological Association

Delegate(s)
Hans C. Arora, Chapel Hill NC

Richard S. Pelman, Seattle WA

Alternate Delegate(s)
Jason Jameson, Phoenix AZ

Resident and Fellow Sectional Delegate(s)
Ruchika Talwar, Philadelphia PA

Army

Delegate(s)
Erin Keyser, San Antonio TX

Association for Clinical Oncology

Delegate(s)
Steve Y. Lee, Oakland CA

Barbara L. McAneny, Albuquerque NM

Kristina Novick, West Chester PA

Ray D Page, Fort Worth TX

Erin Schwab, Dillon CO

Alternate Delegate(s)
Jill Gilbert, Nashville TN

David J Savage, La Jolla CA

Ashley Sumrall, Charlotte NC

Association of University Radiologists

Delegate(s)
Stephen Chan, Closter NJ

Alternate Delegate(s)
Shyam Sabat, Gainesville FL

College of American Pathologists

Delegate(s)
James L. Caruso, Castle Rock CO

Joe Saad, Dallas TX

Susan Strate, Wichita Falls TX

Mark S. Synovec, Topeka KS

Alternate Delegate(s)
Jean Elizabeth Forsberg, Pineville LA

Matthew Foster, Lynchburg VA

Joseph Sanfrancesco, Charleston SC

Emily Volk, Louisville KY

Congress of Neurological Surgeons

Delegate(s)
Jason Schwalb, West Bloomfield MI

Ann R. Stroink, Heyworth IL

Alternate Delegate(s)
Maya A. Babu, Englewood FL

Michael Feldman, Nashville TN

Endocrine Society, The

Delegate(s)
Amanda Bell, Kansas City MO

Palak U. Choksi, Ann Arbor MI

Alternate Delegate(s)
Daniel Spratt, Portland ME

GLMA: Health Professionals Advancing LGBT Equality

Delegate(s)
Jason S. Schneider, Atlanta GA

Alternate Delegate(s)
Carl Streed, Boston MA

Heart Rhythm Society

Delegate(s)
Steve Hao, San Francisco CA

Timothy Larsen, Chicago IL

Infectious Diseases Society of America

Resident and Fellow Sectional Delegate(s)
Aaron J Wolbrueck, Honlulu HI

International College of Surgeons-US Section

Delegate(s)
Joshua Mammen, Omaha NE

Alternate Delegate(s)
Rifat Latifi, Valhalla NY

International Pain and Spine Intervention Society

Delegate(s)
William D. Mauck, Rochester MN

Alternate Delegate(s)
Kate Sully, Niceville FL

International Society of Hair Restoration Surgery

Delegate(s)
Carlos J. Puig, Houston TX

Alternate Delegate(s)
Sara M Wasserbauer, Walnut Creek CA

National Association of Medical Examiners

Delegate(s)
Michelle Jorden, San Jose CA

National Medical Association

Delegate(s)
Edith Mitchell, Philadelphia PA

Alternate Delegate(s)
Nelson Adams, Miami Shores FL

Navy

Delegate(s)
Teresa Mae Allen, Jacksonville FL

North American Neuromodulation Society

Delegate(s)
Nameer R. Haider, New Hartford NY

Alternate Delegate(s)
Brice Kessler, Durham NC

North American Neuro-Ophthalmology Society

Delegate(s)
Benjamin Frishberg, Carlsbad CA

North American Spine Society

Delegate(s)
R Dale Blasier, Little Rock AR

William Mitchell, Marlton NJ

Obesity Medicine Association

Delegate(s)
Ethan Lazarus, Lone Tree CO

Alternate Delegate(s)
Anthony Auriemma, Elmhurst IL

Radiological Society of North America

Delegate(s)
Nandini M. Meyersohn, Cambridge MA

Kevin C. Reilly, Elizabethtown KY

Laura E. Traube, San Luis Obispo CA

Alternate Delegate(s)
Bhavika Patel,

Renal Physicians Association

Delegate(s)
Rebecca Schmidt, Morgantown WV

Alternate Delegate(s)
Louis H. Diamond, Rockville MD

Current as of: 10/12/2023

Society for Cardiovascular Angiography and Interventions

Delegate(s)

J. Jeffrey Marshall, Atlanta GA

Edward Tuohy, Milford CT

Alternate Delegate(s)

Richard "Rick" Snyder, Fort Worth TX

Society for Cardiovascular Magnetic Resonance

Delegate(s)

Edward T. Martin, Tulsa OK

Alternate Delegate(s)

Anthon Fuisz, Valhalla NY

Society for Investigative Dermatology

Delegate(s)

Erica Dommasch, Boston MA

Society for Vascular Surgery

Delegate(s)

Nicolas J. Mouawad, Bay City MI

Society of American Gastrointestinal Endoscopic Surgeons

Delegate(s)

Kevin Reavis, Portland OR

Paresh Shah, New York NY

Alternate Delegate(s)

Kellie Marie McFarlin, Detroit MI

Society of Cardiovascular Computed Tomography

Delegate(s)

Kanae Mukai, Salinas CA

Alternate Delegate(s)

Irfan Zeb, Morgantown WV

Society of Critical Care Medicine

Delegate(s)

Kathleen Doo, Orinda CA

Tina R. Shah, Atlanta GA

Alternate Delegate(s)

Michael Nurok, Los Angeles CA

Daniel Udrea, Loma Linda CA

Resident and Fellow Sectional Delegate(s)

Maria Saraf, Burlington MA

Society of Hospital Medicine

Delegate(s)

Steven Deitelzweig, New Orleans LA

Brad Flansbaum, Danville PA

Ron Greeno, Los Angeles CA

Society of Interventional Radiology

Delegate(s)

Meridith Englander, Albany NY

Charles Ray, Chicago IL

Alternate Delegate(s)

Christine Kim, Los Angeles CA

Annie K Lim, Denver CO

Resident and Fellow Sectional Alternate Delegate(s)

Dipesh Patel, East Haven CT

Society of Nuclear Medicine and Molecular Imaging

Delegate(s)

Gary L. Dillehay, Chicago IL

Resident and Fellow Sectional Alternate Delegate(s)

Gbenga Shogbesan, Atlanta GA

Society of Thoracic Surgeons

Delegate(s)

Jeffrey P. Gold, Omaha NE

David D. Odell, Chicago IL

Triological Society, The

Delegate(s)

Michael E. Hoffer, Miami FL

US Public Health Service

Delegate(s)

Lily Balasuriya, New Haven CT

Alternate Delegate(s)

Elizabeth Davlantes, Atlanta GA

Veterans Affairs

Delegate(s)

Carolyn M. Clancy, Silver Spring MD

Academic Physicians Section

Delegate(s)
Alma B. Littles, Tallahassee FL

Alternate Delegate(s)
Gary Gaddis, St. Louis MO

Integrated Physician Practice Section

Delegate(s)
Steven Wang, Bakersfield CA

Alternate Delegate(s)
Russell C. Libby, Fairfax VA

International Medical Graduates Section

Delegate(s)
Afifa Adiba, Wallingford CT

Alternate Delegate(s)
Natalia Solenkova, Aventura FL

Medical Student Section

Delegate(s)
Rajadhar Reddy, Houston TX

Alternate Delegate(s)
Laurie Lapp, Madison WI

Minority Affairs Section

Delegate(s)
Luis Seija, New York NY

Alternate Delegate(s)
Shannon Zullo,

Organized Medical Staff Section

Delegate(s)
Matthew Gold, Winchester MA

Alternate Delegate(s)
Nancy Fan, Wilmington DE

Private Practice Physician Section

Delegate(s)
Timothy G. Mc Avoy, Waukesha WI

Alternate Delegate(s)
Daniel Eunsuk Choi, Garden City Park NY

Resident and Fellow Section

Delegate(s)
Anna Heffron, New York NY

Alternate Delegate(s)
Joey Whelihan, Philadelphia PA

Senior Physicians Section

Delegate(s)
Virginia E. Hall, Hummelstown PA

Alternate Delegate(s)
Douglas M. DeLong, Cherry Valley NY

Women Physicians Section

Delegate(s)
Nicole L. Plenty, Katy TX

Alternate Delegate(s)
Anna Brown, Howard WI

Young Physicians Section

Delegate(s)
Alisha Reiss, Greenville OH

Alternate Delegate(s)
Sean Figy, Omaha NE

Current as of: 10/12/2023

Reference Committee Hearing Room Assignments
Saturday, November 11

1:30pm	**Room**
Amendments to Constitution & Bylaws	Potomac Ballroom A
B Legislative advocacy	Potomac Ballroom B
C Advocacy on medical education	Potomac Ballroom C
F AMA governance and finance	Maryland Ballroom
J Medical Service	Potomac Ballroom D
K Public Health	National Harbor 2/3

AMERICAN MEDICAL ASSOCIATION
HOUSE OF DELEGATES

2023 Interim Meeting
Notes on Orders of Business
Gaylord National Resort & Convention Center, Maryland
Maryland Ballroom

FIRST SESSION, Friday, November 10, 6:00pm

SECOND SESSION, Saturday, November 11, 12:30 – 1:00pm

THIRD SESSION, Monday, November 13, 10:00am – 6:00pm

FOURTH SESSION, Tuesday, November 14, 8:00am – completion of business

SUMMARY OF FISCAL NOTES (I-23)

Report(s) of the Board of Trustees

01 Employed Physicians: Moderate
02 Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies: Minimal
03 Update on Climate Change and Health – AMA Activities: Informational Report
04 Update on Firearm Injury Prevention Task Force: Informational Report
05 AMA Public Health Strategy: The Mental Health Crisis: Minimal
06 Universal Good Samaritan Statute: Moderate
07 Obtaining Professional Recognition for Medical Service Professionals: Minimal
08 AMA Efforts on Medicare Payment Reform: Informational Report
09 Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted: Informational Report
10 Medical Decision-Making Autonomy of the Attending Physician: Minimal
11 Criminalization of Providing Medical Care: Informational Report
12 American Medical Association Meeting Venues and Accessibility: Minimal
13 House of Delegates (HOD) Modernization: Minimal
14 Funding for Physicians to Provide Safe Storage Devices to Patients with Unsecured Firearms in the Home: Minimal
15 Redefining AMA's Position on ACA and Health Care Reform: Informational Report
16 2023 AMA Advocacy Efforts: Informational Report

Report(s) of the Council on Ethical and Judicial Affairs

01 Physicians' Use of Social Media for Product Promotion and Compensation: Minimal
02 Research Handling of De-Identified Patient Data: Minimal

Opinion(s) of the Council on Ethical and Judicial Affairs

01 Responsibilities to Promote Equitable Care: Informational Report

Report(s) of the Council on Long Range Planning and Development

01 Women Physicians Section Five-Year Review: Minimal
02 Generative AI in Medicine and Health Care: Informational Report

Report(s) of the Council on Medical Education

01 Leave Policies for Medical Students, Residents, Fellows, and Physicians: Minimal
02 Update on Continuing Board Certification: Minimal
03 Ensuring Equity in Interview Processes for Entry to Undergraduate and Graduate Medical Education: Modest
04 Recognizing Specialty Certifications for Physicians: Modest
05 Organizations to Represent the Interests of Resident and Fellow Physicians: Modest

Report(s) of the Council on Medical Service

01 ACO REACH: Minimal
02 Health Insurers and Collection of Patient Cost-Sharing: Minimal
03 Strengthening Network Adequacy: Minimal
04 Physician-Owned Hospitals: Minimal
05 Medicaid Unwinding Update: Minimal
06 Rural Hospital Payment Models: Minimal
07 Sustainable Payment for Community Practices: Minimal

Report(s) of the Council on Science and Public Health

01 Drug Shortages: 2023 Update: Minimal
02 Precision Medicine and Health Equity: Minimal
03 HPV-Associated Cancer Prevention: Moderate
04 Supporting and Funding Sobering Centers: Modest
05 Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room: Moderate
06 Marketing Guardrails for the "Over-Medicalization" of Cannabis Use: Minimal
07 Efficacy of Requirements for Metal Detection/Weapons Interdiction Systems in Health Care Facilities: Minimal

Report(s) of the HOD Committee on Compensation of the Officers

01 Report of the House of Delegates Committee on the Compensation of the Officers: $29,861

Report(s) of the Speakers

01 Report of the Resolution Modernization Task Force Update: Informational Report
02 Extending Online Forum Trial Through A-24: Minimal
03 Report of the Election Task Force 2: Minimal

Resolutions

002 Support for International Aid for Reproductive Healthcare: Modest
004 Reconsideration of Medical Aid in Dying (MAID): Modest
005 Adopting a Neutral Stance on Medical Aid in Dying: Modest
006 Inappropriate Use of Health Records in Criminal Proceedings: Modest
007 Improving Access to Forensic Medical Evaluations and Legal Representation for Asylum Seekers: Modest
009 Physicians arrested for Non-Violent Crimes While Engaged in Public Protests: Moderate
201 Opposition to the Restriction and Criminalization of Appropriate Use of Psychotropics in Long Term Care: Minimal
202 Protecting the Health of Patients Incarcerated in For-Profit Prisons: Modest

203 Anti-Discrimination Protections for Housing Vouchers: Minimal
204 Improving PrEP & PEP Access: Minimal
205 Cannabis Product Safety: Modest
206 The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice: Minimal
207 On-Site Physician Requirement for Emergency Departments: Modest
208 Non-Physician Practitioners Oversight and Training: Minimal
210 Immigration Status in Medicaid and CHIP: Modest
213 Health Technology Accessibility for Aging Patients: Minimal
215 A Public Health-Centered Criminal Justice System: Minimal
216 Saving Traditional Medicare: Moderate
217 Addressing Work Requirements for J-1 Visa Waiver Physicians: Minimal
218 Youth Residential Treatment Program Regulation: Modest
219 Improving Access to Post-Acute Medical Care for Patients with Substance Use Disorder (SUD): Modest
220 Merit-Based Process for the Selection of all Federal Administrative Law Judges: Minimal
222 Expansion of Remote Digital Laboratory Access Under CLIA: Modest
223 Initial Consultation for Clinical Trials Under Medicare Advantage: Minimal
224 ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers: Moderate
301 Clarification of AMA Policy D-310-948 “Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure”: Minimal
302 Medical Student Reports of Disability-Related Mistreatment: Minimal
304 Health Insurance Options for Medical Students: Modest
305 Addressing Burnout and Physician Shortages for Public Health: Modest
601 Carbon Pricing to Address Climate Change: Modest
606 Prevention of Healthcare-Related Scams: Modest
801 Improving Pharmaceutical Access and Affordability: Minimal
802 Improving Nonprofit Hospital Charity Care Policies: Modest
803 Improving Medicaid and CHIP Access and Affordability: Minimal
804 Required Clinical Qualifications in Determining Medical Diagnoses and Medical Necessity: Modest
805 Medication Reconciliation Education: Minimal
806 Evidence-Based Anti-Obesity Medication as a Covered Benefit: Minimal
807 Any Willing Provider: Moderate
808 Prosthodontic Coverage after Oncologic Reconstruction: Modest
809 Outsourcing of Administrative and Clinical Work to Different Time Zones – An Issue of Equity, Diversity, and Inclusion: Modest
811 Expanding the Use of Medical Interpreters: Minimal
812 Indian Health Service Improvements: Moderate
813 Strengthening Efforts Against Horizontal & Vertical Consolidation: Moderate

814 Providing Parity for Medicare Facility Fees: Moderate
815 Long-Term Care and Support Services for Seniors: Modest
817 Expanding AMA Payment Reform Work and Advocacy to Medicaid and other non-Medicare payment modules for Pediatric Healthcare and Specialty Populations: Moderate
819 Amend Virtual Credit Card Policy: Modest
820 Affordability and Accessibility of Treatment of Overweight and Obesity: Moderate
901 Silicosis from Work with Engineered Stone: Moderate
902 Post Market Research Trials: Modest
903 Supporting Emergency Anti-Seizure Interventions: Minimal
904 Universal Return-to-Play Protocols: Minimal
905 Support for Research on the Relationship Between Estrogen and Migraine: Modest
906 Online Content Promoting LGBTQ+ Inclusive Safe Sex Practices: Minimal
909 High Risk HPV Subtypes in Minoritized Populations: Moderate
910 Sickle Cell Disease Workforce: Moderate
913 Public Health Impacts of Industrialized Farms: Moderate
914 Adverse Childhood Experiences: Modest
915 Social Media Impact on Youth Mental Health: $251,462 Convene expert panel, develop & disseminate educational materials
916 Elimination of Buprenorphine Dose Limits: Moderate
922 Prescription Drug Shortages and Pharmacy Inventories: Moderate

Resolutions – consideration not yet determined

306 Increasing Practice Viability for Female Physicians through Increased Employer and Employee Awareness of Protected Leave Policies: Minimal
608 Confronting Ageism in Medicine: Modest
818 Amendment to AMA policy on healthcare system reform proposals: Moderate
917 Advocating for Education and Action Regarding the Health Hazards of PFAS Chemicals: $51,420 Develop continuing medical education module
918 Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals: Moderate
919 Lithium Battery Safety: Modest
920 Antipsychotic Medication Use for Hospice Patients: Modest
921 Addressing Disparities and Lack of Research for Endometriosis: Modest

RESOLUTIONS – BY SPONSOR (I-23)

SPONSOR	Reso #	TITLE
Academic Physicians Section	009	Physicians arrested for Non-Violent Crimes While Engaged in Public Protests
AMDA – The Society for Post-Acute and Long-Term Care Medicine	804	Required Clinical Qualifications in Determining Medical Diagnoses and Medical Necessity
American Academy of Child and Adolescent Psychiatry	218	Youth Residential Treatment Program Regulation
	915	Social Media Impact on Youth Mental Health
American Academy of Ophthalmology	206	The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice
American Academy of Pediatrics	817	Expanding AMA Payment Reform Work and Advocacy to Medicaid and other non-Medicare payment modules for Pediatric Healthcare and Specialty Populations
	914	Adverse Childhood Experiences
American Association for Geriatric Psychiatry	201	Opposition to the Restriction and Criminalization of Appropriate Use of Psychotropics in Long Term Care
American Association of Neurological Surgeons	922	Prescription Drug Shortages and Pharmacy Inventories
American Association of Public Health Physicians	305	Addressing Burnout and Physician Shortages for Public Health
American College of Legal Medicine	220	Merit-Based Process for the Selection of all Federal Administrative Law Judges
Arizona	901	Silicosis from Work with Engineered Stone
Association for Clinical Oncology	222	Expansion of Remote Digital Laboratory Access Under CLIA
	223	Initial Consultation for Clinical Trials Under Medicare Advantage
	224	ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers
Indiana	919	Lithium Battery Safety
	920	Antipsychotic Medication Use for Hospice Patients
Integrated Physician Practice Section	902	Post Market Research Trials
International Medical Graduates Section	217	Addressing Work Requirements for J-1 Visa Waiver Physicians
Kelly Caverzagie, MD	301	Clarification of AMA Policy D-310-948 “Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure”
Medical Student Section	002	Support for International Aid for Reproductive Healthcare
	004	Reconsideration of Medical Aid in Dying (MAID)
	006	Inappropriate Use of Health Records in Criminal Proceedings

SPONSOR	Reso #	TITLE
Medical Student Section	007	Improving Access to Forensic Medical Evaluations and Legal Representation for Asylum Seekers
	202	Protecting the Health of Patients Incarcerated in For-Profit Prisons
	203	Anti-Discrimination Protections for Housing Vouchers
	204	Improving PrEP & PEP Access
	210	Immigration Status in Medicaid and CHIP
	213	Health Technology Accessibility for Aging Patients
	215	A Public Health-Centered Criminal Justice System
	302	Medical Student Reports of Disability-Related Mistreatment
	304	Health Insurance Options for Medical Students
	601	Carbon Pricing to Address Climate Change
	606	Prevention of Healthcare-Related Scams
	801	Improving Pharmaceutical Access and Affordability
	802	Improving Nonprofit Hospital Charity Care Policies
	803	Improving Medicaid and CHIP Access and Affordability
	811	Expanding the Use of Medical Interpreters
	812	Indian Health Service Improvements
	813	Strengthening Efforts Against Horizontal & Vertical Consolidation
	903	Supporting Emergency Anti-Seizure Interventions
	904	Universal Return-to-Play Protocols
	905	Support for Research on the Relationship Between Estrogen and Migraine
	906	Online Content Promoting LGBTQ+ Inclusive Safe Sex Practices
	909	High Risk HPV Subtypes in Minoritized Populations
	910	Sickle Cell Disease Workforce
	913	Public Health Impacts of Industrialized Farms
Michigan	207	On-Site Physician Requirement for Emergency Departments
	805	Medication Reconciliation Education
	806	Evidence-Based Anti-Obesity Medication as a Covered Benefit

SPONSOR	Reso #	TITLE
New England	818	Amendment to AMA policy on healthcare system reform proposals
	917	Advocating for Education and Action Regarding the Health Hazards of PFAS Chemicals
	918	Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals
New York	809	Outsourcing of Administrative and Clinical Work to Different Time Zones – An Issue of Equity, Diversity, and Inclusion
	819	Amend Virtual Credit Card Policy
Oklahoma	205	Cannabis Product Safety
Oregon	820	Affordability and Accessibility of Treatment of Overweight and Obesity
Resident and Fellow Section	005	Adopting a Neutral Stance on Medical Aid in Dying
Senior Physicians Section	216	Saving Traditional Medicare
	608	Confronting Ageism in Medicine
	814	Providing Parity for Medicare Facility Fees
	815	Long-Term Care and Support Services for Seniors
Washington	219	Improving Access to Post-Acute Medical Care for Patients with Substance Use Disorder (SUD)
	916	Elimination of Buprenorphine Dose Limits
Women Physicians Section	306	Increasing Practice Viability for Female Physicians through Increased Employer and Employee Awareness of Protected Leave Policies
	921	Addressing Disparities and Lack of Research for Endometriosis
Young Physicians Section	208	Non-Physician Practitioners Oversight and Training
	807	Any Willing Provider
	808	Prosthodontic Coverage after Oncologic Reconstruction

Reference Committee on Amendments to Constitution and Bylaws

Report(s) of the Board of Trustees

01 Employed Physicians
10 Medical Decision-Making Autonomy of the Attending Physician

Report(s) of the Council on Ethical and Judicial Affairs

01 Physicians' Use of Social Media for Product Promotion and Compensation
02 Research Handling of De-Identified Patient Data

Report(s) of the Speakers

03 Report of the Election Task Force 2

Resolutions

002 Support for International Aid for Reproductive Healthcare
004 Reconsideration of Medical Aid in Dying (MAID)
005 Adopting a Neutral Stance on Medical Aid in Dying
006 Inappropriate Use of Health Records in Criminal Proceedings
007 Improving Access to Forensic Medical Evaluations and Legal Representation for Asylum Seekers
009 Physicians arrested for Non-Violent Crimes While Engaged in Public Protests

REPORT OF THE BOARD OF TRUSTEES

B of T Report 01-I-23

Subject: Employed Physicians
(BOT Report 09-I-22)

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

Referred to: Reference Committee on Amendments to Constitution and Bylaws

---

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

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

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

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

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

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

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

RECOMMENDATION

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

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

Fiscal Note: No significant fiscal impact

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-I-23

Subject:	Medical Decision-Making Autonomy of the Attending Physician (Resolution 009-I-22)
Presented by:	Willie Underwood III, MD, MSc, MPH, Chair
Referred to:	Reference Committee on Amendments to Constitution and Bylaws

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

BACKGROUND

Resolution 009 explains that "the majority of [American] physicians are now employed" by an entity such as a physician group, insurers, or hospital system rather than being self-employed in private practice. Additionally, recent "growth in the number of health care administrators has far outpaced growth in the number of physicians." [1] The rise of employed physicians and health care administrators—i.e., those administrative roles such as Chief Medical Officer or Chief Health Officer—has created a tension, and there is often a "disconnect" and "lack of understanding" between these professional groups. [1] This tension may be viewed as diverging goals or diverging responsibilities between physicians and administrators, i.e., the professional ethical duties physicians possess contrasted with administrators' fiduciary obligations to their business interests.[1] For example, Chandrashekar and Jain explain that while physicians and administrators often share certain "core values", their approaches to health care fundamentally differ as "[p]hysicians are focused on delivering patient-centered care, whereas administrators are focused on managing resources. Physicians are trained to think patient by patient, whereas administrators are trained to create system-level change." [1]

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

department who could be treated in an observation setting or as an outpatient" or pressured to "discharg[e] Medicare patients" earlier than clinically appropriate." [3]

RESOLUTION 009-I-22 and AMA POLICY

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

First Resolve Clause

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

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

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

Second Resolve Clause

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

> That our AMA advocate strongly that if there is a unique circumstance that puts the attending physician's care into question by a hospital administrator of any sort such as listed above [listed in the resolution's whereas clauses; list contains examples of administrative roles: Chief Executive Officer, Chief Medical Officer, etc.] but certainly not limited to that list– physician or not- in the event of a disagreement between an administrator and the attending physician regarding a decision one would call a mere judgment call, the onus would be on the administrator to prove to an ethics committee why the attending physician is wrong prior to anyone having the authority to overturn or overrule the order of the physician attending the patient directly (Directive to Take Action). (Emphasis added)

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

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

Third Resolve Clause

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

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

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

Fourth Resolve Clause

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

> That our AMA aggressively pursue any encroachment of administrators upon the medical decision making of attending physicians that is not in the best interest of patients as strongly as

possible, for there is no more sacred relationship than that of a doctor and his/her patient, and as listed above, first, we do no harm (Directive to Take Action). (Emphasis added)

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

Broad Themes of Concerns

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

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

Primacy of the Patient-Physician Relationship

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

Deference to Physician Decision-Making

- D-125.997 – "Interference in the Practice of Medicine"
- D-285.959 – "Prevent Medicare Advantage Plans from Limiting Care"
- D-285.954 – "Physician Decision-Making in Health Care System"
- H-285.931 – "The Critical Role of Physicians in Health Plans and Integrated Delivery Systems"
- H-225.957 – "Principles for Strengthening the Physician-Hospital Relationship"
- H-285.910 – "The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community"
- H-285.954 – "Physician Decision-Making in Health Care Systems"
- H-225.942 – "Physician and Medical Staff Member Bill of Rights"

- H-225.947 – "Physician Employment Trends and Principles"
- H-225.950 – "AMA Principles for Physician Employment"
- H-285.959 – "Prevent Medicare Advantage Plans from Limiting Care"
- H-285.920 – "Criterial for Level of Care Status"
- H-285.983 – "Organized Medical Staffs in Medical Delivery Systems"
- H-235.980 – "Hospital Medical Staff Self-Governance"
- Opinion 10.2 – "Physician Employment by a Nonphysician Supervisee"
- Opinion 9.4.1 – "Peer Review & Due Process"

Well-Being and Best Interests of Patients

- H-285.910 – "The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community"
- H-285.931 – "The Critical Role of Physicians in Health Plans and Integrated Delivery Systems"
- H-225.957 – "Principles for Strengthening the Physician-Hospital Relationship"
- H-285.910 – "The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community"
- H-285.954 – "Physician Decision-Making in Health Care Systems"
- H-225.942 – "Physician and Medical Staff Member Bill of Rights"
- H-225.947 – "Physician Employment Trends and Principles"
- H-225.950 – "AMA Principles for Physician Employment"
- H-285.998 – "Managed Care"
- H-285.951 – "Financial Incentives Utilized in the Management of Medical Care"
- H-320.953 – "Definitions of 'Screening' and 'Medical Necessity'"
- Opinion 1.1.1 – "Patient-Physician Relationships"
- Opinion 1.1.6 – "Quality"
- Opinion 10.1.1 – " Ethical Obligations of Medical Directors"
- Opinion 10.2 – "Physician Employment by a Nonphysician Supervisee"
- Opinion 10.7 – "Ethics Committees in Health Care Institutions"
- Opinion 10.7.1 – "Ethics Consultations"
- Opinion 11.2.1 – "Professionalism in Health Care Systems"
- Opinion 11.2.6 – "Mergers of Secular and Religiously Affiliated Health Care Institutions"
- Opinion 11.2.2 – "Conflicts of Interest in Patient Care"
- Opinion 11.2.3 – "Contract to Deliver Health Care Services"

CONCLUSION

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

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

- Moreover, existing policy recognizes that the primary role of ethics committees is to serve consultative and educational functions and to foster ethically sound decision making within the context of patient-physician relationships, in keeping with consensus in the ethics

community. The second resolve clause of Resolution 009 conflicts with this established consensus in the field and AMA policy.

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

RECOMMENDATION

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

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

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

Fiscal note: Minimal - less than $500

REFERENCES

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

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 1-I-23

Subject:	Physicians' Use of Social Media for Product Promotion and Compensation (Resolution 25, A-22)
Presented by:	David Fleming, MD, Chair
Referred to:	Reference Committee on Amendments to Constitution and Bylaws

---

At its 2022 Annual Meeting, the House of Delegates referred Resolution 025-A-22 (Resolution 025), "Use of Social Media for Product Promotion and Compensation" which asked that the American Medical Association (AMA) "study the ethical issues of medical students, residents, fellows, and physicians endorsing non-health related products through social and mainstream media for personal or financial gain."

This report by the Council on Ethical and Judicial Affairs (CEJA) explores ethical issues posed by this use of social media and reviews existing guidance in the AMA *Code of Medical Ethics* (*Code*).

BACKGROUND

Resolution 025 details the recent phenomenon of physicians' involvement in promotions and endorsements on social media. While Resolution 025 is limited to the context of physicians promoting non-health related products through social media, it also raises issues connected to the practice of physicians selling and promoting products and services in general. As such, this report discusses a range of issues associated with the sale and promotion of all types of products, as well as the use of social media specifically for this purpose. "Sale" refers to a physician's actual selling of a product or service to consumers for financial or other consideration. Products or services may be sold from a physician's office, via the internet, or from a business venture separate from the physician's practice of medicine. "Promotion" refers to a physician's advertising of a product or service that they are personally selling or the compensated endorsement of another entity's product or services. Products or goods may be promoted via traditional media or via the internet or social media.

The ethical concerns of physician sales and promotions of both health-related and non-health related products and services are interrelated and worth exploring holistically, rather than separately as Resolution 025 suggests.

Additionally, the concept of social media has changed dramatically in the last couple of decades and has altered how consumer goods and services are advertised, promoted, and sold. Social media now accounts for a broad range of communication—e.g. Tik Tok, Instagram, Facebook, X (formerly Twitter), YouTube—that can reach millions of people, and now often involves "influencing", where individuals

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

promote or sell goods and services or promote themselves (e.g. their personality or lifestyle) as a financial venture.

ETHICAL CONCERNS

Physicians' and medical students' sale and promotion of products or services and use of social media raises several ethical concerns. (1) These practices may damage the patient-physician relationship. If patients feel pressured to purchase products or services, this may undermine the trust that grounds patient-physician relationships, since it raises questions about whether physicians are fulfilling their fiduciary duty to put patients' interests above their own financial interests. (2) If inappropriate pressure is applied, then selling and promotion of products may result in the exploitation of patient vulnerability. (3) If physicians lend their credibility as medical professionals to products or services that are not supported by peer-reviewed evidence or are of questionable value, then they may put patient well-being and the integrity of the profession in jeopardy in the interest of profit-making.

Welfare of the Patient and the Patient-Physician Relationship

The sale and promotion of goods and services by physicians has the potential to negatively affect the welfare of patients. If a physician puts their financial interests above the interests of the patients, then this undercuts the foundational ethical principle that physicians must regard their "responsibility to the patient as paramount. [Principle VIII]. In addition, since patients are "vulnerable and dependent on the doctor's expertise" and there is an "asymmetry of knowledge" between patients and physicians, there is a risk that patients may be exploited and this, in turn, can "undermine a patient's trust" [1]. Further, if patients find out about a physician's financial incentive to recommend certain products or services after the fact, they may feel that they have been purposefully deceived, and so have reason to distrust both that individual physician and the profession as a whole. It is therefore imperative that physicians conscientiously distinguish when they are acting in their professional capacity by recommending products or services intended for patient benefit or public health, and when they are acting as commercial agents independent of their professional identity.

Integrity of the Profession

Physician sales and promotion of products and services may also damage the integrity of the profession. Physicians have an ethical duty to uphold professional standards in their role as physician in all areas of life. A key principle of professional integrity is that physicians should recognize that they carry the authority of their professional role with them into other social spheres. Physicians "engage in a number or roles" which include conveyors of information, advocates, experts, and commentators on medically related issues [2]. For many physicians, "navigating successfully among the potentially overlapping roles …poses challenges."[2] Physicians "carry with them heightened expectations as trusted…representatives of the medical profession." [2] Physicians should be aware that these expectations cannot be entirely separated from their personal identity either online or elsewhere and should take care to curate their social media presence accordingly.

PHYSICIAN SALES AND PROMOTIONS

The *Code* addresses the ethical concerns reflected above--both with regards to the physician sale of health and non-health related products--in Opinion 9.6.4, "Sale of Health Related Products" and Opinion 9.6.5,"Sale of Non-Health Related Goods". Opinion 9.6.4 directly acknowledges conflict of interest and states that "[p]hysician sale of health-related products raises ethical concerns about financial conflict of interest, risks placing undue pressure on the patient, threatens to erode patient trust, undermine the primary obligation of physicians to serve the interests of their patients before their own, and demean the

profession of medicine." It specifies that physicians have obligations to offer only peer-reviewed products, to "fully disclos[e] the nature of their financial interest," to limit "sales to products that serve immediate and pressing needs to their patients," and to avoid exclusive distributorships. Opinion 9.6.5 acknowledges the importance of physicians serving "the interests of their patients above their own" and explains that sales of non-health related goods can be acceptable under the following conditions: when the goods being sold are "low cost," when a physician takes "no share in profit" from such sales, or when the sales are "for the benefit of community organizations."

While the guidance offered by these opinions is valuable and relevant, it is limited to only some of the possible contexts in which physicians are promoting products and services, and does not include the social media scenario outlined in Resolution 025. These opinions also do not reflect the reality of physicians being involved with side businesses that are independent of their medical practices. Opinion 9.6.5 seems to suggest that physicians selling non-health-related products are doing so only for the good of the patient and should not expect to make a profit on these ventures, which is unrealistic.

Health-related products or services marketed to patients

This scenario is the one most closely aligned and envisioned by the guidance offered in Opinion 9.6.4, which encompasses the context of a physician selling health-related products (often in their office), marketed directly to their patients. Patients are often "vulnerable and dependent" on the physician's expertise" [3], so when a health-related product is promoted to a patient (especially in the physician's office) the power imbalance in the relationship makes the ethical risk particularly acute. Additionally, because the products in question are health-related, it also carries physician obligations to ensure that the products are peer reviewed and safe and that proper disclosure of the risks and benefits are given to patients. [Opinion 9.6.4]. To avoid taking advantage of patients, sale of health-related goods should be limited to only to those that serve their immediate needs, and goods should be offered at a reasonable cost.

Health-related products or services marketed to the general public

An example of this scenario might be where a physician has some side business or paid promotion to sell a health-related good, but the business is aimed at the general public. It is not performed in a physician's office nor specifically directed at patients. Hence, in most cases like this, the concern about harming the patient-physician relationship is somewhat minimized. However, it is still the case that the well-being of the general public should not be diminished for the financial gain of the physician. In all cases of the sale and promotion of health-related goods, physicians must disclose the nature of their financial interest in the product or service, and ensure that they only promote products offering benefits supported by peer-reviewed scientific evidence.

Non-health related product or service marketed to patients

This scenario is the one envisioned by the guidance of Opinion 9.6.5, which encompasses physicians selling non-health related products to their patients. An example in this case might be where a physician has a side business unrelated to their practice, but they promote the business in their office and to their patients. Here, there still may be improper influence upon the patient and such behavior may impact the trust of the patient-physician relationship while also undermining professional integrity. Opinion 9.6.5. reflects these concerns by requiring that physicians conduct such sales in a "dignified manner" and that "patients are not pressured in to making purchases" [Opinion 9.6.5]. In general, physicians should refrain from leveraging their professional role as physicians to promote unrelated business ventures and should not allow the sale or promotion of non-health-related goods or services to be a regular part of their practice of medicine.

Non-health related products to marketed to the general public

This scenario involves physicians who are selling or promoting non-health related products or services and marketing them to the general public. An example is when a physician operates a side business, such as a restaurant or a used-car dealership, and the business is promoted through the usual channels to a wide audience. This is the scenario imagined in Resolution 025, where physicians are promoting non-health-related goods through social media. Physicians should be mindful that it is still possible that patients could be customers of a physician's "side business," and in such contexts, patients may still feel pressured to become customers. Additionally, physicians must take care not to abuse their professional authority in such commercial activities and thus risk demeaning the profession. Such abuses of authority might include wearing a white coat or emphasizing medical professional credentials while selling or promoting a product. Physicians should also ensure that the information they provide about non-health-related products is trustworthy and not deceptive.

PROFESSIONALISM IN THE USE OF SOCIAL MEDIA

The concept of social media has changed since the technology's first appearance and widespread adoption. Today, social media are broadly internet-enabled technologies that enable individuals to have a presence online and ability to share opinions and self-generated media content to a wide audience.

Opinion 2.3.2 "Professionalism in Social Media" reflects an outdated understanding of the types and uses of social media, modeling its guidance on traditional sites such as Facebook, where the primary purposes are social networking among friends and colleagues, and perhaps also disseminating beneficial public health messages. While guidance that addresses these uses is still necessary (and so should be retained), modifications are required to reflect the fact that social media can now be used as a form of marketing intended to financially benefit individuals and corporations. The ethical concerns that arise in this context mirror those that arise in other situations where physicians are selling and promoting goods and services, that is, use of social media by medical professionals can undermine trust and damage the integrity of patient-physician relationships and the profession as a whole when physicians inappropriately use their social media presence to promote personal interests.

CONCLUSION

Combining the relevant parts of Opinion 9.6.4 and Opinion 9.6.5 into a single opinion and broadening the scope will allow for the *Code* to better address the full range of scenarios in which physicians may now sell and promote products or services. Updating 2.3.2 "Professionalism in the Use of Social Media" so that it includes guidance on using thes media to sell and promote products makes it clear that the consolidated guidance clearly applies to the concerns raised in Resolution 025. Revising these opinions also provides an opportunity to update language to reflect the current realities of technology and contemporary business practices.

RECOMMENDATION

In consideration of the foregoing, the Council on Ethical and Judicial Affairs recommends that:

1. Opinion 9.6.4, "Sale of Health-Related Products," and Opinion 9.6.5, "Sale of Non-Health-Related Products" be consolidated and amended by substitution to read as follows:

   The sale or promotion of products or services by physicians may offer benefit to patients or the public but may also conflict with their professional ethical responsibilities. Whether intended or not, they may be perceived to use their professional knowledge and stature as inducements to consumers. There

are four key scenarios of sales or promotion: (1) health-related products or services marketed to patients, (2) health-related products or services marketed to the general public, (3) non-health-related product or services marketed to patients, and (4) non-health-related products or services marketed to the general public.

Of greatest concern are commercial practices in which physicians sell or promote goods or services to patients. In these circumstances patients may feel pressured to purchase the product or service, which may compromise the physician's fiduciary obligation to put patients' interests above their own financial interests and undermine the trust that grounds patient-physician relationships. Similarly, if physicians lend their credibility as medical professionals to products or services that are not supported by peer-reviewed evidence or are of questionable value they may put patient well-being and the integrity of the profession in jeopardy.

Physicians and medical students therefore should:

(a) Refrain from leveraging their professional role to promote unrelated business ventures.

(b) Fully disclose the nature of their financial interest in the product or service.

(c) Avoid exclusive distributorship arrangements that make products or services available only through the individual's commercial venue.

(d) Limit the sale or promotion of health-related goods or services only to those that serve the immediate needs of patients and strive to make the product or service available at a reasonable cost.

(e) Refrain from the sale or promotion of non-health-related goods or services as a regular part of their professional activities. (Modify HOD/CEJA Policy); and

2. Opinion 2.3.2, "Professionalism in the Use of Social Media" be amended by substitution to read as follows:

Social media—internet-enabled communication technologies—enable individual medical students and physicians to have both a personal and a professional presence online. Social media can foster collegiality and camaraderie within the profession as well as provide opportunities to disseminate public health messages and other health communication widely. However, use of social media by medical professionals can also undermine trust and damage the integrity of patient-physician relationships and the profession as a whole, especially when medical students and physicians use their social media presence to promote personal interests.

Physicians and medical students should be aware that they cannot realistically separate their personal and professional personas entirely online and should curate their social media presence accordingly. Physicians and medical students therefore should:

(a) Use caution when publishing any content that could damage their individual professional reputation or impugn the integrity of the profession.

(b) Respect professional standards of patient privacy and confidentiality and refrain from publishing identifiable patient information online. When they use social media for educational purposes or to exchange information professionally with other physicians or medical students they should follow ethics guidance regarding confidentiality, privacy, and informed consent.

(c) Maintain appropriate boundaries of the patient-physician relationship in accordance with ethics guidance if they interact with patients through social media, just as they would in any other context.

(d) Use privacy settings to safeguard personal information and content, but be aware that once on the Internet, content is likely there permanently. They should routinely monitor their social media presence to ensure that their personal and professional information and content published about them by others is accurate and appropriate.

(e) Disclose any financial interests related to their social media content, including, but not limited to, paid partnerships and corporate sponsorships.

(f) When using social media platforms to disseminate medical health care information, ensure that such information is useful and accurate. They should likewise ensure to the best of their ability that non-health-related information is not deceptive. (Modify HOD/CEJA Policy); and

3. The remainder of this report be filed.

Fiscal Note: Less than $500

REFERENCES

1. Council on Ethical and Judicial Affairs, CEJA Report 5-I-97, "Sale of Non-Health Related Goods." https://code-medical-ethics.ama-assn.org/sites/default/files/2022-08/9.6.5%20Sale%20of%20non-health-related%20goods%20--%20background%20reports.pdf.
2. Council on Ethical and Judicial Affairs, CEJA Report 2-I-17, “Ethical Physician Conduct in the Media.” https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/councils/Council%20Reports/council-on-ethics-and-judicial-affairs/ceja-report-2-i17.pdf.
3. Council on Ethical and Judicial Affairs, CEJA Report 1-A-99, “Sale of Health-Related Products form Physician's Offices.” https://code-medical-ethics.ama-assn.org/sites/default/files/2022-08/9.6.4%20Sale%20of%20health-related%20products%20--%20background%20reports.pdf.

REPORT2 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (I-23)
Research Handling of De-Identified Patient Data
(D-315.969)
(Constitution and Bylaws)

EXECUTIVE SUMMARY

In adopting policy D-315.969, "Research Handling of De-Identified Patient Data," the House of Delegates directed the Council on Ethical and Judicial Affairs (CEJA) to examine guidance related to the use of de-identified patient data and the risks of re-identification. In response to this directive, CEJA carried out an extensive review of relevant philosophical and empirical literature and presented an informational report at the 2023 Annual Meeting.

This report expands on that previous work to articulate a series of recommendations on how best to respond to the increasing collection, sale, and use of de-identified patient data and the associated risks. The report outlines how health data exist within digital information ecosystems, how such complex ecosystems pose challenges to data privacy, how de-identified data functions as a public good for clinical research, and how de-identified data derived within the context of health care institutions lead to certain ethical standards for and protections of that data.

Because CEJA recognizes both the promise of de-identified datasets for advancing health and the concerns surrounding the use of de-identified patient data including the risks of re-identification that extend from the level of individual physicians collecting clinical data to hospitals and other health care institutions as repositories and stewards of data, this report proposes a new *Code of Medical Ethics* opinion be adopted in conjunction with amendments to four existing opinions to provide ethics guidance in this rapidly evolving digital health ecosystem.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-I-23

Subject:	Research Handling of De-Identified Patient Data (D-315.969)
Presented by:	David A. Flemming, MD, Chair
Referred to:	Reference Committee on Amendments to Constitution and Bylaws

Policy D-315.969, "Research Handling of De-Identified Patient Data," adopted by the American Medical Association (AMA) House of Delegates in November 2021, asked the Council on Ethical and Judicial Affairs (CEJA) to examine guidance related to the use of de-identified patient data and the risks of re-identification.

In its informational report on de-identified data [CEJA 6-A-23], CEJA examined a range of challenges that health care professionals and institutions are now confronted with as technological innovations rapidly evolve both within and outside of health care, blurring the boundary distinctions between these spheres. The Council's exploration suggested that in this dynamic environment, foundational ethical concepts of privacy and consent likely need to be revisited to better reflect that personal health information today exists in digital environments where responsibilities are distributed among multiple stakeholders.

This report expands on the previous work to articulate a series of recommendations on how best to respond to the increasing collection, sale, and use of de-identified patient data and the associated risks. The report outlines how health data exist within digital information ecosystems, how such ecosystems pose challenges to data privacy, what the *Code* says about data privacy and informed consent, how de-identified data functions as a public good for clinical research, how privacy scholars are reconceptualizing privacy as contextual integrity, and how de-identified data derived within the context of health care institutions lead to certain ethical standards for and protections of that data.

Because CEJA recognizes both the promise of de-identified datasets for advancing health and the concerns surrounding the use of de-identified patient data including the risks of re-identification that extend from the level of individual physicians collecting clinical data to hospitals and other health care institutions as repositories and stewards of data, this report proposes a new ethics opinion in conjunction with amendments to four existing opinions to provide ethics guidance in this rapidly evolving digital health ecosystem.

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

HEALTH DATA & DIGITAL ECOSYSTEMS

De-identified patient data are a subset of health data that exists within larger digital health information ecosystems [1]. Such ecosystems are highly dynamic and distributed, with health information often being combined from multiple datasets and distributed among multiple stakeholders [1]. Traditionally, health data has referred to patient health information produced from patient–physician interactions and stored by health care organizations [2]. This type of data is typically recorded as identifiable patient data and entered into the patient's Electronic Medical Record (EMR); from there, it can be de-identified and bundled together with other patent data to form an aggregated dataset. In the age of Big Data, however, where large datasets can reveal complex patterns and trends, diverse sets of information are increasingly brought together. Health data now extends to all health-relevant data, including data collected anywhere from individuals both passively and actively that can reveal information about health and health care use [2].

Within digital health ecosystems, health-related data can be generated by health care systems (e.g., EMRs, prescriptions, laboratory data, radiology), the consumer health and wellness industry (e.g., wearable fitness tracking devices, wearable medical devices such as insulin pumps, home DNA tests), digital exhaust from daily digital activities (e.g., social media posts, internet search histories, location and proximity data), as well as non-health sources of data (e.g., non-medical records of race, gender, education level, residential zip code, credit history) [2]. The ethical challenges raised by such widely distributed data ecosystems, with their vast array of data types and multiple stakeholders, require a holistic approach to the moral issues caused by digital innovation. Digital ethics has arisen as a theoretical framework to analyze these recent challenges and examine such ethical concerns from multiple levels of abstraction. The digital ethics framework takes into account the general environment in which ethical concerns arise and examines ethical dilemmas as they relate to information and data, algorithms, practices and infrastructure, and their impact on the digital world [3].

CHALLENGES TO DATA PRIVACY

In the U.S., the Health Insurance Portability and Accountability Act (HIPAA) imposes constraints on the sharing of "protected health information," including individually identifiable health information contained in the EMR, by "covered entities," including physicians, hospitals, pharmacies, and third-party payers. HIPAA's scope is narrow and does not cover other health-relevant data, such as data generated voluntarily by patients themselves, for example, through the use of commercial health-related apps or devices, or identifiable data individuals provide to municipal authorities, utilities, retailers, or on social media. Furthermore, information that began in the medical record can take on a new, independent life when linked with personal information widely available through datasets generated outside of health care. As McGraw and Mandl explain, "since HIPAA's coverage is about 'who' holds the data, but not what type of data, much of the health-relevant data collected today are collected by entities outside of HIPAA's coverage bubble and thus resides outside of HIPAA's protections" [2]. HIPAA is thus limited in its ability to protect patient data within digital health information ecosystems.

Complicating the matter is the fact that once patient health data has been de-identified, it is no longer protected by HIPAA, and can be freely bought, sold, and combined with other datasets. Hospitals now frequently sell de-identified datasets to researchers and industry. Recent

developments in AI and its use within health care have similarly created new difficulties. While many within health care are hopeful that the use of generative AI technologies will improve care and efficiency, the input of any identifiable private health information into an AI chatbot from a private company that has not signed an agreement with the health care institution means the input of any private health information is an unauthorized disclosure under HIPAA [4].

Patients, and patient privacy advocates, are often concerned about who has access to their data. As data ecosystems have grown larger and more distributed, this has become increasingly more difficult to ascertain. In the age of Big Data, the global sale of data has become a multibillion-dollar industry, with individuals' data viewed by industry as "new oil" [1]. Industry often purchases hospital datasets to improve marketing and sales, predict consumer behaviors, and to resell to other entities. Within health care and research settings, the massive datasets collected from clinical data—used initially in the care and treatment of individual patients—have created the potential for secondary use as a means for quality improvement and innovation that can be used for the benefit of future patients and patient populations [5].

The dynamic and distributed nature of today's digital health information ecosystems challenges the prevailing procedural model for protecting patient privacy: informed consent and de-identification. In a world where the secondary use of patient data within large datasets can easily enter into a global marketplace, the intended use is almost impossible to discern. Patients cannot be honestly and accurately informed about the specific terms of interactions between their collected data and the data collector and any potential risks that may emerge [1,6]. Therefore, patients are unable to truly give informed consent. Furthermore, whether de-identifying datasets truly prevents individual data subjects from being re-identified has been increasingly called into question. Removing the 18 identifiers specified in HIPAA does not ensure that the data subject cannot be re-identified by triangulation with identifying information from other readily available datasets [7]. Machine learning and AI technologies have advanced to the point that virtually all de-identified datasets risk re-identification, such that "even when individuals are not 'identifiable', they may still be 'reachable'" [6].

A final avenue to consider with respect to private health information and patient privacy is the risk of health care data breaches. Raghupathi et al note, "[h]ealthcare is a lucrative target for hackers. As a result, the healthcare industry is suffering from massive data breaches" [8]. The number of health care data breaches continues to increase every year, exposing the private health information of millions of Americans. Despite being heavily targeted by cybercriminals, health care providing institutions are widely considered by cybersecurity experts to lack sufficient security safeguards [8]. Raghupathi et al note, "healthcare entities gathering and storing individual health data have a fiduciary and regulatory duty to protect such data and, therefore, need to be proactive in understanding the nature and dimensions of health data breaches" [8].

CLINICAL DATA AND PRIVACY

Within the *Code,* Opinion 3.1.1, "Privacy in Health Care," distinguishes four aspects of privacy:

> personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).

The *Code* does not explicitly examine whether personal medical or health information are ethically distinct from other kinds of personal information (e.g., financial records) or in what way. Current guidance treats the importance of protecting privacy in all its forms as self-evident, holding that respecting privacy in all its aspects is of fundamental importance, "an expression of respect for autonomy and a prerequisite for trust" [Opinion 3.1.1]. However, Opinion 3.3.3, "Breach of Security in Electronic Medical Records," directly acknowledges that data security breaches create potential "physical, emotional, and dignity harms" to patients. Similarly, Opinion 7.3.7, "Safeguards in the Use of DNA Databanks," states that breaches of confidential patient information "may result in discrimination or stigmatization and may carry implications for important personal choices."

Violations of privacy can result in both harm—tangible negative consequences, such as discrimination in insurance or employment or identity theft—and in wrongs that occur from the fact of personal information being known without the subject's awareness, even if the subject suffers no tangible harm [7]. Price and Cohen note that privacy issues can arise not only when data are known, but when data mining enables others to "generate knowledge about individuals through the process of inference rather than direct observation or access" [7].

CLINICAL DATA AND INFORMED CONSENT

With respect to Opinion 2.1.1, "Informed Consent," in the *Code,* successful communication is seen as essential to fostering trust that is fundamental to the patient–physician relationship and to supporting shared decision making. Opinion 2.1.1 states: "[t]he process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention." In seeking a patient's informed consent, physicians are directed to include information about "the burdens, risks, and expected benefits of all options, including forgoing treatment" [Opinion 2.1.1]. It should be noted, however, that no direct mention of patient data is discussed in the opinion, other than that documentation of consent should be recorded in the patient's medical record.

CLINICAL DATA, DATASETS, AND THE PUBLIC GOOD

While legally, clinical data are the property of the health care organization, ethically, because such aggregated data has the potential for secondary use that can benefit all of society, it has been argued that such data should be treated as a form of public good [5]. When clinical data are de-identified and aggregated, the potential use for societal benefits through research and development is an emergent, secondary side effect of electronic health records that goes beyond individual benefit. Larson et al argue that not only does the public possess an interest in safeguarding and promoting clinical data for societal benefits, but all those who participate in health care systems have an ethical responsibility to treat such data as a form of public good [5]. They propose:

> all individuals and entities with access to clinical data inherently take on the same fiduciary obligations as those of medical professionals, including for-profit entities. For example, those who are granted access to the data must accept responsibility for safeguarding protected health information [5].

This entails that any entity that purchases private health information, whether or not it has been de-identified, has an ethical obligation to adhere to the ethical standards of health care where such data were produced. Hospitals thus have an ethical responsibility to ensure that their contracts of sale for datasets insist that all entities that gain access to the data adhere to the ethical standards and values of the health care industry.

This is particularly important when we recall that the wide distribution of digital health information ecosystems increasingly includes non-health-related parties from industry that may have market interests that conflict with the ethical obligations that follow health data. Within this framework, the fiduciary duty to protect patient privacy as well as to society to improve future health care follows the data and thus applies to all entities that use that data, such that all entities granted access to the data become data stewards, including for-profit parties [5]. This also includes patients, such that they bear a responsibility to allow their data to be used for the future improvement of health care for society, especially when we recognize that current health care has already benefited from past data collection [5].

While the re-identification of aggregated patient data should generally be prohibited, there are rare exceptions. There may be occasions when researchers wish to re-identify a dataset, such as sometimes occurs in the study of rare diseases that rely on international registries; in such situations, all individuals must be re-contacted, and their consent obtained in order to re-identify their data since this would represent a significant change to the initial research protocols and respective risks [9]. Re-identification of datasets for research is uncommon, however, because obtaining re-consent can be difficult and can lead to flawed research if data is lost because patients do not re-consent. The other situation in which it may be permissible, or even obligatory, to re-identify aggregated patient data is when doing so would be in the interest of the health of individual patients, such as might occur in the study of a rare genetic disorder. Even within these exceptions, the risks associated with re-identification remain and re-identified data should thus never be published. Re-identification of de-identified patient data for any other purposes, by anyone inside or outside of health care, must be avoided.

AN ALTERNATIVE APPROACH: PRIVACY AS CONTEXTUAL INTEGRITY

Within today's digital health information ecosystems, physicians and hospitals face several challenges to protecting patient privacy. Barocas and Nissenbaum contend that "even if [prevailing forms of consent and anonymization] were achievable, they would be ineffective against the novel threats to privacy posed by big data" [6]. A more effective option, Nissenbaum has argued, would understand privacy protection as a function of "contextual integrity," i.e., that in a given social domain, information flows conform to the context-specific informational norms of that domain. Whether a transmission of information is appropriate depends on "the type of information in question, about whom it is, by whom and to whom it is transmitted, and conditions or constraints under which this transmission takes place" [10]. The view of privacy as contextual integrity—that our conception of privacy is contextual and governed by various norms of information flow—recognizes that there exist different norms regarding privacy within different spheres of any distributed digital ecosystem [7,11]. The challenge within health care, as we have seen, is how to balance these various norms when they conflict and how to ensure that health care's ethical standards and values are maintained throughout the distributed use of de-identified private health information.

THE CONTEXTUAL INTEGRITY OF DE-IDENTIFIED HEALTH DATA

In handling patient data, individual physicians strive to balance supporting and respecting patient privacy while also upholding ethical obligations to the betterment of public health. Through their own actions, as well as through their membership organizations and through their healthcare organizations, physicians should: (1) ensure that data entered into electronic records are accurate and reliable to the best of their ability; (2) be transparent with patients regarding the limited extent to which their data can be safely protected, how their data may be used, and why the use of such data is crucial for improving health care outcomes within society; and (3) ensure that proper oversight and protections of data are in place, including contractual provisions that any data sold or shared with outside entities stay in alignment with the ethical standards of the medical profession, and that meaningful sanctions or penalties are in place and enforced against any actors that violate those ethical standards. It is critical to recognize, as is outlined in the *Code,* that the patient–physician relationship is built on trust, and that this trust relies heavily on transparency.

It is important for both patient care and research that clinical data entered into the EMR be as accurate and complete as possible. Some data capture practices, such as copying-and-pasting daily progress notes from previous encounters, which may contribute to efficiency, can lead to documentation errors [12]. One avenue for improving EMR accuracy is that, under HIPAA, patients have the right to access their data and request any perceived errors be amended. While there is no one solution to improving accuracy of EMR data, further study into how to improve EMR accuracy is important. One challenge to both EMR accuracy and completeness is the limited interoperability of different EMR systems. Matching digital health records for the same patient across and within health care facilities can be a challenge, further contributing to the potential for EMR errors. Standardization of recording data elements, such as capturing patient address and last name in a consistent format, may improve matching of patient records and thus improve the accuracy of the EMR [13].

Another challenge to EMR data quality is the risk of bias, primarily due to implicit bias in EMR design and underrepresentation of patients from historically marginalized groups, low socioeconomic status, and rural areas [14,15]. Critically important for research involving data collected from EMRs, available EMR data only reflects those with access to health care in the first place. While certain study designs and tools have been developed to reduce these biases in research, physicians and health care institutions should be looking into ways to reduce bias within EMRs, such as features to optimize effective EMR use and to consistently capture patient data, especially data on race/ethnicity and social determinants of health that are often inconsistently and inaccurately captured in EMR systems [14,15,16].

Patients have a right to know how and why their data are being used. While physicians should be able to answer questions regarding patient data as they relate to HIPAA protections, it is the responsibility of health care institutions to provide more detailed information regarding expectations of data privacy, how patient data may be used, and why such use is important to improve the future of health care. Health care systems may consider fulfilling this ethical obligation by creating a patient notification of data use built into the patient registration process (using language similar to the NIH's Introduction-Description component, meant to provide prospective research participants with an introduction to and description of the planned storage and sharing of data and biospecimens [17]).

As stewards of health data, health care institutions have an ethical responsibility to protect data privacy. This fiduciary duty to patient data should be seen as following the data even after they are de-identified and leave the institution where they were initially captured [5,8]. While hospitals and health care organizations increasingly come under cyberattack, they consistently lag behind other industries in cybersecurity [18]. With regards to protecting the data they maintain, health care institutions have a responsibility to make more significant investments in cybersecurity.

In order to ensure that the ethical standards of health care are maintained even after data leaves health care institutions, McGraw and Mandl propose that companies collecting or using health-relevant data could be required to establish independent data ethics review boards [2]. They write that such boards could be similar to Institutional Review Boards (IRBs) but should focus more on privacy than on participant risk, evaluating proposed data projects for legal and ethical implications as well as their potential to improve health and/or the health care system [2]. In practice, ethics review boards involved with industry face challenges to both independence and efficacy. Independence can be compromised by influences such as conflicts of interest, while efficacy can be compromised by the absence of authority, procedures, and systems to enact recommendations made by these review bodies. To be effective, data ethics review boards must be independent and free of conflicts of interest from the company or organization whose data research proposal(s) they are evaluating and have systems in place for both transparency and implementation of feedback for remediations of privacy and other quality and ethics concerns. Though not a comprehensive solution, independent data ethics review boards could be an effective safeguard against industry conflicts of interest and should be considered as a required part of contracts of sale of health data, with contracts stipulating that any future resale of the data also undergo review by a data ethics review board.

The need for more transparent disclosure to patients regarding their data use as well as the importance of building the values of medical ethics into the contracts of sale of aggregate datasets created by hospitals highlights the fact that the ethical responsibilities to respond to the risks of de-identified data should not be borne by physicians alone. Respecting patient privacy and their informed consent are responsibilities that physician member organizations and health care institutions must take on because the risks to these rights that patients face within digital health ecosystems radiate far beyond the patient–physician relationship to areas where individual physicians have little influence.

RECOMMENDATIONS

In light of the challenges considered with regard to constructing a framework for holding stakeholders accountable within digital health information ecosystems, the Council on Ethical and Judicial Affairs recommends:

1. That the following be adopted:

    Within health care systems, identifiable private health information, initially derived from and used in the care and treatment of individual patients, has led to the creation of massive de-identified datasets. As aggregate datasets, clinical data takes on a secondary promising use as a means for quality improvement and innovation that can be used for the benefit of future patients and patient populations. While de-identification of data is meant to protect the privacy

of patients, there remains a risk of re-identification, so while patient anonymity can be safeguarded it cannot be guaranteed. In handling patient data, individual physicians thus strive to balance supporting and respecting patient privacy while also upholding ethical obligations to the betterment of public health.

When clinical data are de-identified and aggregated, their potential use for societal benefits through research and development is an emergent, secondary use of electronic health records that goes beyond individual benefit. Such data, due to their potential to benefit public health, should thus be treated as a form of public good, and the ethical standards and values of health care should follow the data and be upheld and maintained even if the data are sold to entities outside of health care. The medical profession's responsibility to protect patient privacy as well as to society to improve future health care should be recognized as inherently tied to these datasets, such that all entities granted access to the data become data stewards with a duty to uphold the ethical values of health care in which the data were produced.

As members of health care institutions, physicians should:

(a) Follow existing and emerging regulatory safety measures to protect patient privacy;

(b) Practice good data intake, including collecting patient data equitably to reduce bias in datasets;

(c) Answer any patient questions about data use in an honest and transparent manner to the best of their ability in accordance with HIPAA (or current legal standards).

Health care systems, in interacting with patients, should adopt policies and practices that provide patients with transparent information regarding:

(d) The high value that health care institutions place on protecting patient data;

(e) The reality that no data can be guaranteed to be permanently anonymized, and that risk of re-identification does exist;

(f) How patient data may be used and by whom;

(g) The importance of de-identified aggregated data for improving the care of future patients.

Health care systems, as health data stewards, should:

(h) Establish appropriate data collection methods and practices that meet industry standards to ensure the creation of high-quality datasets;

(i) Ensure proper oversight of patient data is in place, including provisions for the use of de-identified datasets that may be shared, sold, or resold;

(j) Develop models for the ethical use of de-identified datasets when such provisions do not exist, such as establishing and contractually requiring independent data ethics review

boards free of conflicts of interest to evaluate the sale and potential resale of clinically-derived datasets;

(k) Take appropriate cyber security measures to ensure the highest level of protection is provided to patients and patient data;

(l) Develop proactive post-compromise planning strategies for use in the event of a data breach to minimize additional harm to patients;

(m) Advocate that health- and non-health entities using any health data adopt the strongest protections and uphold the ethical values of the medical profession.

There is an inherent tension between the potential benefits and burdens of de-identified datasets as both sources for quality improvement to care as well as risks to patient privacy. Re-identification of data may be permissible, or even obligatory, in rare circumstances when done in the interest of the health of individual patients. Re-identification of aggregated patient data for other purposes without obtaining patients' express consent, by anyone outside or inside of health care, is impermissible. (New HOD/CEJA Policy); and

2. That Opinion 2.1.1, "Informed Consent"; Opinion 3.1.1, "Privacy in Health Care"; Opinion 3.2.4, "Access to Medical Records by Data Collection Companies"; and Opinion 3.3.2, "Confidentiality and Electronic Medical Records" be amended by addition as follows:

a. Opinion 2.1.1, Informed Consent

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making. Transparency with patients regarding all options of treatment is critical to establishing trust and should extend to discussions regarding who has access to patients' health data and how data may be used.

The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:

(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.

(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:

(i) the diagnosis (when known);

(ii) the nature and purpose of recommended interventions;

(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.

(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.

In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines. (Modify HOD/CEJA Policy)

b. Opinion 3.1.1, Privacy in Health Care

Protecting information gathered in association with the care of the patient is a core value in health care. However, respecting patient privacy in other forms is also fundamental, as an expression of respect for patient autonomy and a prerequisite for trust.

Patient privacy encompasses a number of aspects, including personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).

Physicians must seek to protect patient privacy in all settings to the greatest extent possible and should:

(a) Minimize intrusion on privacy when the patient's privacy must be balanced against other factors.

(b) Inform the patient when there has been a significant infringement on privacy of which the patient would otherwise not be aware.

(c) Be mindful that individual patients may have special concerns about privacy in any or all of these areas.

(d) Be transparent that privacy safeguards for patient data are in place but acknowledge that anonymity cannot be guaranteed and that breaches can occur notwithstanding best data safety practices. (Modify HOD/CEJA Policy)

c. Opinion 3.2.4, Access to Medical Records by Data Collection Companies

Information contained in patients' medical records about physicians' prescribing practices or other treatment decisions can serve many valuable purposes, such as improving quality of care. However, ethical concerns arise when access to such information is sought for marketing purposes on behalf of commercial entities that have financial interests in physicians' treatment recommendations, such as pharmaceutical or medical device companies.

Information gathered and recorded in association with the care of a patient is confidential. Patients are entitled to expect that the sensitive personal information they divulge will be used solely to enable their physician to most effectively provide needed services. Disclosing

information to third parties for commercial purposes without consent undermines trust, violates principles of informed consent and confidentiality, and may harm the integrity of the patient-physician relationship.

Physicians who propose to permit third-party access to specific patient information for commercial purposes should:

(a) Only provide data that has been de-identified.

(b) Fully inform each patient whose record would be involved (or the patient's authorized surrogate when the individual lacks decision-making capacity) about the purpose(s) for which access would be granted.

Physicians who propose to permit third parties to access the patient's full medical record should:

(c) Obtain the consent of the patient (or authorized surrogate) to permit access to the patient's medical record.

(d) Prohibit access to or decline to provide information from individual medical records for which consent has not been given.

(e) Decline incentives that constitute ethically inappropriate gifts, in keeping with ethics guidance.

Because de-identified datasets are derived from patient data as a secondary source of data for the public good, health care professionals and/or institutions who propose to permit third-party access to such information have a responsibility to ensure that any use of data derived from health care adhere to the ethical standards of the medical profession. (Modify HOD/CEJA Policy)

d. Opinion 3.3.2, Confidentiality and Electronic Medical Records

Information gathered and recorded in association with the care of a patient is confidential, regardless of the form in which it is collected or stored.

Physicians who collect or store patient information electronically, whether on stand-alone systems in their own practice or through contracts with service providers, must:

(a) Choose a system that conforms to acceptable industry practices and standards with respect to:

(i) restriction of data entry and access to authorized personnel;

(ii) capacity to routinely monitor/audit access to records;

(iii) measures to ensure data security and integrity; and

(iv) policies and practices to address record retrieval, data sharing, third-party access and release of information, and disposition of records (when outdated or on termination of the service relationship) in keeping with ethics guidance.

(b) Describe how the confidentiality and integrity of information is protected if the patient requests.

(c) Release patient information only in keeping with ethics guidance for confidentiality and privacy. (Modify HOD/CEJA Policy); and

3. That the remainder of this report be filed.

Fiscal Note: Less than $500

REFERENCES

1. Ruotsalainen P, Blobel B. Health information systems in the digital health ecosystem—problems and solutions for ethics, trust and privacy. Int J of Envir Res and Pub health 2020;17(9):3006.
2. McGraw D, Mandl KD. Privacy protections to encourage use of health-relevant digital data in a learning health system. NPJ dig med 2021;4(1):2.
3. Floridi L, Cath C, Taddeo M. Digital ethics: its nature and scope. *The 2018 yearbook of the digital ethics lab* 2019:9-17.
4. Kanter GP, Packel EA. Health Care Privacy Risks of AI Chatbots. JAMA 2023.
5. Larson DB, Magnus DC, Lungren MP, Shah NH, Langlotz CP. Ethics of using and sharing clinical imaging data for artificial intelligence: a proposed framework. Radiology 2020;295(3):675-82.
6. Barocas S, Nissenbaum H. Big data's end run around anonymity and consent. *Privacy, big data, and the public good: Frameworks for engagement* 2014;1:44-75.
7. Price WN II, Cohen IG. Privacy in the age of medical big data. Nat Med 2019;25:37–43.
8. Raghupathi W, Raghupathi V, Saharia A. Analyzing Health Data Breaches: A Visual Analytics Approach. AppliedMath 2023;3(1):175-99.
9. Hansson MG, Lochmüller H, Riess O, Schaefer F, Orth M, Rubinstein Y, Molster C, Dawkins H, Taruscio D, Posada M, Woods S. The risk of re-identification versus the need to identify individuals in rare disease research. Eur J Hum Genet 2016;24(11):1553-1558. doi:10.1038/ejhg.2016.52.
10. Nissenbaum, H. Respecting context to protect privacy: why meaning matters. Sci Eng Ethics 2018;24:831–52.
11. Nissenbaum H. Privacy as contextual integrity. Wash. L. Rev 2004;79:119-158.
12. Weng CY. Data Accuracy in Electronic Medical Record Documentation. JAMA Ophthalmol 2017;135(3):232–233. doi:10.1001/jamaophthalmol.2016.5562
13. Pew. Enhancing patient matching is critical to achieving full promise of digital health records: Accurately linking individuals with their health records essential to improving care. Pew Trust Report October 2, 2018. https://www.pewtrusts.org/en/research-and-analysis/reports/2018/10/02/enhanced-patient-matching-critical-to-achieving-full-promise-of-digital-health-records
14. Boyd AD, Gonzalez-Guarda R, Lawrence K, Patil CL, Ezenwa MO, O'Brien EC, Paek H, Braciszewski JM, Adeyemi O, Cuthel AM, Darby JE. Equity and bias in electronic health records data. Contemp Clinic Trials 2023;130:107238.
15. Boyd AD, Gonzalez-Guarda R, Lawrence K, Patil CL, Ezenwa MO, O'Brien EC, Paek H, Braciszewski JM, Adeyemi O, Cuthel AM, Darby JE. Potential bias and lack of generalizability in electronic health record data: reflections on health equity from the National Institutes of Health Pragmatic Trials Collaboratory. J of the Am Medl Informat Ass 2023:ocad115.
16. Khurshid S, Reeder C, Harrington LX, Singh P, Sarma G, Friedman SF, Di Achille P, Diamant N, Cunningham JW, Turner AC, Lau ES. Cohort design and natural language processing to reduce bias in electronic health records research. NPJ Digital Med 2022;5(1):47.
17. NIH. Informed consent for secondary research with data and biospecimens: Points to consider and sample language for future use and/or sharing. NIH Office of Science Policy Office of Extramural Research May 2020. https://osp.od.nih.gov/wp-content/uploads/Informed-Consent-Resource-for-Secondary-Research-with-Data-and-Biospecimens.pdf

18. Skahill E, West DM. Why hospitals and healthcare organizations need to take cybersecurity more seriously. Brookings August 9, 2021. https://www.brookings.edu/articles/why-hospitals-and-healthcare-organizations-need-to-take-cybersecurity-more-seriously/

REPORT OF THE SPEAKERS

Speakers Report 03-I-23

Subject:	Report of the Election Task Force 2
Presented by:	Lisa Bohman Egbert, MD, Speaker; and John H. Armstrong, MD, Vice Speaker
Referred to:	Reference Committee on Amendments to Constitution and Bylaws

BACKGROUND

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

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

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

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

*ETF 1 Member

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

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

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

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

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

DISCUSSION

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

Stickers, Buttons, and Pins

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

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

Campaign Receptions

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

Dinners, Suites, and Such

The ETF2 spent a significant amount of time discussing dinners, suites, and interactions that occur during these activities. In the last two election cycles, this topic has generated multiple questions requiring speaker clarifications regarding the possibility of candidate exposure to complaints of a campaign violation. There is a balance that must be struck between allowing organic discussions that should be encouraged to enable delegates to learn about a candidate versus overt campaigning. Exchanges that result from invitations to suites and group dinners are difficult to monitor but can be easily misconstrued, particularly in the age of social media and "gotcha" moments. Candidates and organizations should be aware of the scrutiny that their participation may bring and should always conduct themselves in a way that minimizes any appearance of impropriety. The task force does not wish to be overly prescriptive yet believes there is need for clearer parameters and therefore offers the following recommendations.

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

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

Finally, ETF2 recommends that prior to the active campaigning period, currently contested candidates may discuss their candidacy on an individual basis in private conversations after announcement to the HOD. This would exclude all other individuals such as members of their campaign teams, delegations, caucuses, and "friends" from campaigning or discussing the

candidacy. Under current rules, candidates, once announced, are not allowed to openly discuss their candidacy until active campaigning has commenced. Any casual discussion can easily be construed as "campaigning" and can put a candidate in an awkward position of not knowing what can and cannot be said. The task force decided that candidates should be able to acknowledge their candidacy in private conversations with other individuals without fear of being "reported" for a campaign violation.

Campaign Literature
Electronic Communications
Website and Social Media

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

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

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

Interviews

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

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

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

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

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

Voting Process and Election Session

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

Bylaw 3.4.2.1.3

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

Bylaw 3.4.2.2

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

Bylaw 6.8.1.4

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

The ETF1 report encouraged the speaker "to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced, including collecting written personal points from candidates to be shared electronically with the House after the meeting or imposing time limits on such comments." After the virtual meetings and at all subsequent elections, the speaker has collected and emailed "points" from candidates to the House. Given the time constraints at A-22, the speaker did not allow candidates to make in-person points of personal privilege; however, at A-23 points were allowed after the lunch break on Tuesday

following the Election Session that morning. The task force recommends that the speaker continue to have discretion regarding in-person points, and time permitting should offer the opportunity for candidates to present abbreviated personal points at the HOD business session after lunch on the same day that the Election Session was held. In addition, written points should continue to be collected and emailed to the House with a deadline of 10 days after the conclusion of the meeting.

Announcements and Nomination

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

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

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

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

> Members of these Councils, except the medical student member, shall be elected by the House of Delegates. Nominations shall be made by the <u>chair of</u> the Board of Trustees ~~and~~

~~may also be made from the floor~~ or by a member of the House of Delegates at the opening session of the meeting at which the election will take place.

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

Election Committee

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

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

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

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

enhances your speakers' and the EC's ability to provide clarification and often resolution regarding a "possible violation" in a more timely fashion.

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

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

Endorsements

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

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

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

CONCLUSION

The recommendations of ETF1 have made substantive improvements to the AMA election process over the last two election cycles. The ETF2 commends ETF1 for their work to make our AMA

HOD elections more fair, equitable and transparent. The ETF2 offers recommendations to codify initial changes from ETF1, enhance and clarify the rules adopted with ETF1, and simplify further the election process. In addition, the ETF2 recommends that these new and modified rules and bylaws changes be effective upon adjournment of the House at I-23, and the remainder of this report be filed.

RECOMMENDATIONS

Stickers, Buttons, and Pins

Recommendation 1: Policy G-610.020, Rules for AMA Elections, paragraph 18 be amended by addition and deletion to read as follows:

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

Campaign Receptions

Recommendation 2: Policy D-610.998, Election Task Force, paragraph 1 be amended by addition and deletion to read as follows:

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

Dinners, Suites and Such

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

Recommendation 4: Policy G-610.020, Rules for AMA Elections, paragraph 19 be amended by addition and deletion to read as follows:

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

Recommendation 5: Policy G-610.020, Rules for AMA Elections, paragraph 21 be amended by deletion to read as follows:

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

Recommendation 6: Only an announced candidate in a currently contested election may discuss their candidacy on an individual basis in private conversations from announcement of candidacy until the active campaigning period begins. Prior to the active campaigning period, no other individual may discuss the candidacy including members of campaign teams, delegations or caucuses, and "friends." (New HOD Policy)

Campaign Literature
Electronic Communications
Website and Social Media

Recommendation 7: Policy G-610.020, Rules for AMA Elections, paragraph 15 be amended by addition and deletion to read as follows:

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

Recommendation 8: Policy G-610.020, Rules for AMA Elections, paragraph 16 be amended by addition and deletion to read as follows:

16) Active campaigning via mass outreach to delegates by candidates or on behalf of a candidate by any method is prohibited. ~~A reduction in the volume of telephone calls and~~ Personal electronic communication and telephone calls from candidates and on behalf of candidates is discouraged~~encouraged~~. ~~The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of e~~Electronic messages ~~to contact~~

~~electors should be minimized, and if used~~ must include a simple mechanism to allow recipients to opt out of receiving future messages. (Modify Current HOD Policy)

Interviews

Recommendation 9: Policy G-610.020, Rules for AMA Elections, paragraph 11 be amended by addition and deletion to read as follows:

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

Recommendation 10: Policy G-610.020, Rules for AMA Elections, paragraph 12 be amended by addition and renumbered to read as follows:

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

Recommendation 11: Any formal questioning of an announced candidate, including a written questionnaire, is an interview and subject to the rules for virtual interviews. (New HOD Policy)

Recommendation 12: Any "presentation" to an assembly, with or without being followed by a discussion, question and answer session, or a vote of the assembly, is an interview and subject to the rules on in-person interviews. (New HOD Policy)

Voting Process and Election Session

Recommendation 13: That Bylaws 3.4.2.1.3, 3.4.2.2, and 6.8.1.4 be amended to change the rules for elections of officers and councils with multiple candidates so that the lowest vote getter on each ballot is dropped on the subsequent ballot, with the exception of a tie for lowest vote getter in which case both would be dropped. (Directive to take Action)

Recommendation 14: Policy D-610.998, "Directives from the Election Task Force," paragraph 4 be amended by addition and deletion to read as follows:

4. The Speaker is encouraged to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced. If adequate time remains on the agenda when the business session reconvenes after lunch on the day

that the Election Session was held, the Speaker is encouraged to allow candidate personal points from the floor confined to the current time limit for testimony. ~~including collecting w~~Written personal points from candidates should be sent to the HOD office within 10 days following the close of the meeting to be shared electronically with the House ~~after the meeting or imposing time limits on such comments~~. (Modify Current HOD Policy)

Announcements and Nomination

Recommendation 15: Policy G-610.020, Rules for AMA Elections, paragraph 2 be amended by addition and deletion to read as follows:

2) Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers, generally by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, email address, ~~URL,~~ the office sought and a list of up to four (4) endorsing societies. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed ~~in the venue where the House of Delegates meets. Announcements sent by candidates~~ to members of the House by any method. ~~are considered campaigning and are specifically prohibited prior to the start of active campaigning. The Speakers may use additional means to make delegates aware of those members intending to seek election.~~ (Modify Current HOD Policy)

Recommendation 16: Candidates may not produce a personal campaign website or direct to personal or professional websites other than the AMA Candidates' Page. (New HOD Policy)

Recommendation 17: Policy G-610.020, Rules for AMA Elections, paragraph 3, be amended by addition and deletion to read as follows:

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

Recommendation 18: Policy G-610.020, Rules for AMA Elections, paragraph 10, be amended by addition and deletion to read as follows:

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

~~campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates.~~ (Modify Current HOD Policy)

Recommendation 19: Policy G-610.020, Rules for AMA Elections, paragraph 25, be amended by addition and deletion to read as follows:

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

Recommendation 20: Policy G-610.010, Rules for AMA Elections, paragraphs 3 and 4, be rescinded:

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

Recommendation 21: That the language in Bylaw 6.8.1, "Nomination and Election" be updated to clarify that nominations are made by the chair of the Board of Trustees or by a member of the House of Delegates at the opening session of the meeting at which elections take place. (Directive to Take Action)

Election Committee

Recommendation 22: Policy D-610.998, "Directives from the Election Task Force," paragraph 7 be amended by addition to read as follows:

7. Campaign violation complaints will be investigated by the Election Committee or a subcommittee thereof with the option of including the Office of General Counsel or the Director of the House of Delegates.
a. The Committee will collectively determine whether a campaign violation has occurred. As part of the investigation process the Election Committee or its subcommittee shall inform the candidate of the complaint filed and give the candidate the opportunity to respond to the allegation.
b. If the complaint implicates a delegation or caucus, the Election Committee or its subcommittee shall inform the chair of the implicated delegation or caucus of the complaint filed and give the implicated delegation or caucus chair(s) the opportunity to answer to the allegation as a part of the investigative process.
c. For validated complaints, the Committee will determine appropriate penalties, which may include an announcement of the violation by the Speaker to the House.

d. Committee members with a conflict of interest may participate in discussions but must recuse themselves from decisions regarding the merits of the complaint or penalties.
e. Deliberations of the Election Committee shall be confidential.
f. The Speaker shall include a summary of the Election Committee's activities in "Official Candidate Notifications" sent to the House, following each meeting at which an election was held. Details may be provided at the discretion of the Election Committee and must be provided when the penalty includes an announcement about the violator to the House. (Modify Current HOD Policy)

Recommendation 23: Candidates and their identified members of campaign teams will be provided a copy of the current election rules and will be required to attest to abiding by them. (New HOD Policy)

Recommendation 24: Candidates, members of their campaign teams, including Federation staff, and HOD members will agree to be interviewed by the Speakers or members of the Election Committee who will identify themselves and the reason for the request. (New HOD Policy)

Recommendation 25: Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," be amended by addition and deletion to read as follows:

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

Recommendation 26: That our AMA consider developing bylaw language regarding removal of elected individuals and the criteria by which this would be accomplished and to report back at A-24. (New HOD Policy)

Endorsements

Recommendation 27: A maximum of four endorsements may be obtained by each candidate. These endorsements must be from organizations in which the candidate is an active and dues paying member, where applicable. Endorsements may only be obtained from a candidate's state and one specialty organization and from caucuses in which the endorsing state or specialty society

is a current member. Endorsements may not be obtained from the AMA Sections, Advisory Committees, or the Specialty and Service Society. (New HOD Policy)

Recommendation 28: Policy D-610.998, "Directives from the Election Task Force," paragraph 10 & 11 be rescinded.

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

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

(13) RESOLUTION 603 - CREATION OF AN AMA ELECTION REFORM COMMITTEE
RESOLUTION 611 - ELECTION REFORM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Alternative Resolution 603 be adopted in lieu of Resolutions 603 and 611.

RESOLVED, That our AMA create a Speaker-appointed task force for the purpose of recommending improvements to the current AMA House of Delegates election process with a broad purview to evaluate all aspects. The task force shall present an initial status report at the 2019 Interim Meeting.

HOD ACTION: Alternative Resolution 603 adopted in lieu of Resolutions 603 and 611.

Resolution 603 calls upon our AMA to appoint a House of Delegates Election Reform Committee to develop recommendations with which to expedite and streamline the current election and voting process for AMA officers and council positions, and to report back to the House of Delegates at the 2019 Interim Meeting.

Options that should be considered by the Election Reform Committee, include:

- the creation of an interactive election web page;
- candidate video submissions submitted in advance for HOD members to view;
- eliminate all speeches and concession speeches during HOD deliberations, with the exception of the President-Elect, Speaker, and Board of Trustee positions;
- move elections earlier in the meeting to Sunday or Monday;
- conduct voting from HOD seats; and
- reduce and control the cost of campaigns.

Resolution 611 calls upon our AMA to create a Speaker-appointed task force to re-examine election rules and logistics, including social media, emails, mailers, receptions, and parties; the ability of candidates from smaller delegations to compete; electronic balloting; and timing within the meeting. The task force shall report back at the 2019 Interim Meeting recommendations regarding election processes and procedures to accommodate improvements, which allow delegates to focus their efforts and time on policy-making.

Additionally, Resolution 611 calls upon the Speaker-appointed task force to consider addressing the following ideas:

a. elections being held on the Sunday morning of the Annual and Interim meetings of the House of Delegates;
b. coordination of a large format interview session on Saturday by the Speakers to allow interview of candidates by all interested delegations simultaneously;
c. separating the logistical election process based on the office (e.g., larger interview session for council candidates, more granular process for other offices);
d. an easily accessible system allowing voting members to either opt in or opt out of receiving AMA approved forms of election materials from candidates with respect to email and physical mail;
e. electronic balloting potentially using delegates' personal devices as an option for initial elections and runoffs to facilitate timely results and minimal interruptions to the business;
f. seeking process and logistics suggestions and feedback from HOD caucus leaders, non-HOD physicians (potentially more objective and less influenced by current politics in the HOD), and other constituent groups with a stake in the election process; and
g. address the propriety and/or recommended limits of the practice of delegates being directed on how to vote by other than their sponsoring society (e.g., vote trading, block voting, etc.).

Your Reference Committee heard overwhelming support in favor of appointing a committee to look at the current AMA House of Delegates election process. As noted by testimony, the original resolutions proffered were proscriptive. It is believed that a Speaker-appointed task force, comprised of AMA House of Delegates members,

will address the ideas outlined in Resolutions 603 and 611. Furthermore, your Reference Committee believes that an initial status report at the 2019 Interim Meeting will include a project timeline established by the task force.

REPORT OF THE SPEAKERS

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

1. SPEAKERS' REPORT: TASK FORCE ON ELECTION REFORM

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At this past June's meeting the House of Delegates adopted policy calling for the Speaker to appoint a task force that would recommend improvements to our AMA's election processes. The following members were appointed to the task force:

- Jenni Barlotti-Telesz, MD, American Society of Anesthesiologists
- Richard Evans, MD, Maine
- James Hay, MD, California
- Dan Heinemann, MD, American Academy of Family Physicians
- David Henkes, MD, Texas
- Jessica Krant, MD, American Society for Dermatologic Surgery
- Josh Lesko, MD, Resident Physician, Virginia
- John Poole, MD, New Jersey
- Karthik Sarma, immediate past medical student trustee
- Stephen Tharp, MD, Indiana
- Jordan Warchol, MD, MPH, Nebraska
- Bruce Scott, MD, Speaker, Kentucky
- Lisa Bohman Egbert, MD, Vice Speaker, Ohio

Interest in the task force was high, with more than 60 requests to serve. Selection was based primarily on experience with AMA elections, either as a candidate or part of a campaign committee, and most members had been involved multiple times and in multiple ways. Consideration was also given to ensuring a broad cross section of the House of Delegates.

BACKGROUND

The task force is not yet prepared to propose specific changes to the election rules, but rather is seeking broad input from the HOD. This report describes activities undertaken since the task force was launched and outlines topics that have been discussed among members. Your speakers have arranged for an open forum to be held during the Interim Meeting to solicit thoughts across topics outlined below. A report with recommendations should be expected at the 2020 Annual Meeting.

Current election rules are found in both AMA bylaws and policy (see Appendix A) but are also dependent on Speaker rulings and discretion (eg, the cap on expenditures for giveaways). Chief among expressed concerns were the expense and time invested in campaigns, but also mentioned were associated effects such as decisions by otherwise qualified candidates to not seek office and the limiting effect of election-related activities on the ability to fully address policy matters. In the view of the task force, costs are real, measured not only in dollars but in time, distractions and stress. Moreover, these costs are shared by both candidates and the larger House.

The task force is assessing the entirety of our election process, and while recommendations are forthcoming next June, the task force would note that its primary goal is to ensure that the best candidates are selected as AMA's leaders in free and fair elections and in furtherance of AMA's "Guiding principles for House Elections." For candidates, the task force hopes to make campaigns less expensive and more equitable, while removing obstacles that discourage qualified members from seeking election. At the same time, the task force seeks to ensure that electors constitute an informed electorate. While the task force believes the election process should not be unduly distracting from our policy discussions, we also recognize the importance of our elected leadership and believe it is appropriate for the House to spend time and focus on selecting these individuals.

Additionally, the task force holds that addressing our AMA's election rules should be an evolutionary process, with the task force's eventual recommendations only a step along a path that is sensitive to changes in technology, the needs of the profession, the diversity of AMA membership and the makeup of the House of Delegates. That said, the task force does not mean to suggest that it should be an ongoing entity. Rather changes should henceforth be organic.

For example, in some of the task force discussions questions arose about the value of certain actions or activities that more often than not are part of most candidates' election efforts. The consensus within the task force is that many of these actions add little, if any, value to a candidate's likelihood of election, but candidates or their supporters are hesitant to not continue the activity because "everyone does it." From the perspective of the task force, one would hope that both rules and practice would be modified over time when new norms become the standard.

Task Force Activity

After it was formed, the task force engaged in a series of email exchanges on multiple election-related topics; those have continued even with the approach of the Interim Meeting. Typically, the Speaker, Dr. Scott, proposed a relatively narrow item for discussion, with his initial question directed to all members of the task force and responses shared across the group. As an example, one of the early discussions dealt with the giveaways that are included in the not for official business bag at the opening session of the Annual Meeting. Each discussion thread was conducted independently and allowed to conclude naturally.

The task force also met face to face and will be meeting again during the Interim Meeting. The in-person meetings afford an opportunity for the members to interact and discuss ideas and concerns about more conceptual ideas, not easily handled by email because nuance and slight alterations can affect the ensuing dialog.

ITEMS FOR CONSIDERATION

The task force has discussed and would like input on multiple items, but it should be noted that inclusion on this list does not imply that the task force has concluded its discussion of the matter or that they have adopted a position.

> Note in each area of consideration you will find highlighted questions to be discussed at the open forum. These should not be considered as all-inclusive or in any way exclusive of other comments. Open discussion of each topic is welcome.
>
> Additionally, Appendix B includes a list of topics that will be discussed in the open forum.

Interviews

It is common for candidates to be interviewed by literally dozens of caucuses and delegations. This process stretches over several days and has been described as "grueling." Delegations and interview committees spend considerable time listening and evaluating candidates. Some complain that these presentations interrupt their policy discussions and delegates report hearing redundant presentations (others report hearing conflicting comments from some candidates in different venues).While there is no question that this process is time consuming for both the candidates and those interviewing them, others defend this as "the most important way candidates are vetted."

The Office of House of Delegates Affairs currently schedules 10-minute interviews for officer candidates in contested elections. Those interviews are scheduled only with geographic caucuses, because scheduling interviews with every interested group would be prohibitively complex and time consuming. Nonetheless, other groups can and do schedule interviews with officer candidates, and candidates in council elections are scheduled either by the interviewing group or the candidates themselves (or their campaign team). Some delegations employ committees to conduct candidate interviews, with the committee's recommendation then provided to members of that delegation (or caucus). Other groups and caucuses allow candidates to present to the entire delegation. Still other delegations handle officer and council candidates differently.

> Open Forum Topic #1
> The election task force wants to hear what changes, if any, would improve the interview process. Should there be formalized interview forums (like currently held for president elect candidates) before the entire HOD or large assembly, perhaps just for officers or for all candidates? Would delegations support being

grouped together to reduce the number of interviews or do delegations want to continue their individual or small group interviews? What measures should be taken to ensure interviews are equally available to all candidates for a given position? Should council and officer candidates be handled differently? (this same question could be asked about subsequent topics as well)

Campaign expenses

One of the major areas of expressed concern regarding campaigns is the real or anticipated expense. While there is wide variability in the costs of campaigns and some would argue that big budgets don't necessarily lead to election, it has been said that there are individuals that do not seek election because of the anticipated cost. Some delegations have more resources available than others, but most all associations are facing increasing budgetary concerns. In fact, financial concerns have been stated as a reason for some societies to not fill their entire delegation. Budgetary considerations should not be a deciding factor in the election of candidates.

Strict limits on campaign expense or required transparency of expenditures have been recommended to the task force. It is difficult to measure actual expenditures particularly for larger delegations that routinely have receptions, suites, dinners and giveaways. Some delegations are willing and able to spend more on campaigns. Some candidates have more available resources whether financial or otherwise (eg, web design expertise, video studio,) from their family, friends or medical association.

Open Forum Topic #2
Should there be a limit on campaign expense or required reporting? How would actual expenditures be accurately measured and reported? Is there a true correlation between expenditure and election? The possibility of "public funding" of elections has been raised – how would the funds be raised and distributed? Should AMA be expected to finance the election process? Would delegations be willing to share expense per capita or otherwise?

Campaign receptions

Campaign receptions are likely the largest single expenditure for most campaigns, with estimates ranging upward from $20,000 and the overall cost dependent on decorations and refreshments, and some costs are shared across a caucus. Providing alcohol is already prohibited by the rules, which serves to some extent to limit the cost. While candidates have been elected without a reception (and others with well attended, elaborate receptions have not been elected) some may be deterred from running because of the perceived need for a reception and the anticipated expense. These continue to be well attended and candidates seem to have no hesitation (and feel welcome) attending other receptions, even that of their opponents, so there seems to be little exclusivity. While there is no question that most, if not all, open receptions have a campaign component, conversations typically include policy discussions and valued social interaction. Some have complained about long receiving lines that delay mingling and constructive discussion.

Open Forum Topic #3
Is there an option that would provide the opportunity for candidates to interact with a broad range of delegates outside the formal interviews and at the same time provide social interaction for others to encourage their attendance? Could individual receptions be replaced by a joint reception or perhaps separate receptions for different categories of candidates (eg, officers versus council candidates)? Some states and regional delegations have parties every year, with or without a candidate (eg, ice cream social, chili, chowder or wine tasting). If a general reception were offered, should separate receptions be allowed? If receptions are continued should receiving lines be discouraged or should this decision be left to the host?

Campaign memorabilia

Giveaways or gifts: Our current rules allow the Speaker to set an expenditure limit for the giveaways that are distributed via the not for official business bag or at a party. The limit is calculated on a per capita basis given the number of delegates and alternate delegates. This past June the aggregate limit was $3200. Although not one of the larger campaign expenses, every dollar counts particularly for candidates with limited budgets. Many would say that while they enjoy the treats that this is not a factor in their vote; others argue these allow candidates to display their individuality and draw attention to literature that is often attached.

Open Forum Topic #4
Should gifts be "discouraged" or even disallowed altogether? What if a state wants to provide a gift that is not "tied to" a candidate? Some states put something in the bag or distribute a gift that they believe represents their state even when they don't have a candidate (eg, Virginia peanuts, New England lobsters).

Pins, buttons and stickers: The rules separate pins, buttons and stickers from campaign giveaways, noting that they do not count against spending limits, but the rules also say they should be simple. Although not a major expenditure, concerns have arisen around their distribution and appropriateness for a professional association. Some individuals feel pressured to wear stickers and object to "forced stickering;" while others say that the stickers are used as a conversation starter and allow one to display their support for a candidate.

Open Forum Topic #5
Should pins / buttons / stickers be disallowed? Several specialty societies and some states have pins or stickers that may not necessarily include a candidate's name but may still be perceived as campaign material. Where do we draw the line?

Campaign literature

Campaign mailings preceding the Annual Meeting are common, and the not for official business bag is generally filled with campaign material. Some of the materials attest to the qualifications of a candidate, while others include little more than a photo and endorsement. Under current rules electronic (email) communications to members of the House "must allow recipients to opt out" of future messages. Considerable effort and funds are spent on creating and distributing this material. Some delegates read the material considering it an important source of information and have commented that it gives them a sense of the candidate's personality and background. Others believe this is a waste of resources, particularly the printed material, and should be banned or at least switched to electronic only.

An AMA election manual has been prepared for the last 33 years and starting in 2016 has appeared exclusively in electronic form on our AMA's website. Candidates are responsible for the content of their submissions, but our AMA does minimal copy editing to ensure a consistent style. The manual is intended in part to reduce the need for other forms of communication as well as provide a level playing field.

Open Forum Topic #6
Does the election manual alone provide sufficient information? If technically feasible, should individuals be allowed to select electronic communications only or opt out of receiving campaign literature altogether? Do materials in the not for official business bag provide meaningful information or are they a waste of resources and should be discouraged or even disallowed?

Election process

Elections are scheduled on Tuesday morning at the Annual Meeting, and the initial round of voting is conducted before the House opens its business session that morning. Runoffs, if they are needed, are held in the House by paper ballot once ballots are prepared. Comments have been heard regarding the timing of the vote, including the day it should occur, along with suggestions to employ electronic voting for runoffs and concerns about the disruptions caused by runoffs and victory and concession speeches. Electronic voting will expedite runoffs (and potentially initial voting as well) and reduce disruption. Victory and concession speeches could be time limited. Any change to the day or time of the elections would likely require other adjustments to our typical schedule.

Open Forum Topic #7
The task force is interested in members' comments about any aspect of the processes associated with the actual voting. Assuming technology can provide secure voting from delegate seats within the House, does the HOD support a move to electronic voting? What are the advantages and disadvantages of moving the day or time of the election? Should post-election speeches be time limited or even not allowed?

Other issues

The task force has received comments regarding "pop up" candidates – previously unannounced candidates that are nominated from the floor when a new opening is created by the election of a sitting council member or trustee to a higher office. These candidates do not receive the scrutiny of the normal election process yet are elected to a full term. Further concern was expressed that the potential of opening a new seat has become a strategy for election. It has been suggested that sitting council or board members with unexpired terms that are nominated for higher office be required to resign their current position thus opening their seat regardless of the outcome of their new election. This would provide for nominations for the opened seat to follow the normal election process but would truncate the service of experienced leaders and possibly lead to more individuals remaining in their seats for full terms reducing opportunity for new leadership. Others have suggested that the vacated seat remain open until the next annual election. Still others have noted that pop-up candidates choose to "pop-up" because of the opportunity to run for a desired office without the burden of the campaign expense.

> Open Forum Topic #8
> Do pop-up candidates distort the election process? Should our process of electing individuals for newly opened positions after regular nominations are closed be changed? If so, how?

Concerns have been expressed about suites, dinners and other gatherings that are in effect campaign events occurring at our annual meeting and before "official campaigning" is allowed (National Advocacy Conference, State Legislative Conference and Interim Meeting). These add considerable expense. It is difficult to determine when a gathering in a suite or a dinner is simply a social event for individuals to interact socially, which your task force believes is important, or a campaign event.

> Open Forum Topic #9
> Would a restriction that dinners be "Dutch treat" if an announced candidate was present be effective? How can we tell delegations they can't entertain their friends or colleagues? Would restrictions on campaign receptions considered above actually drive more resources to these less regulated events?

Final discussion

The election task force believes that while the current election process certainly can and should be improved that the current elected AMA leadership retains our fullest confidence. Your speakers have noted that while there have been general comments about behavior that might be considered a violation of the rules, formal reports of violations have been remarkably few.

Finally, in reviewing the history of our election process the task force wondered how familiar candidates, delegates and alternate delegates are with our current election rules. Many of the expressed concerns including those regarding vote trading, block voting, caucuses attempting to direct individual delegate votes and negative campaigning are contrary to our current "Guiding Principles." Perhaps adherence to the policies and rules previously adopted by the HOD should be given greater emphasis. While one would hope that professionalism alone would demand compliance, the challenge for many of the concerns is surveillance and enforcement. We encourage everyone to review the current rules and principles listed in the appendix of this report.

> Open Forum Topic #10
> The question arises should election reforms simply discourage undesirable behavior or attempt to prohibit such behavior. The task force welcomes comments regarding monitoring and enforcement of what are often considered the most problematic potential violations which are also those most difficult to track and prevent.

CONCLUSION

The election task force seeks the appropriate balance between an informed electorate who are selecting the best candidates after adequate exposure and proper opportunity for due diligence while eliminating obstacles, particularly those that do not add to the selection of the most qualified candidates. We understand that any recommended changes to our election process must ensure that the best candidates are selected as AMA's leaders in free and fair elections.

This report is meant as informational only. The task force has discussed all the issues detailed here and more. We have planned an open forum at Interim 2019 and look forward to hearing from members of the House. While the agenda of the open forum will include discussion of the topics highlighted above, these are not meant to be totally inclusive and certainly not exclusive. Within discussion of each of these topics we hope to hear what the HOD believes should be retained, modified or eliminated. What do delegates value, what helps you make an informed decision on the best candidates, how to balance distractions from policy discussion with appropriate attention on election of leaders? For candidates what can be done to remove obstacles and create a fair, equitable campaign? We will include time for additional comments on issues not detailed here and we continue to welcome written comments from individuals and delegations.

APPENDIX A – AMA Election-related policies

Policy G-610.031, Creation of an AMA Election Reform Committee
Our AMA will create a Speaker-appointed task force for the purpose of recommending improvements to the current AMA House of Delegates election process with a broad purview to evaluate all aspects. The task force shall present an initial status report at the 2019 Interim Meeting.

Policy G-610.020, Rules for AMA Elections

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

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

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

(4) An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates;

(5) A reduction in the volume of telephone calls from candidates, and literature and letters by or on behalf of candidates is encouraged. The use of electronic messages to contact electors should be minimized, and if used must allow recipients to opt out of receiving future messages;

(6) At the Interim Meeting, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited at the Interim Meeting. It is permissible at the Interim Meeting for candidates seeking election to engage in individual outreach, such as small group meetings, including informal dinners, meant to familiarize others with a candidate's opinions and positions on issues;

(7) Our AMA believes that: (a) specialty society candidates for AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides; (b) elected specialty society members should be identified in that capacity while serving their term of office; and (c) nothing in the above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose;

(8) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside of the party venue, or (c) distributing stickers, buttons, etc. with the candidate's name on them. At these events, alcohol may be served only on a cash or no-host bar basis;

(9) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at campaign parties, and campaign literature may be distributed in the non-official business bag for members of the House of Delegates. No campaign literature shall be distributed and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates;

(10) Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. Campaign gifts can be distributed only at the Annual Meeting in the non-official business bag and at one campaign party. Campaign gifts should only be distributed during the Annual Meeting and not mailed to delegates and alternate delegates in advance of the meeting. The Speaker of the House of Delegates shall establish a limit on allowable expenditures for campaign-related gifts. In addition to these giveaway gifts, campaign memorabilia are allowed but are limited to a button, pin, or sticker. No other campaign memorabilia shall be distributed at any time;

(11) The Speaker's Office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker);

(12) At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place his or her name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker;

(13) Candidates for AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society;

(14) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities; and

(15) Our AMA (a) requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election; and (b) will expand accessibility to completed conflict of interest information by posting such information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.

Policy G-610.021, Guiding Principles for House Elections
The following principles provide guidance on how House elections should be conducted and how the selection of AMA leaders should occur:

(1) AMA delegates should: (a) avail themselves of all available background information about candidates for elected positions in the AMA; (b) determine which candidates are best qualified to help the AMA achieve its mission; and (c) make independent decisions about which candidates to vote for.

(2) Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable.

(3) Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.

(4) Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for AMA leadership positions.

(5) Incumbency should not assure the re-election of an individual to an AMA leadership position.

(6) Service in any AMA leadership position should not assure ascendancy to another leadership position.

Policy G-610.030, Election Process
AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at each Annual Meeting; (2) Poll hours will not be extended beyond the times posted. All delegates eligible to vote must be in line to vote at the time appointed for the close of polls; and (3) The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House.

APPENDIX B – Topics for discussion during open forum.

This listing of topics and questions is not meant to be exhaustive. Rather it is illustrative, and other matters are welcome. An "open discussion" is included as the last topical section. Cutting across all topics, consider whether officer and council candidates should be treated differently.

See the text of the report for fuller discussion of each topic.

Topic 1 – Interviews
Possibility of interview forums
Reducing the number of interviews
Equity of access to interviews across candidates in a race

Topic 2 – Campaign expenses
Should expenses be limited / capped?
Required reporting
Public funding, i.e., AMA contributions and shared expenses among sponsors

Topic 3 – Campaign receptions
Options to allow interaction with candidates
Possibility of joint receptions
Separate receptions for officers and council candidates
Receiving lines
Receptions with and without candidates

Topic 4 – Campaign memorabilia
Giveaways – allowed or disallowed
Gifts unrelated to campaigns

Topic 5 – Pins, buttons and stickers
Allowed or disallowed
Distribution and their role

Topic 6 – Campaign literature
Mailings versus the election manual
Option to choose electronic communications or to opt out of campaign literature
Material in not-for-official-business bag

Topic 7 – Election process
Day and time of election
Secure voting from delegate seats using electronic devices
Thank you and concession speeches

Topic 8 – Pop-up candidates
A distortion of the process?
Filling new vacancies

Topic 9 – Suites, dinners and gatherings
"Dutch treat" dinners if a candidate is present
Would rules changes for receptions lead to more campaign suites and dinners?

Topic 10 – Monitoring and enforcing rules
Appropriate monitoring of rules
Role of professionalism relative to active enforcement of rules

Topic 11 – Open discussion of any topic

2. REPORT OF THE ELECTION TASK FORCE

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

HOUSE ACTION: RECOMMENDATIONS 1 TO 15, 17 TO 31, 33, 34, AND 36 TO 41 ADOPTED
RECOMMENDATION 35 ADOPTED AS FOLLOWS
RECOMMENDATION 16 REFERRED
RECOMMENDATION 32 NOT ADOPTED
REMAINDER OF REPORT FILED
See Policies G-610.010, G-610.020, G-610.021, G-610.030 and D-610.998

Policy G-610.031, "Creation of an AMA Election Reform Committee," was adopted at A-19 and called on your Speakers to appoint a task force to recommend improvements to our AMA's election process. (See Appendix A for actual policy text.) Eleven people, primarily delegates, were appointed to the election task force (ETF) to serve alongside your Speakers, as we are charged with overall responsibility for AMA elections (G-610.020, Appendix B). The appointees are listed in Appendix A, and the task force's preliminary report was presented at I-19 as called for by the policy. Written comments have been solicited and several hours of debate were heard at an Open Forum held at I-19. Over the past two years the Speakers and the ETF have spent well over a hundred hours reviewing our current election processes, discussing concerns and deliberating possible solutions.

The task force defined the following goals specific to our stakeholders:
For candidates: Remove obstacles that discourage qualified individuals from seeking elected positions and improve equity and transparency in the campaign.
For delegates: Provide ample opportunity to gain knowledge about each candidate (informed electorate) without undue distraction from policy development.
For our AMA and our members: Ensure the best possible governance with election of the most qualified candidates to lead our Association.

Election-related concerns that underlay the call to review and improve election rules fall into four categories:

- *Cost, with the consensus being that campaigns are too expensive, which may dissuade some potential candidates, particularly those from smaller societies.*
- *Fairness, with concerns expressed about equality of opportunity for candidates from different delegations given the influence of sponsoring organizations.*
- *Distractions, with elections and the associated activities detracting from the development of AMA policy, which is the House of Delegates' primary purpose under the AMA constitution; this includes time required during House business sessions for speeches and voting, as well as various campaign activities.*
- *Technology, with hope expressed for a move towards electronic communications and more efficient mechanisms for voting.*

These concerns are reflected in the resolutions submitted at the 2019 Annual Meeting, which are reproduced in Appendix C, in comments provided to the task force, and in survey responses provided by members of the House at I-19, which are presented in Appendix D; and are further discussed throughout this document (*set off by italics*). Many of our findings and recommendations relate to more than one of these concerns.

Current election rules are found in both AMA bylaws and policy (see Appendix B) but are also dependent on some Speaker rulings and discretion (eg, the cap on expenditures for giveaways). In proposing changes to our election processes, the task force has sought to ensure that the best candidates can be selected in free and fair elections while reducing obstacles, or perceived obstacles, that dissuade qualified members from seeking elective office. At the same time the task force has sought not to detract from the ability to ensure an informed electorate.

While this report proposes several changes to current rules, to be effective upon adjournment of this 2021 Special Meeting, worth repeating is a comment from the report of this task force dated November 2019:

> [A]ddressing our AMA's election rules should be an evolutionary process, with the task force's recommendations only a step along a path that is sensitive to changes in technology, the needs of the profession, the diversity of AMA membership and the makeup of the House of Delegates.

Some of the reforms proposed should thus be considered initial steps, with additional changes somewhat dependent on the success—or failure—of the recommendations herein. Members of the task force have considerable experience either as candidates or as members of others' campaign teams, so the recommendations constitute the group's best current, collective judgement. Some of the recommendations flow from comments heard at the open forum and responses to the survey administered at I-19, which proved persuasive in many cases. In addition, several changes that were made of necessity to accommodate the virtual election process for the Special Meetings in June 2020 and 2021 served as models for proposed reforms. Every recommendation, however, derives from a consensus decision within the task force.

Campaign Expense
The cost of running a successful campaign is generally the most prominent among concerns expressed. Whether costs are a real or a perceived problem is unclear insofar as a review of historical evidence shows that large expenditures do not necessarily lead to election. However, the concern does appear to discourage some otherwise qualified candidates from seeking office. Many societies that sponsor candidates are encountering tightened budgets, and concern has been expressed about the wisdom of expending members' dues money on AMA campaigns. Expense is associated with several components of a typical AMA campaign. Some of these are discussed below along with recommendations. The ETF endeavored to reduce campaign costs with an emphasis on eliminating expenses that the survey of the HOD found not to be significant factors in the evaluation of candidates or in determining voting decisions.

CAMPAIGN MEMORABILIA

One of the most obvious expenses incurred by nearly every candidate is some sort of trinket or geegaw, generally imprinted with the candidate's name and distributed in the "not for official business" (NFOB) bag at the opening session of the Annual Meeting. While the overall expenditure is relatively small—a cap of $3445 for such gifts to delegates and alternates at A19—it represents an easily foregone expense. One would surely hope that election decisions are not based on gifts, which over the last few years have included golf tees, pens, lip balm, cookies, candy, water bottles, calculators and small flashlights. In fact, the survey of the HOD found that only 6% of respondents consider these an important factor in determining their vote (see survey results in Appendix D).

Some concern was expressed about doing away with the giveaways, because some candidates make a contribution to the AMA Foundation in lieu of a giveaway. Doing away with giveaways does not, however, preclude contributions to the Foundation. Anyone and everyone is not only invited but encouraged to donate to the Foundation. Moreover, over the last several years, few candidates have donated to the Foundation in lieu of providing a gift in the NFOB bag. Maintaining giveaways to facilitate relatively rare "in-lieu-of" donations to the Foundation seems a bit disingenuous, particularly as donors can just as easily proclaim their support of the Foundation in more efficient ways.

Your task force struggled somewhat with gifts that are provided by certain delegations in the NFOB bag seemingly every year whether or not they have a candidate. These would fall under the rule for giveaways from candidates in any year in which that delegation had a candidate and a candidate's name was associated with the item, and while not directly linked to a candidate in other years, could be interpreted as an inducement for future candidates from that delegation. In addition, the task force felt any exceptions to the rule would complicate enforcement and potentially lead to a slippery slope with other delegations deciding to supply giveaways every year to remain competitive. In addition, observations at the last two in-person meetings found a majority of the material in the NFOB bag was left on the tables or otherwise discarded. Given the move towards electronic communication and an overall desire to reduce waste, your ETF is recommending the elimination of all campaign materials distributed in the NFOB bag. Although beyond our purview, we believe the other materials that are included in the NFOB bag should also be discontinued or distributed in other more meaningful ways. Ultimately, we believe the entire NFOB bag should be eliminated.

The ETF discussed whether delegations should be allowed to provide token gifts at a reception. For some delegations the gift or raffle item has become a tradition at their reception. The ETF decided not to recommend prohibiting such giveaways <u>as long as they do not include a candidate's name or likeness</u>. We recommend monitoring this to see if delegations attempt to indirectly link these gifts to campaigns or use them as an inducement for a vote, in which case they could be prohibited in the future.

STICKERS, BUTTONS, and PINS

Another area which may seem trivial but adds to the overall cost of a campaign with little to no perceived impact on the election outcome is stickers, buttons, ribbons and pins. While they don't cost much, every dollar counts. In addition to the expense, these items appear to have negative appeal to a number of delegates. Your ETF heard many negative comments about "forced stickering" particularly in receiving lines at receptions. Individuals said they felt pressured to accept and wear stickers, even for candidates they did not support. Others responded that they wear every candidate's stickers, which diminishes the value of all the stickers and clutters their badge. The necessary increased security surrounding our recent meetings, including measures added to our badges, pose an additional argument against stickers, and placing stickers other than on badges may conflict with our enhanced behavior policies. Buttons and pins share similar negatives and create holes in clothing. Finally, all of these, particularly when multiple are worn, project a less than professional image to our meeting and elections. The ETF recommends that campaign stickers, pins and buttons be disallowed.

Distinctly separate from the above are pins and ribbons worn to designate support of AMPAC and our AMA Foundation. Pins for specialties, delegations, regions and even certain causes that do not include any candidate identifier should be allowed. These should be small, not worn on the badge and distributed only to members of the designated group. To prevent a "slippery slope" or problems with enforcement, general distribution of any pin, button or sticker would be disallowed no matter how worthy the cause.

CAMPAIGN RECEPTIONS

A reception is probably the largest single expenditure for most campaigns, with the cost ranging from several thousand to 20 or even 30 thousand dollars, even with our current election rules, adopted by this House several years ago, which disallow alcohol unless available only on a cash bar basis. Such prices make the cost of a reception an impediment or unbearable by some potential candidates. Even candidates from larger delegations have expressed concern about the expense, and some candidates have used personal funds to finance part or all of the expense.

Experience over the last few years also suggests that the impact of a reception on campaign success is, at best, questionable, as candidates who have been featured at a large reception have not been successful in their campaigns, while some with a small or no reception have been successful. Responses to the survey administered at the 2019 Interim Meeting provide support for this position. Fully one-third of the House indicated that receptions are <u>not a factor</u> in determining their votes, and another quarter indicated that receptions were <u>a minimal factor</u> in voting; together those figures constitute three-fifths of the House. Fewer than one in five members of the House indicated that receptions are an important or very important factor in their voting decisions. Yet, your task force heard comments that some delegations wish to continue their receptions.

While a majority of delegates consider receptions of little importance in their election vote, your task force heard multiple comments supporting the existence of receptions for the opportunities they provide for informal social interaction, meeting new individuals and even policy discussion. It is important to note that receptions in their current form are typically open to all, and in fact, candidates seem to be comfortable attending and campaigning at receptions even when sponsored by a competing campaign. Some felt that receptions allowed delegates to interact with candidates (not just the "featured candidate") in an informal and often more personal way.

Current rules allow each candidate to be "featured" (defined in our election rules as being present in a receiving line, appearing by name or in a picture on a poster or notice in or outside of the party venue, …) at only one reception. Delegations or coalitions may finance only a single large reception regardless of the number of candidates from that society or coalition. As noted above, alcohol may be served at these receptions only on a cash bar basis (G-610.020).

Your ETF agrees that there is value to candidates and delegates interacting in social settings outside the rigors of an interview and other formal campaign activities, but we also recognize that the expense of a reception may be a deterrent or cause financial strain for many potential candidates. We hesitate to tell delegations that they may not host a reception but want to create a similar opportunity for other candidates without the resources to host a reception.

In lieu of the multiple, competing receptions sponsored by individual campaigns, we are recommending that our AMA investigate the feasibility of sponsoring a welcome reception open to <u>all</u> candidates and <u>all</u> meeting attendees. Such a reception could allow any candidate the opportunity to be "featured" at the AMA reception. Featured candidates could

be allowed to set up in a space within the reception to visit with anyone who chooses to stop by or could choose to circulate among guests. Such an arrangement would do away with the receiving lines, about which the task force heard negative commentary, and the "forced stickering" that seems to occur whenever one enters the current receptions (see above for further discussion of campaign stickers). It would facilitate informal interaction between candidates and members of the House. Two-thirds of those responding to the survey of the House (Appendix D) indicated that they probably or almost certainly would attend such an event. Nothing in this recommendation would prevent other candidates who elect not to use this reception as their single allowed reception from attending. Other receptions sponsored by societies or coalitions, whether featuring a candidate or not, would not be prohibited, but the current rules regarding cash bars only at campaign receptions and limiting each candidate to be featured at a single reception (the AMA reception or another) would remain.

DINNERS, SUITES AND SUCH

Significant money is spent on informal dinners and entertainment in suites. These are often held at AMA events before active campaigning is allowed. These gatherings are inherently difficult to monitor and to enforce potential rules regarding them. Interestingly, these gatherings actually scored better in the HOD survey than large receptions (see survey results in Appendix D). Some say these are a great way to meet fellow delegates while others point to this as an extravagance that many candidates cannot afford.

The task force recognizes that meeting attendees enjoy these informal social gatherings but has sought to reduce the actual or perceived expense of campaigning. The major concern expressed is indeed the cost. To address this the ETF recommends that any group dinners, if attended by an announced candidate (see Announcement and Nomination below) in a currently contested election, must be "Dutch treat," each participant paying their share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. Recognizing that candidates should be allowed to dine with a small group of friends or share the tab at the bar without fear of a campaign violation, we propose that gatherings of 4 or fewer delegates or alternate delegates should be exempt.

Given the complexity of enforcement and the relatively less opportunity for excess, the task force does not make any recommendation for limiting interactions in delegation suites at this time. All are reminded that active campaigning prior to the April date, whether in a suite or elsewhere, is specifically prohibited by other rules.

CAMPAIGN LITERATURE

Brochures, letters, flyers and other campaign literature are often mailed to delegates before the Annual Meeting and distributed in the not for official business (NFOB) bag at the opening session. According to the survey of the House (Appendix D), these materials carry little impact on the delegate's vote, regardless of how delivered, yet require significant expenditure to develop, print and distribute. Just six percent of respondents in the House find mailed literature important or very important. Slightly more than half declared that campaign literature was <u>not a factor</u> in determining their vote, and more than a quarter reported it to be of minimal importance. The task force has even heard that a surplus of such material can have a negative impact on a candidate's chances. Campaign material emailed before the meeting fared only slightly better: almost seven percent found it important or very important and three-quarters reported it to be of no or minimal import. Literature distributed in the NFOB bag performed no better than items distributed before the meeting. In fact, a casual survey of the House after the opening session would find most of the campaign literature still in the bags, on the floor, or in receptacles near the exits.

These materials as currently distributed constitute an unnecessary expense and waste of resources particularly because they go unread by the vast majority of delegates. Furthermore, we recognize that some candidates have resources for developing such materials that are not available to other candidates or potential candidates. However, your task force believes an informed electorate needs to have available information about candidates' background, experience and qualifications for the position they seek. We encourage elimination of all printed campaign materials while recommending an alternate electronic means of providing this information on a more equal platform. It seems few if any candidates "want" to send these materials, but most feel "required" to send because other candidates do. Because mailed materials carry the greatest expense we propose prohibiting these and would end the current process of the HOD office supplying a list of postal addresses to candidates. The election manual has not been printed since 2015

with no apparent negative effects, and in fact, when the House adopted the policy to move to an exclusively online manual, not a single concern was raised, nor have concerns been raised since.

In lieu of printed material, we propose maintaining the online election manual and providing each candidate the opportunity to post materials on the AMA website, within an expanded elections-related set of pages (see discussion below), and the election manual would link to these pages as it does to conflict of interest statements.

ELECTRONIC COMMUNICATION

The AMA rules of contact and privacy policy have been interpreted to not allow the HOD to provide delegate/alternate delegate email addresses to candidates. The ETF has heard that some campaigns have "harvested" email addresses from the pictorial directory and others have not. At best this creates inequality and could even be seen as contrary to the spirit of AMA policy against sharing email addresses. It is necessary that your Speakers and the HOD Office be able to contact members of the House with confidence that the messages will not be regarded as spam; thus your Speakers strive to limit our communications to essential material. At no time was this more clear than leading up to the Special Meetings in the last year. Options of requiring "opting in" or "opting out" so email addresses can be shared with campaigns, as some have suggested, could threaten essential HOD communication. AMA corporate policies would likely be interpreted as not allowing "opting in" as a default and even candidates have expressed that they believe few would elect to "opt in" if required to make this choice.

For the June 2020 Special Meeting, the Speakers, upon request from the majority of candidates, provided the opportunity for candidates to submit material to the HOD office which was then sent electronically by the HOD in a single communication to all delegates and alternates. While this was optional, every candidate took advantage of this opportunity. Parameters were established regarding content, but there was considerable variability in the materials submitted, ranging from resume style materials and photos to simple prose messages or endorsements. Favorable feedback was received and the Speakers have continued this process for June 2021. The ETF recommends continuation of this process even after return to in-person meetings.

A goal of the ETF was to create an equal opportunity for all candidates to share information regarding their candidacy while also reducing the amount of unwelcomed material that delegates receive. At the same time, the task force did not want to create communication rules that would be difficult to track and enforce. While this recommendation does not prohibit candidates from sending their own additional electronic campaign messages, campaigns are reminded that current campaign rules require that any such communication must include an "unsubscribe option." Many delegates expressed that electronic communications from individual candidates are unwanted and may even negatively impact their view of the candidate. Given the electronic communication we propose to be sent by the HOD office on behalf of all candidates it should be anticipated that additional electronic communications from individual candidates would not be well received. With the enhanced opportunity to communicate, we would anticipate less tolerance of mass communications by candidates and more reporting of the failure to include an unsubscribe option for all such campaign related emails.

WEBSITES AND SOCIAL MEDIA

As mentioned above, the ETF recommends providing each candidate the opportunity to post materials on the AMA website, within an expanded elections-related set of pages. Although the parameters need to be established, the task force envisions a web page template supported by the AMA that could be filled in by candidates without resorting to web design experts. For example, one page might incorporate a biographical resume style listing, another page might incorporate photos of the candidate's selection, and a third page might allow the candidate to post position statements or other information about themselves or that they consider relevant to their campaign. Some design elements might be left up to the candidate (eg, colors and fonts) even while the overall structure of the page(s) is consistent across candidates.

This proposal is supported by the survey of the House at I-19, in which fewer than one in seven delegates indicated that they "probably" or "almost for sure" look at a candidate's website, whereas over half said they would probably or "almost for sure" look at an AMA candidate site. In addition, the fact that all candidate sites would be listed together and linked to the election manual would facilitate delegates review of the material (they would not have to search for individual websites). Candidates would submit their material and all pages would go live simultaneously once campaigning is officially allowed.

At this time, the ETF does not recommend prohibiting candidates from having personal, professional or even campaign-related websites, but the election manual would not link to these independent candidate pages. Similarly, we do not recommend attempting to prohibit or control social media. These forms of communication are embraced by many and importantly individuals must elect to go to the sites or join to receive messages. Since these are not "pushed" to anyone, it should eliminate the concerns of those that feel overwhelmed with electronic information while still providing a resource for delegates that want more information about the candidates.

Fairness
Concern was expressed about inequality of opportunity and the undue influence of caucuses and sponsoring organizations. The ETF hopes that by reducing many of the campaign expenses with the recommendations above, the obstacle of cost will be lowered for all candidates, including those from smaller delegations or with less deep pockets. With all candidates able to participate in the AMA reception, post on the AMA website candidates' pages, and participate in electronic communication originating from the HOD office, opportunities should be less dependent on a candidate's caucus or sponsoring organization. The survey identified interviews as having the greatest influence on the voting decision and our recommendations below should enhance fairness and transparency for this process.

INTERVIEWS

In the survey of our HOD at I-19, candidate interviews were far and away the most important decision-making element in our AMA's election processes, considered an important or very important factor by more than three quarters of those responding (Appendix D). The task force fully agrees with the importance of interviewing.

At the same time, the number of interviews and the time required for them has been likened to a gauntlet for the candidates, and it is no less onerous for those conducting the interviews. For example, at A-19, interviews for contested slots would require no less than 13 interviews if every candidate was to be interviewed. Ten-minute interviews thus require over two hours, not including any "travel time" between interviews. Added to the actual interviewing time is the time required to arrange and manage these interviews, which is necessary for both the candidates and the interviewers. Yet, virtually every person who spoke on the issue at the open forum, including successful and unsuccessful candidates, expressed the view that the interview process was a valuable experience. A clear majority expressed that interviews were time well spent to meet and become informed about the candidates.

Some delegations expressed that the stream of candidates interrupts their policy deliberations. Other delegations responded that they use interview committees, made up of delegates with special interest in a particular council's activities, which often meet simultaneously with candidates for different races, thus lessening the time required for interviews. The task force believes this may be an acceptable option for some delegations.

Consideration was given to grouping interviews together. Over the past several years the HOD office has coordinated grouping section interviews together but has received negative reaction from the groups preferring to have their own interviews. At the open forum and in communications since there has been broad support from delegations to be allowed to continue their specific interviews. While your task force believes grouping of interviews to reduce the number of interviews is desirable, we believe such grouping is best done voluntarily by delegations that find they share similar interests.

Others suggested that interviews be held in a format in which candidates assemble at an appointed hour in front of those who are interested and questions are asked by a moderator similar to the debate held when the president-elect race is contested. Concerns were raised regarding the stress that would be associated with such a high stakes interview, particularly for council candidates who would not typically face such a situation during council service. Others commented that these interviews often result in candidates repeating or even learning from the responses of those answering before them. The Specialty and Service Society holds such an interview panel, yet many specialty delegations continue separate interviews. Several large delegations and even small delegations confirmed that they would continue their interviews even if such a group interview process was instituted, seemingly adding another round of interviews during an already packed meeting rather than replacing or eliminating interviews.

Of necessity for the June 2020 Special Meeting and now again for J-21, virtual interviews have been conducted by both the Speakers and individual caucuses and delegations. Given the overall positive feedback received, the task force recommends continuing the option for virtual interviews, including recorded interviews by the Speakers, in

advance of the meeting even after we return to in-person meetings. In addition, the Speakers would continue to conduct interviews with all candidates to be posted on the AMA website.

Virtual interviews would be allowed during a defined period prior to the meeting in lieu of in-person interviews. Caucuses could choose either method, but not both for a given race. For example, a caucus may choose to conduct virtual interviews for all council races but choose to conduct live interviews for all officer races. These interviews would be facilitated by the HOD Office similarly to how they have been handled for the June 2020 and 2021 campaigns. Recording of virtual interviews must be disclosed to candidates prior to recording and only with their consent, and the recordings may only be shared with members of the interviewing caucus/group.

It has been reported that some candidates have been unable to schedule interviews with some groups, and some groups interview some but not all candidates for a given office. In addition, some candidates have been unaware of the opportunity to interview with some groups or did not know how to arrange such an interview. Democratic principles should favor interviewing all announced candidates for an office. To create equal opportunity for all candidates, we recommend a rule that requires groups electing to interview candidates for a given office to provide an equal opportunity for all currently announced candidates for that office to be interviewed using the same format and platform. An exception would allow a group to meet with a candidate who is from their own delegation without interviewing other candidates. This rule would apply to both virtual and in person interviews.

Distractions and Technology
Concern raised was that there is too much emphasis placed on campaigning and that the election process interrupts and distracts from more important policy discussion. Others expressed that election of leadership is an essential function of our House and a core responsibility of delegates. Your ETF believes both viewpoints are valid and has sought to design a process that is less disruptive to our policy deliberation, consumes less time, and yet allows for secure voting. This can be accomplished by streamlining our processes and utilizing new technologies.

VOTING PROCESS AND ELECTIONS SESSION

Our current voting process at in-person meetings crafted by bylaws, rules, and tradition developed 20 plus years ago involves casting ballots in a separate room in “voting booths” on Tuesday morning during a 75-minute voting window. Results for each race are announced in the House once they become available, typically 30-40 minutes after the House has come to order, interrupting the discussion of reference committee reports. Oftentimes, runoff voting is required and accomplished using paper ballots which are printed, distributed, collected and counted (by hand) by the election tellers, again disrupting the policy discussion. If new openings are created, new nominations, speeches, voting and possibly further runoffs all interrupt House debate. Twice in the last several years elections have extended to Wednesday morning. Voting delegates must be seated at these somewhat random moments to receive a ballot, resulting in reshuffling of delegates and alternate delegates, further disrupting the deliberations. All of this when combined with appreciation and concession speeches, consumes considerable time and detracts from policy discussion. While initial voting is secure in a private booth, runoff paper ballots are distributed in the House to credentialed delegates only, but there is little actual security in this regard as ballots are “passed down the row.”

The original resolutions adopted by the HOD specifically called for consideration of electronic voting. In 2020, in the virtual format, all the voting was done electronically by necessity. Electronic voting was secure and effective in the virtual situation and should be acceptable in person. We are confident that voting can be done with the electronic voting devices—colloquially referred to as “clickers”—that are used in business sessions of the House. The devices are easy to use, and their security and privacy features are at least as great as current methods. Briefly described, delegates (not alternate delegates) can be issued a security card that must be inserted into the device in order to vote in elections. While all devices can be used to vote on policy matters without the card, the security card is required to cast a vote in an election. Each vote should take under a minute, results are almost instantaneous and the devices can be reset for a runoff election within a minute or two. Given the virtual nature of the June 21 HOD meeting, election voting will again be electronic. Accordingly, the ETF recommends that electronic voting should be continued when we return to in-person elections at the 2022 Annual Meeting. We believe this change will simplify voting, allow results of each race including runoffs to be known before ballots are cast for the next position and facilitate a new method of handling positions that were unscheduled but created by a prior election result, henceforth “newly opened positions” (see Newly Opened Positions below).

To further reduce the interruption of policy discussion, our Speakers have scheduled a specific "Election Session" on the agenda for the June 21 HOD meeting. All election activity (except for those unopposed candidates elected by acclamation at the time of nominations) including voting, runoffs and speeches will occur at a scheduled time on Tuesday morning (see discussion on "the day of elections") separate from policymaking sessions. The House deliberation of reference committee reports will resume at a "time certain" to be specified. Delegates only will be voting at this time, but alternates and guests are welcome to observe. The ETF recommends continuing this scheduling once in-person meetings resume.

Additionally, while the task force understands the tradition of thank you speeches by both the victors and unsuccessful candidates, the task force nevertheless prefers that all such speeches be discontinued. No one doubts the sincerity of the thank you delivered by those speaking, but those words of appreciation could better be delivered privately. Moreover, sparing losing candidates the discomfort, often palpable throughout the House, of appearing at a microphone shortly after hearing negative results should be considered a kindness, not a slight, and allows them a graceful exit. These "points of personal privilege" were not heard in June 2020 and will not occur in June 2021. Candidates were invited to share written comments which were subsequently sent to the House. The Speakers have heard no complaints regarding this decision. Our intention is not to create a rule disallowing these speeches (since no rule allowing them exists), but rather to set the stage for the Speakers to use their discretion based upon the volume of business at hand and the number of candidates. We encourage the Speakers to continue to collect personal points from candidates and share them electronically with the House after the meeting, eliminating the need for the speeches during the meeting itself. If such speeches are allowed in the future, we strongly suggest that they be limited to 60 seconds.

With these proposed changes, the task force believes voting will be secure, the time consumed for elections will be greatly reduced, and there will be no interruptions of policy discussion.

ANNOUNCEMENTS AND NOMINATIONS

The ETF considered various announcement/nomination scenarios with the intent of clarifying this process, increasing vetting of all candidates, ameliorating the negative aspects of "pop-ups" (see Newly Opened Positions below) and maintaining the time limit on active campaigning to the period of April through June.

Currently candidates for all elected positions may announce their candidacy with a virtual card projected at the conclusion of the Annual and/or Interim Meetings and then posted on the AMA candidate website. In addition, current rules allow candidates that do not submit an announcement card at these times to send an announcement to delegates even before the "active campaign" has begun. As a result candidates may in effect announce their candidacy directly to delegates at any time, making it difficult to stay abreast of all current candidates for a particular position.

The ETF believes that this loophole should be closed and that such announcements, just like any other campaign communication, sent to delegates before active campaigning is allowed would be a violation of campaign rules. In addition, we propose additional "official" announcement dates be established at which time additional announcements cards would be added to the AMA website and communication would be sent to the HOD. Under our proposal any candidate could still independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than at the specified times.

We propose that the HOD office review all known candidates following the Annual and Interim Meetings and at other specified announcement times to identify unscheduled seats that may potentially be newly opened by election of any announced candidates and communicate this information to the House along with the names of all the candidates for each position. These "Official Candidate Notifications" would add transparency and alert delegations and members of the possibility of unscheduled positions that may become open if certain announced candidates are elected. Members interested in becoming candidates for open or potential newly opened positions would be required to send a virtual announcement card to the HOD Office and complete a conflict of interest (COI) form.

The AMA Board of Trustees considers applications from council candidates at its April meeting and then announces the candidates shortly thereafter. Active campaigning is allowed after this announcement. Currently there is no official notification and oftentimes delegates are uncertain of the exact date of the BOT meeting and start of active campaigning. Therefore, at this time another "Official Candidate Notification" would be sent to the HOD. This would also signal the start of the active campaigning period. Subsequent "Official Announcement Dates" would be determined by the Speakers.

Candidates who become aware of potential newly opened positions for any office or council could notify the HOD Office at any date of their intent to join the campaign and then would be included at the next official announcement and in all subsequent announcements. Presumably this would occur well before nominations occur at the Opening Session of the House. All previously announced candidates will continue to be included at each official announcement (i.e. those announced in June will again be presented in November, April, etc.) and all who had notified the HOD Office of their intent to be nominated and completed a COI would be included in any campaign activity that had not yet been finalized. This modified announcement process would not prohibit late entry into the campaign but provides advantages to early entries.

As discussed below, our bylaws allow for nomination "from the floor" during the Opening Session of the HOD, so candidates could elect to be nominated who had not notified the HOD office of their intent and who had not been included in any official announcement. While it would still be possible for a new candidate to first announce at the time they are nominated from the floor at the Opening Session of the House, waiting until this moment when given the opportunity to announce their candidacy in advance, would seem to put that candidate at a significant disadvantage, thus encouraging candidates to announce early and be vetted. The earlier the announcement, the more the opportunity to participate in the campaign process, including interviews which the survey identified as the most important factor in the voting decision. This proposal would allow for posting of the COI at the time of announcement (likely well before election day) or at the latest at the Opening Session of the House, more than two days before the election in our current schedule.

The task force carefully considered the bylaws that allow for nominations from the floor during the Opening Session. This bylaw is common among associations that hold open nominations and elections. Typically nominations are declared open and then closed by a motion. No doubt this option complicates the campaign process and potentially creates chaos at the last moment. However, nomination at the last possible minute allows for the rare case where a candidate is determined to be unavailable or unacceptable to fill a position, or a late nominated candidate for some reason is an overwhelming choice. While relatively rare, this has occurred, and candidates waiting until this last moment have been elected. The ETF believes this option should remain and recommends the more formalized announcement process as a solution to at least the most common aspects of the problem of late announcements and unvetted candidates.

During the ETF exploration of announcements and nominations we found inconsistencies in our rules surrounding the concept of announcements versus nominations. These two terms seem to be used interchangeably without a clear delineation between the two. For example, we could not find a basis for the Board nominating council candidates in conjunction with the April Board meeting. Bylaw 6.8.1 specifies that nominations for the elected councils are made by the Board **or** by a delegate from the floor. It does not specify when the Board actually places the names of their nominees into nomination. In fact, as discussed in the paragraphs above and below all nominations actually occur at the Opening Session of the House. Under the current process, candidates for council positions submit applications to the Board for consideration at their April meeting prior to an established March 15 deadline as discussed in Policy G-610.010, "Nominations," shown below [*emphasis* added]:

> Policy G-610.010, Nominations
> Guidelines for nominations for AMA elected offices include the following: (1) every effort should be made to nominate two or more eligible members for each Council vacancy; (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity; (3) the date for submission of nominations to the Council on Legislation, Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, Council on Science and Public Health, Council on Long Range Planning and Development, and Council on Ethical and Judicial Affairs is made uniform to March 15th of each year; (4) the announcement of the Council nominations and the official ballot should list candidates in alphabetical order by name only;

These "nominations" are then announced at the conclusion of the Board's April meeting at which time active campaigning may begin. Policy G-610.020 which reads in item 3 [*emphasis* added]:

> (3) Active campaigning for AMA elective office may not begin until the Board of Trustees, after its April meeting, announces the nominees for council seats. Active campaigning includes mass outreach activities directed to all or

a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates;

It is our understanding that Policy G-610.020 (3) was written more to define the start of active campaigning rather than to specify the timing of the nomination process. Note that this only specifies the Board "announcing the nominees" for council candidates; they are actually nominated by the Board at the Opening of the House. However, council candidates under our current rules may "announce" their candidacy at any point, even after the March deadline, and then be nominated "from the floor" by a delegate without completing an application or being considered by the Board. Review of available history did not identify a single instance when the Board did not "nominate" a council candidate who submitted an application. In reality the Board review of these candidates, who must be AMA members, is largely perfunctory. Procedurally nominations are declared open by the presiding officer, nominations are announced by the presiding officer or Board chair or made from the floor by a delegate. Then a motion is accepted to close nominations (typically the presiding officer will accept nominations be closed "without objection" once no further nominations appear to be pending even without a formal motion and second). To eliminate the confusion between nomination and submitting applications for review by the Board at their April meeting while maintaining the uniform March 15 deadline, the ETF recommends Policy G-610.010, "Nominations," paragraph 3 be amended.

Guidelines for nominations for AMA elected offices include the following: (1) every effort should be made to nominate two or more eligible members for each Council vacancy; (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity; (3) the date for submission of ~~nominations to~~ applications for consideration by the Board of Trustees at its April meeting for the Council on Legislation, Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, Council on Science and Public Health, Council on Long Range Planning and Development, and Council on Ethical and Judicial Affairs is made uniform to March 15th of each year; (4) the announcement of the Council nominations and the official ballot should list candidates in alphabetical order by name only;

In addition, Policy G-610.020 (3) be amended by deleting the word "nominees" and inserting the word "candidates" to clarify that the Board is announcing the candidates and not actually nominating them.

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

The ETF believes these proposed changes to our announcement process will clarify the process while maintaining the current nominations that occur at the Opening Session of the House. These changes provide transparency for delegates to know the candidates for all positions and have an opportunity to vet those candidates. It also allows potential candidates to learn of the opportunities to run for an unscheduled position that may become newly open as a result of another pending election.

NEWLY OPENED POSITIONS

Significant concern was raised regarding how to handle elections to fill previously unscheduled vacancies that are created as a result of prior elections. This most often occurs when a council member with an unexpired term is elected to an officer position but may also occur when a current Board member with a continuing term becomes president-elect. Current bylaws prescribe that the newly opened position is filled in a separate election with nominations to be held after completion of election for previously known open positions. Over the past several years multiple previously unannounced candidates are then nominated, all candidates give a speech before the House and then voting ensues. In the past these have been called "pop-ups."

Three general concerns have been expressed regarding "pop-up:" first, these individuals are being elected without the usual vetting; second, the process of new nominations and speeches before the HOD delays and distracts from policy

discussion; and third, the possibility of opening a seat has become a campaign strategy. In addition, our rules require a conflict of interest disclosure to be submitted before the election and presumably there should be ample opportunity for delegates to review the COI before voting. The ETF considered a number of potential solutions, including requiring candidates seeking another office to resign their current position, leaving the seat of a successful candidate vacant until the next meeting, delaying voting on these positions until the next day, or forcing potential candidates to declare in advance (an analysis of each of these options is included in Appendix E).

These options were discussed at the open forum held at the 2019 Interim Meeting and were also a subject of the survey of the House. Each option received support and opposition, with no consensus reached, but a majority favored some change over the current process. After further exploration, the ETF discovered that simply embracing newly available voting technology that allows sequential voting with nearly instantaneous results and rapid ballot preparation eliminates most of the problems associated with "pop-ups" without necessitating the more radical changes associated with the options presented at I-19.

The problems associated with newly opened positions are the result of the limitations of our current voting process. The change in our election process to electronic voting as detailed above (see Election Process) technically eliminates "pop-ups." Pop-ups occur only when a new position opens "that did not exist at the time of the prior ballot" (Bylaws 3.4.2.2 and 6.8.1.5). With sequential electronic voting all open positions, including those created by a preceding vote for an officer position, will "exist" at the time of the initial ballot. During the election session, proposed above, the vote for the Board of Trustees will be held (including any runoffs) with the results known, before the first ballot and voting for the councils will occur. With this process there has been no "prior ballot" for any of the councils. Similarly, the vote for president-elect will be concluded before the voting for the Board begins. For example, hypothetically a current member of the Council on Medical Service (CMS) with an unexpired term is elected to the Board; the first vote for CMS will occur after the result of the Board election is known. Therefore, the first ballot for CMS will include candidates for all open seats including the newly opened position. With this process there is no "newly opened seat that did not exist at the time of the first ballot," thus no "pop-up," no new nominations, and no speeches before the House. Based upon the change to electronic voting for each position in a sequential fashion, Bylaws 3.4.2.2 and 6.8.1.5 are no longer relevant, and we recommend they be rescinded to eliminate future confusion.

While this technically eliminates "pop-ups,"' this does not completely solve the problem. Nominations are accepted on Saturday afternoon (in our usual meeting schedule) and elections are held on Tuesday. Therefore, candidates who are considering nomination do not know whether a newly opened position will be created before the close of nominations. To solve this problem, the ETF is suggesting a modified announcement and nominations process that entails informing delegates at specific times in advance of the meeting of the current candidates for each position and the seats that could potentially be newly opened as a result of pending elections (see Announcements and Nominations). The proposed process as detailed above includes a series of announcement deadlines with notification sent to delegates with subsequent opportunity for new candidates to announce their intention to run for these potential newly opened positions. This proposed announcement process will encourage candidates to announce in advance for potential newly opened positions and require candidates that hope to be elected to one of these positions to be nominated during the Opening Session of the House. Changes suggested below will allow candidates the opportunity to withdraw their nomination in the event the potential seat does not open. However, once nominations are closed, no further nominations will be accepted. This proposal, while requiring candidates to be nominated for a position that may not ultimately open, will allow vetting of candidates that announce their intention to be nominated.

Currently when an unopposed candidate with an unexpired term is elected by acclamation, nominations for the newly opened council or Board seat are accepted at the time of initial nominations along with nominations for any previously known open seats. In fact, this is the model we have used above in our proposal to handle potential newly opened positions.

If there are no open positions scheduled for election in a given year for a particular council or the Board, but there is the potential for a newly opened position (one or more current candidates for a higher office hold an unexpired term on a council or the Board) candidates will be solicited as detailed above for the potential newly opened position. These announced candidates for the potential newly opened position will proceed with all campaign activities available to them from the time of their announcement forward. If the potential newly opened position does not open (ie., the individual with the unexpired term is not elected to the office they sought), no election will be held. In this event these candidates will have campaigned even though there ultimately was no vote. The ETF considered that this may be an

unnecessary burden on the candidates, but thought that this campaign experience and the resulting exposure of the candidate to the House would actually be beneficial to the candidate.

If the potential newly opened position does not open but there are other open positions for the same council or the Board, an election will proceed for the existing open seats. Candidates will be offered the opportunity to withdraw their nomination prior to the vote. This will allow candidates from the same delegation to avoid potential conflicts. Conversely, all candidates may also choose to continue with the election to compete for the available positions.

Following the implementation of electronic voting during a specified election session and the proposed new announcement process, in the unlikely event that a prior election results in a newly opened position without a nominated candidate or more positions are open than nominated candidates, the unfilled position(s) would remain unfilled until the next Annual Meeting.

There is no perfect solution to the problem of newly opened positions, but the ETF believes this proposal will encourage candidates to announce their candidacy early, add transparency to our elections, result in more contested elections, allow delegations the opportunity to vet candidates for newly opened positions, and eliminate the distraction from policy discussion that occurs with our prior "pop-up" process.

APPOINTING SELECT COUNCILS

Careful consideration was given to the idea of appointing some or all of the currently elected council positions. Appointment would eliminate most if not all the issues of concern heard regarding elections. In addition, appointment by a nominations committee allows for careful consideration of diversity and expertise needs of a council.

The concept of appointing members to councils has several precedents within our AMA. Current rules provide multiple methods of selecting appointed councils (CLRPD--selected by the BOT and the Speaker, COL--selected by BOT, CEJA--nominated by the President), the public member of the Board is chosen by a search committee and confirmed by the HOD, and the House Compensation Committee is a combined appointment by the President and the Speaker. These committees function well with the members selected by the current appointment process and the task force does not recommend any change in these councils.

In addition, these various methods all enjoy a plethora of candidates for each position which is in contrast to the few candidates, often unopposed, that run for councils. This may reflect a desire by some to avoid the election process which has been called into question by the resolutions that called for this report. It can be argued that more candidates would come forward if councils were appointed. Appointing one or more councils would lessen the number of interviews and remove most if not all associated campaign expenses.

The task force believes that all officers and most council members should continue to be elected, but recommends that the Council on Constitution & Bylaws (CC&B) should be transitioned over to selection by appointment. This council, perhaps more than any other council, benefits from members with particular backgrounds and skill sets that are not always appreciated in our campaign process. For example, during interviews candidates for CC&B are rarely asked questions regarding bylaws. Over the past several elections CC&B has attracted relatively few candidates as compared to other elected councils and far fewer than appointed councils.

Concern was expressed that service on a council often leads to future leadership positions and appointment may have a deleterious effect on the potential of council members moving forward. A review of current and recent past successful officer candidates found that there was a balance between those that had previously served on elected and appointed councils, and in fact a lower representation of past CC&B members.

The specific process of appointment could be determined subsequently, but the task force favors a process that would include consideration by the Board of Trustees of nominated candidates with a slate for each open position presented to the House of Delegates for approval. Terms, tenure and role of the council would remain unchanged.

THE ROLE AND INFLUENCE OF CAUCUSES

Concerns about the role played by caucuses in the election process have been heard for many years, perhaps getting louder as caucuses have grown larger. There is little question that delegations and caucuses have significant influence in our elections.

These caucuses are often the source of interviews of candidates and subsequently suggest to varying degrees voting for particular candidates. A small number of delegates (5%) in the HOD survey responded that they felt their vote was "mandated" by their delegation and others, while still a minority (15%), said they felt "strong pressure" to vote for particular candidates. Meanwhile, our current guiding principles for elections, Policy G-610.021 [*emphasis* added] clearly states –

> 1. AMA delegates should: (a) avail themselves of all available background information about candidates for elected positions in the AMA; (b) determine which candidates are best qualified to help the AMA achieve its mission; and (c) make independent decisions about which candidates to vote for .

Insofar as AMA's elections are conducted by secret ballot, the task force believes that delegates ought to be able to hew closely to these principles with little fear of repercussions. Further review of the survey results show that almost ⅔ of the respondents (65%) "make their own decision" with or without input from their delegation or caucus. This is not meant to suggest that delegates should ignore their sponsoring organization's endorsements, only that the sponsoring organization's recommendations are but a single element in a delegate's decision-making armamentarium with respect to elections.

Others say they are offended by "vote trading and deals" made within and between caucuses. The ETF notes that our principles go on to state:

> 2. Any electioneering practices that distort the democratic processes of the AMA-HOD elections, such as vote trading for the purpose of supporting candidates, are unacceptable.

In addition, we recommend Principle 2 should be strengthened by adding the following: "This policy applies between as well as within caucuses and delegations."

Furthermore, we recommend addition of another principle to discourage delegations from using "rank order" lists of candidates and encourage delegations to provide an opportunity for their members to have an open discussion regarding candidates.

Candidates typically seek nomination and endorsement from the groups with which they associate or with whom they have perceived connection. Some argue that this provides a desirable screening of candidates and a way to gain support. Others see this as controlling who is allowed to become a candidate and preventing some qualified individuals from entering a race. The ETF believes delegations and caucuses should have autonomy in deciding whom they support as candidates, but we emphasize that the goal of our elections should be to select the most qualified leaders for our Association. As such we propose another additional guiding principle for election as follows:

> (8) Delegations and caucuses should be a source of encouragement and assistance to qualified candidates. Nomination and endorsement should be based upon selecting the most qualified individuals to lead our AMA regardless of the number of positions up for election in a given race. Delegations and caucuses are reminded that all potential candidates may choose to run for office, with or without their endorsement and support.

In addition, the ETF believes other recommendations within this report (recorded interviews, posted website materials, electronic communications originating from the HOD Office, etc.) will provide candidates more opportunity independent of the assistance from well funded delegations and large caucuses. Any candidate will be able to participate in the AMA reception providing them exposure without the need for a separate reception. Several other recommendations should also reduce the expense of campaigns, further reducing the influence of delegations and caucuses.

During the task force discussions, the question was raised about the size of caucuses. That is, should the size of a caucus be capped such that its influence—whether real or perceived—does not become outsized? The task force is

not making a recommendation on this matter at this time. It remains a question whether limitations on caucuses are within the House's authority at all. The ETF recommends continued monitoring of the effects of the adopted recommendations and consideration of future changes should they be deemed necessary.

THE DAY OF THE ELECTIONS

The task force heard suggestions for moving the day of the elections to earlier in the Annual Meeting, but does not favor such a change. First, determining who are the best candidates takes time, and the time devoted to interviews is valued by both candidates and the electorate. An earlier date would increase reliance on speeches and written materials rather than "getting to know" the candidates. Truncating the vetting process would be most harmful to lesser known candidates and those from smaller delegations. After examining the other days of the Annual Meeting, the ETF concluded that moving the elections would cause greater disruption to the already full agenda for each of the other days. The potential to adversely affect the elections by moving them forward seems too great to alter the day of the elections. Therefore, the task force favors implementation of the reforms proposed herein, which we believe will address the concerns underlying proposals to move the day of elections. (See Appendix F for detailed discussion of the ETF consideration of alternative days of election.)

ELECTION COMMITTEE

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

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

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

REVIEW OF IMPLEMENTATION

The above recommendations are all derived from our extensive review and deliberation of our AMA election process. These recommendations represent the consensus of the ETF and we are confident that they will lead to improvement. The House of Delegates will undoubtedly have opinions as to whether these are the right solutions but the ultimate determination will only become clear once the adopted recommendations are implemented. Therefore, our final recommendation is for a review to be conducted after an interval of 2 years led by the Speaker and at the Speaker's discretion, the appointment of another election task force, with a report back to the House.

CONCLUSION AND RECOMMENDATIONS

Our AMA election process is guided by our bylaws, various policies adopted by the HOD, the HOD Reference Manual and tradition with overall responsibility resting with the Speaker. As such, the following recommendations, if adopted, will require thorough review and editing of these documents to reflect the changes.

Following the detailed discussion above, the Election Task Force recommends that the following recommendations be adopted, with the rules to be effective upon adjournment of this meeting, and the remainder of this report be filed. Recommendations are listed in order of the topics covered in the body of the report with all modified current policies reconciled in numerical order in Appendix G for clarity.

Campaign Memorabilia

Recommendation 1: Campaign memorabilia may not be distributed in the Not for Official Business (NFOB) bag.

Recommendation 2: Policy G-610.020, Rules for AMA Elections, paragraph 10 be amended by addition and deletion to read as follows:

(10) Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. ~~Campaign gifts can be distributed only at the Annual Meeting in the non-official business bag and at one campaign party. Campaign gifts should only be distributed during the Annual Meeting and not mailed to delegates and alternate delegates in advance of the meeting. The Speaker of the House of Delegates shall establish a limit on allowable expenditures for campaign-related gifts. In addition to these giveaway gifts, campaign memorabilia are allowed but are limited to a button, pin, or sticker. No other c~~Campaign memorabilia and giveaways that include a candidate's name or likeness may not ~~shall~~ be distributed at any time;

Stickers, Buttons, and Pins

Recommendation 3: Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies, state and regional delegations and health related causes that do not include any candidate identifier. These pins should be small, not worn on the badge and distributed only to members of the designated group. General distribution of any pin, button or sticker is disallowed.

Recommendation 4: Policy G-610.020, Rules for AMA Elections, paragraph 8 be amended by deletion to read as follows:

(8) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside of the party venue~~, or (c) distributing stickers, buttons, etc. with the candidate's name on them~~. At these events, alcohol may be served only on a cash or no-host bar basis;

Campaign Receptions

Recommendation 5: Our AMA will investigate the feasibility of a two- (2) year trial of sponsoring a welcome reception open to all candidates and all meeting attendees. Any candidate may elect to be "featured" at the AMA reception. There will not be a receiving line at the AMA reception. Other receptions sponsored by societies or coalitions, whether featuring a candidate or not, would not be prohibited, but the current rules regarding cash bars only at campaign receptions and limiting each candidate to be featured at a single reception (the AMA reception or another) would remain. The Speakers will report back to the House after the two-year trial with a recommendation for possible continuation of the AMA reception.

Recommendation 6: Policy G-610.020, Rules for AMA Elections, paragraph 8 be reaffirmed (minus phrase "c" recommended for deletion above):

(8) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside of the party venue~~, or (c) distributing stickers, buttons, etc. with the candidate's name on them~~. At these events, alcohol may be served only on a cash or no-host bar basis;

Dinners, Suites and Such

Recommendation 7: Group dinners, if attended by an announced candidate in a currently contested election, must be "Dutch treat" - each participant pays their own share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. Gatherings of 4 or fewer delegates or alternates are exempt from this rule.

Recommendation 8: Policy G-610.020, Rules for AMA Elections, paragraph 6 be amended by addition and deletion to read as follows:

(6) At any AMA meeting convened prior to the time period for active campaigning ~~the Interim Meeting~~, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited ~~at the Interim Meeting~~. It is permissible ~~at the Interim Meeting~~ for candidates seeking election to engage in individual outreach~~, such as small group meetings, including informal dinners,~~ meant to familiarize others with a candidate's opinions and positions on issues;

Campaign Literature

Recommendation 9: Campaign materials may not be distributed by postal mail or its equivalent. The AMA Office of House of Delegates Affairs will no longer furnish a file containing the names and mailing addresses of members of the AMA-HOD. Printed campaign materials will not be included in the "Not for Official Business" bag and may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials.

Recommendation 10: Policy G-610.020, Rules for AMA Elections, paragraph 9 be amended by addition and deletion to read as follows:

(9) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at a single campaign reception at which the candidate is featured ~~parties, and campaign literature may be distributed in the non-official business bag for members of the House of Delegates~~. No campaign literature shall be distributed in the House of Delegates and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates;

Recommendation 11: The AMA Office of House of Delegates Affairs will provide an opportunity for all announced candidates to submit material to the HOD office which will then be sent electronically by the HOD Office in a single communication to all delegates and alternates. Parameters regarding content and deadlines for submission will be established by the Speaker and communicated to all announced candidates.

Recommendation 12: Policy G-610.020, Rules for AMA Elections, paragraph 5 be amended by addition and deletion to read as follows:

(5) A reduction in the volume of telephone calls and electronic communication from candidates~~, and literature and letters by or~~ and on behalf of candidates is encouraged. The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of electronic messages to contact electors should be minimized, and if used must include a simple mechanism to allow recipients to opt out of receiving future messages;

Recommendation 13: An AMA Candidates' Page will be created on the AMA website or other appropriate website to allow each candidate the opportunity to post campaign materials. Parameters for the site will be established by the Speaker and communicated to candidates.

Recommendation 14: Policy G-610.020, Rules for AMA Elections, paragraph 4 be amended by addition to read as follows:

(4) An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual will provide a link to the AMA Candidates' Page, but links to personal, professional or campaign related websites will not be allowed. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates;

Interviews

Recommendation 15: Policy G-610.020, Rules for AMA Elections, paragraph 14 be reaffirmed:

(14) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities; and

[Editor's note: Recommendation 16 referred] Recommendation 16: Delegations and caucuses may conduct interviews by virtual means in advance of the Annual Meeting of the House of Delegates during a period of time to be determined by the Speaker in lieu of in-person interviews at the meeting. Delegations and caucuses may choose either method, but not both for a given race. Groups electing to interview candidates for a given position must provide an equal opportunity for all candidates for that position who have announced their intention to be nominated at the time interviews are scheduled, to be interviewed using the same format and platform. An exception being that a group may elect to meet with a candidate who is from their own delegation without interviewing other candidates. Recording of virtual interviews must be disclosed to candidates prior to recording and may only be recorded with candidate consent. Interview recordings may only be shared with members of the interviewing caucus/group.

Recommendation 17: The Speakers are encouraged to continue recorded virtual interviews of announced candidates in contested races, to be posted on the AMA website.

Voting Process and Election Session

Recommendation 18: Voting for all elected positions including runoffs will be conducted electronically during an Election Session to be arranged by the Speaker.

Recommendation 19: Policy G-610.030, Election Process be amended by addition and deletion to read as follows:

AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at each Annual Meeting; (2) ~~Poll hours will not be extended beyond the times posted.~~ All delegates eligible to vote must be seated within the House~~in line to vote~~ at the time appointed to cast their electronic votes~~for the close of polls~~; and (3) The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House.

Recommendation 20: The Speaker is encouraged to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced, including collecting written personal points from candidates to be shared electronically with the House after the meeting or imposing time limits on such comments.

Announcements and Nomination

Recommendation 21: Policy G-610.020, Rules for AMA Elections, paragraph 2 be amended by addition to read as follows:

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

Recommendation 22: Announcement cards of all known candidates will be projected on the last day of the Annual and Interim Meetings of our House of Delegates and posted on the AMA website as per Policy G-610.020, paragraph 2. Following each meeting, an "Official Candidate Notification" will be sent electronically to the House. It will include a list of all announced candidates and all potential newly opened positions which may open as a result of the election of any announced candidate. Additional notices will also be sent out following the April Board meeting and on "Official Announcement Dates" to be established by the Speaker.

Recommendation 23: Candidates may notify the HOD Office of their intention to run for potential newly opened positions, as well as any scheduled open positions on any council or the Board of Trustees, at any time by submitting an announcement card and their conflict of interest statement to the House Office. They will then be included in all subsequent projections of announcements before the House, "Official Candidate Notifications" and in any campaign activity that had not yet been finalized. All previously announced candidates will continue to be included on each Official Announcement Date. Any candidate may independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than at the specified times.

Recommendation 24: Policy G-610.020, Rules for AMA Elections, paragraph 15 be reaffirmed:

(15) Our AMA (a) requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election; and (b) will expand accessibility to completed conflict of interest information by posting such information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.

Recommendation 25: Policy G-610.010, Nominations be amended by addition and deletion to read as follows:

Guidelines for nominations for AMA elected offices include the following: (1) every effort should be made to nominate two or more eligible members for each Council vacancy; (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity; (3) the date for submission of ~~nominations to~~ applications for consideration by the Board of Trustees at its April meeting for the Council on Legislation, Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, Council on Science and Public Health, Council on Long Range Planning and Development, and Council on Ethical and Judicial Affairs is made uniform to March 15th of each year; (4) the announcement of the Council nominations and the official ballot should list candidates in alphabetical order by name only;

Recommendation 26: Policy G-610.020, Rules for AMA Elections, paragraph 3, be amended by addition and deletion to read as follows:

(3) Active campaigning for AMA elective office may not begin until the Board of Trustees, after its April meeting, announces the ~~nominees~~ candidates for council seats. Active campaigning includes mass outreach

activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates;

Newly Opened Positions

Recommendation 27: The Federation and members of the House of Delegates will be notified of unscheduled potential newly opened positions that may become available as a result of the election of announced candidates. Candidates will be allowed to announce their intention to run for these positions.

Recommendation 28: If there are no scheduled open seats on the Board or specified council for which a potential newly opened position is announced and if the potential newly opened position does not open (ie., the individual with the unexpired term is not elected to the office they sought), no election for the position will be held.

Recommendation 29: If a potential newly opened position on the Board or a specified council does not open but there are other open positions for the same council or the Board, an election will proceed for the existing open seats. Candidates will be offered the opportunity to withdraw their nomination prior to the vote.

Recommendation 30: In the event that a prior election results in a newly opened position without a nominated candidate or more positions are open than nominated candidates, the unfilled position/s would remain unfilled until the next annual meeting.

Recommendation 31: Bylaws 3.4.2.2 and 6.8.1.5 be rescinded.

> **3.4.2.2 At-Large Trustees to be Elected to Fill Vacancies after a Prior Ballot**. The nomination and election of Trustees to fill a vacancy that did not exist at the time of the prior ballot shall be held after election of other Trustees and shall follow the same procedure. Individuals so elected shall be elected to a complete 4-year term of office. Unsuccessful candidates in any election for Trustee, other than the young physician trustee and the resident/fellow physician trustee, shall automatically be nominated for subsequent elections until all Trustees have been elected. In addition, nominations from the floor shall be accepted.
>
> **6.8.1.5 Council Members to be Elected to Fill Vacancies after a Prior Ballot.** The nomination and election of members of the Council to fill a vacancy that did not exist at the time of the prior ballot shall be held after election of other members of the Council, and shall follow the same procedure. Individuals elected to such vacancy shall be elected to a complete 4-year term. Unsuccessful candidates in the election for members of the Council shall automatically be nominated for subsequent elections to fill any such vacancy until all members of the Council have been elected. In addition, nominations from the floor shall be accepted.

Appointing Select Councils

[Editor's note: Recommendation 32 not adopted] Recommendation 32: Members of the Council on Constitution & Bylaws (CC&B) will be appointed. The appointment process would include consideration by the Board of Trustees of nominated candidates with a slate for each open position presented to the House of Delegates for approval. Terms, tenure and role of the council would remain unchanged. Appropriate bylaws to accomplish this change will be crafted by CC&B.

The Role and Influence of Caucuses

Recommendation 33: Policy G-610.021, Guiding Principles for House Elections, principle 2 be amended by addition to read as follows:

(2) Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable. This principle applies between as well as within caucuses and delegations.

Recommendation 34: Policy G-610.021, Guiding Principles for House Elections, principles 1, 3, 4, 5 and 6 be reaffirmed:

(1) AMA delegates should: (a) avail themselves of all available background information about candidates for elected positions in the AMA; (b) determine which candidates are best qualified to help the AMA achieve its mission; and (c) make independent decisions about which candidates to vote for.

(3) Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.

(4) Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for AMA leadership positions.

(5) Incumbency should not assure the re-election of an individual to an AMA leadership position.

(6) Service in any AMA leadership position should not assure ascendancy to another leadership position.

Recommendation 35: Policy G-610.021, Guiding Principles for House Elections, be amended by addition of an additional principle 7 to read as follows:

(7) Delegations and caucuses when evaluating candidates may provide information to their members encouraging open discussion regarding the candidates.

Recommendation 36: Policy G-610.021, Guiding Principles for House Elections, be amended by addition of an additional principle 8 to read as follows:

(8) Delegations and caucuses should be a source of encouragement and assistance to qualified candidates. Nomination and endorsement should be based upon selecting the most qualified individuals to lead our AMA regardless of the number of positions up for election in a given race. Delegations and caucuses are reminded that all potential candidates may choose to run for office, with or without their endorsement and support.

The Day of the Elections

Recommendation 37: Policy G-610.030, Election Process, paragraph 1 be reaffirmed:

AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at each Annual Meeting; ...

Election Committee

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

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

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

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

Review of Implementation

Recommendation 41: After an interval of 2 years a review of our election process, including the adopted recommendations from this report, be conducted by the Speaker and, at the Speaker's discretion the appointment of another election task force, with a report back to the House.

APPENDIX A – Task Force Charge and Membership

Policy G-610.031, Creation of an AMA Election Reform Committee
Our AMA will create a Speaker-appointed task force for the purpose of recommending improvements to the current AMA House of Delegates election process with a broad purview to evaluate all aspects. The task force shall present an initial status report at the 2019 Interim Meeting.

- Jenni Barlotti-Telesz, MD, American Society of Anesthesiologists
- Richard Evans, MD, Maine
- James Hay, MD, California
- Dan Heinemann, MD, American Academy of Family Physicians
- David Henkes, MD, Texas
- Jessica Krant, MD, American Society for Dermatologic Surgery
- Josh Lesko, MD, Resident Physician, Virginia
- John Poole, MD, New Jersey
- Karthik Sarma, past medical student trustee
- Stephen Tharp, MD, Indiana
- Jordan Warchol, MD, MPH, Nebraska
- Bruce Scott, MD, Speaker, Kentucky
- Lisa Bohman Egbert, MD, Vice Speaker, Ohio

APPENDIX B – Current AMA Election Rules and Policies

CONSTITUTION - Article IV House of Delegates

The House of Delegates is the legislative and policy-making body of the Association. It is composed of elected representatives and others as provided in the Bylaws. The House of Delegates transacts all business of the Association not otherwise specifically provided for in this Constitution and Bylaws and elects the officers except as otherwise provided in the Bylaws.

BYLAWS

3—Officers

3.1 Designations. The officers of the AMA shall be those specified in Article V of the Constitution.

3.2.1 General. An officer, except the public trustee, must have been an active member of the AMA for at least 2 years immediately prior to election.

3.2.1.3 Restriction on Chair. The Chair of the Board of Trustees is not eligible for election as President-Elect until the Annual Meeting following completion of the term as Chair of the Board of Trustees.

3.3 Nominations. Nominations for President-Elect, Speaker and Vice Speaker, shall be made from the floor by a member of the House of Delegates. Nominations for all other officers, except for Secretary, the medical student trustee, and the public trustee, shall be made from the floor by a member of the House of Delegates and may be announced by the Board of Trustees.

3.4 Elections.

3.4.1 Time of Election. Officers of the AMA, except the Secretary, the medical student trustee, and the public trustee, shall be elected by the House of Delegates at the Annual Meeting, except as provided in Bylaws 3.6 and 3.7. The public trustee may be elected at any meeting of the House of Delegates at which the Selection Committee for the Public Trustee submits a nomination for approval by the House of Delegates. On recommendation of the Committee on Rules and Credentials, the House of Delegates shall set the day and hour of such election. The Medical Student Section shall elect the medical student trustee in accordance with Bylaw 3.5.6.

3.4.2 Method of Election. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by ballot.

3.4.2.1 At-Large Trustees.

3.4.2.1.1 First Ballot. All nominees for the office of At-Large Trustee shall be listed alphabetically on a single ballot. Each elector shall have as many votes as the number of Trustees to be elected, and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer or more votes than the number of Trustees to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if he or she has received a vote on a majority of the legal ballots cast and is one of the nominees receiving the largest number of votes within the number of Trustees to be elected.

3.4.2.1.2 Runoff Ballot. A runoff election shall be held to fill any vacancy not filled because of a tie vote.

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

3.4.2.2 At-Large Trustees to be Elected to Fill Vacancies after a Prior Ballot. The nomination and election of Trustees to fill a vacancy that did not exist at the time of the prior ballot shall be held after election of other Trustees and shall follow the same procedure. Individuals so elected shall be elected to a complete 4-year term of office. Unsuccessful candidates in any election for Trustee, other than the young physician trustee and the resident/fellow physician trustee, shall automatically be nominated for subsequent elections until all Trustees have been elected. In addition, nominations from the floor shall be accepted.

3.4.2.3 All Other Officers, except the Medical Student Trustee and the Public Trustee. All other officers, except the medical student trustee and the public trustee, shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

3.4.2.4 Medical Student Trustee. The medical student trustee is elected by the Medical Student Section in accordance with Bylaw 3.5.6.

3.4.2.5 Public Trustee. The public trustee shall be elected separately. The nomination for the public trustee shall be submitted to the House of Delegates by the Selection Committee for the Public Trustee. Nominations from the floor shall not be accepted. A majority vote of delegates present and voting shall be necessary to elect.

3.5 Terms and Tenure.

3.5.1 President-Elect. The President-Elect shall be elected annually and shall serve as President-Elect until the next inauguration and shall become President upon installation at the inaugural ceremony, serving thereafter as President until the installation of a successor. The inauguration of the President may be held at any time during the meeting.

3.5.2 Speaker and Vice Speaker. The Speaker and Vice Speaker of the House of Delegates shall be elected annually, each to serve for one year or until their successors are elected and installed.

3.5.2.1 Limit on Total Tenure. An individual elected as Speaker may serve a maximum tenure of 4 years as Speaker. An individual elected as Vice Speaker may serve for a maximum tenure of 4 years as Vice Speaker.

3.5.3 Secretary. A Secretary shall be selected by the Board of Trustees from one of its members and shall serve for a term of one year.

3.5.4 At-Large Trustees. At-Large Trustees shall be elected to serve for a term of 4 years, and shall not serve for more than 2 terms.

3.5.4.1 Limit on Total Tenure. Trustees may serve for a maximum tenure of 8 years. Trustees elected at an Interim Meeting may serve for a maximum tenure of 8 years from the Annual Meeting following their election. The limitation on tenure shall take priority over a term length for which the Trustee was elected.

3.5.4.2 Prior Service as Young Physician Trustee. Periods of service as the young physician trustee shall count as part of the maximum Board of Trustees tenure.

3.5.4.3 Prior Service as Resident/Fellow Physician Trustee or Medical Student Trustee. Periods of service as the resident/fellow physician trustee or as the medical student trustee shall not count as part of the maximum Board of Trustees tenure.

3.5.5 Resident/Fellow Physician Trustee. The resident/fellow physician trustee shall serve a term of 2 years and shall not serve for more than 3 terms. If the resident/fellow physician trustee is unable, for any reason, to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected to a term to expire at the conclusion of the second Annual Meeting of the House of Delegates following the meeting at which the resident/fellow physician trustee was elected.

3.5.5.1 Cessation of Residency/Fellowship. The term of the resident/fellow physician trustee shall terminate and the position shall be declared vacant if the trustee should cease to be a resident/fellow physician. If the trustee completes residency or fellowship within 90 days prior to an Annual Meeting, the trustee shall be permitted to continue to serve on the Board of Trustees until the completion of the Annual Meeting.

3.5.6 Medical Student Trustee. The Medical Student Section shall elect the medical student trustee annually. The medical student trustee shall have all of the rights of a trustee to participate fully in meetings of the Board, including the right to make motions and to vote on policy issues, intra-Board elections or other elections, appointments or nominations conducted by the Board of Trustees.

3.5.6.1 Term. The medical student trustee shall be elected at the Business Meeting of the Medical Student Section prior to the Interim Meeting for a term of one year beginning at the close of the next Annual Meeting and concluding at the close of the second Annual Meeting following the meeting at which the trustee was elected.

3.5.6.2\ Re-election. The medical student trustee shall be eligible for re-election as long as the trustee remains eligible for medical student membership in AMA.

3.5.6.3 Cessation of Enrollment. The term of the medical student trustee shall terminate and the position shall be declared vacant if the medical student trustee should cease to be eligible for medical student membership in the AMA by virtue of the termination of the trustee's enrollment in an educational program. If the medical student trustee graduates from an educational program within 90 days prior to an Annual Meeting, the trustee shall be permitted to continue to serve on the Board of Trustees until completion of the Annual Meeting.

3.5.7 Young Physician Trustee. The young physician trustee shall be elected for a term of 4 years, and shall not serve for more than 2 terms.

3.5.7.1 Limitations. No candidate shall be eligible for election or reelection as the young physician trustee unless, at the time of election, he or she is under 40 years of age or within the first eight years of practice after residency and fellowship training, and is not a resident/fellow physician. A young physician trustee shall be eligible to serve on the Board of Trustees for the full term for which elected, even if during that term the trustee reaches 40 years of age or completes the eighth year of practice after residency and fellowship training.

3.5.8 Public Trustee. A public trustee shall be elected for a term of 4 years, and shall not serve for more than one term. A public trustee shall have all of the rights of a trustee to participate fully in meetings of the Board, including the right to make motions and to vote on policy issues, except that a public trustee shall not have the right to vote on intra-Board elections. A public trustee shall not be eligible for election as an officer of the Board of Trustees.

……..…

6.8 Election - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.

6.8.1 Nomination and Election. Members of these Councils, except the medical student member, shall be elected by the House of Delegates. Nominations shall be made by the Board of Trustees and may also be made from the floor by a member of the House of Delegates.

6.8.1.1 Separate Election. The resident/fellow physician member of these Councils shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

6.8.1.2 Other Council Members. With reference to each such Council, all nominees for election shall be listed alphabetically on a single ballot. Each elector shall have as many votes as there are members to be elected, and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer votes or more votes than the number of members to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if he or she has received a vote on a majority of the legal ballots cast and is one of the nominees receiving the largest number of votes within the number of members to be elected.

6.8.1.3 Run-Off Ballot. A run-off election shall be held to fill any vacancy that cannot be filled because of a tie vote.

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

6.8.1.5 Council Members to be Elected to Fill Vacancies after a Prior Ballot. The nomination and election of members of the Council to fill a vacancy that did not exist at the time of the prior ballot shall be held after election of other members of the Council, and shall follow the same procedure. Individuals elected to such vacancy shall be elected to a complete 4-year term. Unsuccessful candidates in the election for members of the Council shall automatically be nominated for subsequent elections to fill any such vacancy until all members of the Council have been elected. In addition, nominations from the floor shall be accepted.

6.8.2 Medical Student Member. Medical student members of these Councils shall be appointed by the Governing Council of the Medical Student Section with the concurrence of the Board of Trustees.

6.9 Term and Tenure - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.

6.9.1 Term.

6.9.1.1 Members other than the Resident/Fellow Physician Member and Medical Student Member. Members of these Councils other than the resident/fellow physician and medical student member shall be elected for terms of 4 years.

6.9.1.2 Resident/Fellow Physician Member. The resident/fellow physician member of these Councils shall be elected for a term of 3 years. Except as provided in Bylaw 6.11, if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.9.1.3 Medical Student Member. The medical student member of these Councils shall be appointed for a term of one year. Except as provided in Bylaw 6.11, if the medical student member ceases to be enrolled in an educational program at any time prior to the expiration of the term for which elected, the service of such medical student member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.9.2 Tenure. Members of these Councils may serve no more than 8 years. The limitation on tenure shall take priority over a term length for which the member was elected. Medical student members who are appointed shall assume office at the close of the Annual Meeting.

6.9.3 Vacancies.

6.9.3.1 Members other than the Resident/Fellow Physician and Medical Student Member. Any vacancy among the members of these Councils other than the resident/fellow physician and medical student member shall be filled at the next Annual Meeting of the House of Delegates. The successor shall be elected by the House of Delegates for a 4-year term.

6.9.3.2 Resident/Fellow Physician Member. If the resident/fellow physician member of these Councils ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates for a 3-year term. 6.10 Commencement of Term. Members of Councils who are elected by the House of Delegates shall assume office at the close of the meeting at which they are elected.

POLICIES

Policy G-610.010, Nominations
Guidelines for nominations for AMA elected offices include the following: (1) every effort should be made to nominate two or more eligible members for each Council vacancy; (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity; (3) the date for submission of nominations to the Council on Legislation, Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, Council on Science and Public Health, Council on Long Range Planning and Development, and Council on Ethical and Judicial Affairs is made uniform to March 15th of each year; (4) the announcement of the Council nominations and the official ballot should list candidates in alphabetical order by name only; and (5) nominating speeches for unopposed candidates for office, except for President-elect, should be eliminated.

Policy G-610.020, Rules for AMA Elections
(1) The Speaker and Vice Speaker of the House of Delegates are responsible for overall administration of our AMA elections, although balloting is conducted under the supervision of the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker will advise candidates on allowable activities and when appropriate will ensure that clarification of these rules is provided to all known candidates. The Speaker, in consultation with the Vice Speaker, is responsible for declaring a violation of the rules;

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

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

(4) An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates;

(5) A reduction in the volume of telephone calls from candidates, and literature and letters by or on behalf of candidates is encouraged. The use of electronic messages to contact electors should be minimized, and if used must allow recipients to opt out of receiving future messages;

(6) At the Interim Meeting, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited at the Interim Meeting. It is permissible at the Interim Meeting for candidates seeking election to engage in individual outreach, such as small group meetings, including informal dinners, meant to familiarize others with a candidate's opinions and positions on issues;

(7) Our AMA believes that: (a) specialty society candidates for AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides; (b) elected specialty society members should be identified in that capacity while serving their term of office; and (c) nothing in the

above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose;

(8) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside of the party venue, or (c) distributing stickers, buttons, etc. with the candidate's name on them. At these events, alcohol may be served only on a cash or no-host bar basis;

(9) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at campaign parties, and campaign literature may be distributed in the non-official business bag for members of the House of Delegates. No campaign literature shall be distributed and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates;

(10) Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. Campaign gifts can be distributed only at the Annual Meeting in the non-official business bag and at one campaign party. Campaign gifts should only be distributed during the Annual Meeting and not mailed to delegates and alternate delegates in advance of the meeting. The Speaker of the House of Delegates shall establish a limit on allowable expenditures for campaign-related gifts. In addition to these giveaway gifts, campaign memorabilia are allowed but are limited to a button, pin, or sticker. No other campaign memorabilia shall be distributed at any time;

(11) The Speaker's Office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker);

(12) At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place his or her name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker;

(13) Candidates for AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society;

(14) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities; and

(15) Our AMA (a) requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election; and (b) will expand accessibility to completed conflict of interest information by posting such information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.

Policy G-610.021, Guiding Principles for House Elections
The following principles provide guidance on how House elections should be conducted and how the selection of AMA leaders should occur:

(1) AMA delegates should: (a) avail themselves of all available background information about candidates for elected positions in the AMA; (b) determine which candidates are best qualified to help the AMA achieve its mission; and (c) make independent decisions about which candidates to vote for.

(2) Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable.

(3) Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.

(4) Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for AMA leadership positions.

(5) Incumbency should not assure the re-election of an individual to an AMA leadership position.

(6) Service in any AMA leadership position should not assure ascendancy to another leadership position.
Policy G-610.030, Election Process

AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at each Annual Meeting; (2) Poll hours will not be extended beyond the times posted. All delegates eligible to vote must be in line to vote at the time appointed for the close of polls; and (3) The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House.

APPENDIX C – Resolutions submitted at the 2019 Annual Meeting

RESOLUTION 603-A-19

Whereas, Members of our AMA House of Delegates cherish our democratic process; and
Whereas, Our current election and voting process for AMA officers and council positions consumes a lot of time and financial resources; and
Whereas, Election reform would allow for more time for policy and debate during HOD sessions; and
Whereas, Cost barriers are often an impediment to candidate elections; and
Whereas, There are significant technological advances that could allow for an expedited process of elections and debate; therefore be it

RESOLVED, That our American Medical Association appoint a House of Delegates Election Reform Committee to examine ways to expedite and streamline the current election and voting process for AMA officers and council positions; and be it further

RESOLVED, That such HOD Election Reform Committee consider, at a minimum, the following options:

- The creation of an interactive election web page;
- Candidate video submissions submitted in advance for HOD members to view;
- Eliminate all speeches and concession speeches during HOD deliberations, with the exception of the President-Elect, Speaker and Board of Trustee positions;
- Move elections earlier to the Sunday or Monday of the meeting;
- Conduct voting from HOD seats; and be it further

RESOLVED, That our AMA review the methods to reduce and control the cost of campaigns; and be it further

RESOLVED, That the HOD Election Reform Committee report back to the HOD at the 2019 Interim Meeting with a list of recommendations.

RESOLUTION 611-A-19

Whereas, There is an arms race in terms of the number of emails, social media posts, handwritten notes and mailers which consumes thousands of hours of time when candidates and their team could be participating in online testimony and preparing for the AMA meeting; and
Whereas, Our candidates attend up to 30 interviews across the Federation consuming at least 5 hours of interview time alone not including traveling time; and
Whereas, Most have an “entourage” of 2 to 15 people which means that at least 10-75 hours of time is taken from their participation in their delegation deliberations and debate; and
Whereas, For the elections in 2018 with 24 people running in competitive elections this amounted to about 1800 hours of lost time at the meeting; and
Whereas, This time is a gross underestimation of the time involved given the walking between sessions; and
Whereas, This does not take into account the time taken from each delegation to participate in the interview process and the time spent waiting for candidates; and
Whereas, Candidates and campaign teams remain distracted by their campaigns throughout the reference committees and even during the business of the House of Delegates; and
Whereas, Even after the primary election, runoffs can consume a tremendous amount of time since they are done with paper; and
Whereas, Sponsoring societies spend extensive resources in the form of time and money to support their individual candidates; and
Whereas, Many qualified candidates from the House of Delegates have chosen not to run campaigns because the burden in terms of money and manpower are prohibitive; and
Whereas, The election process has not been updated in several years despite both our House otherwise going paperless and additional security and technology advancements during that time; and
Whereas, Many specialty societies already hold web-based or device-based elections with no perceived violation of security or confidence in the outcome; therefore be it

RESOLVED, That our American Medical Association create a speaker-appointed task force to re-examine election rules and logistics including regarding social media, emails, mailers, receptions and parties, ability of candidates from smaller delegations to compete, balloting electronically, and timing within the meeting, and report back recommendations regarding election

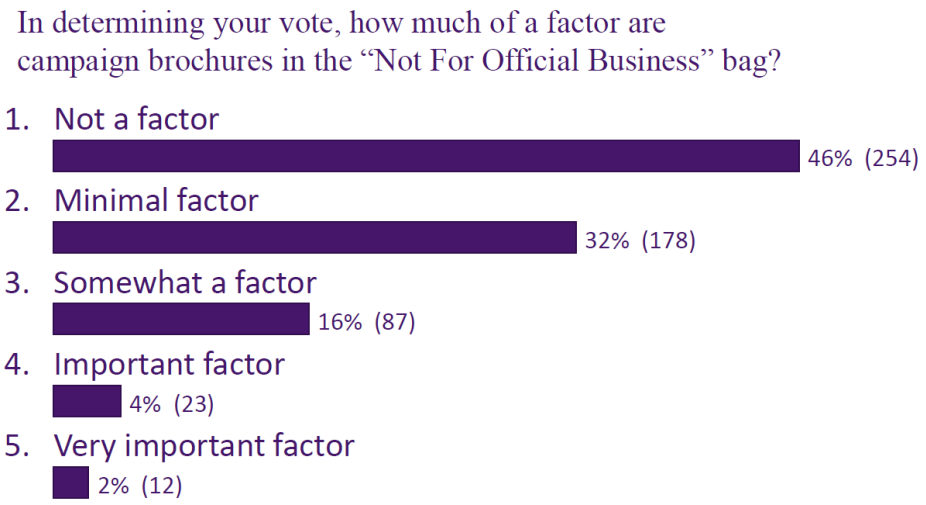
processes and procedures to accommodate improvements to allow delegates to focus their efforts and time on policy-making; and be it further

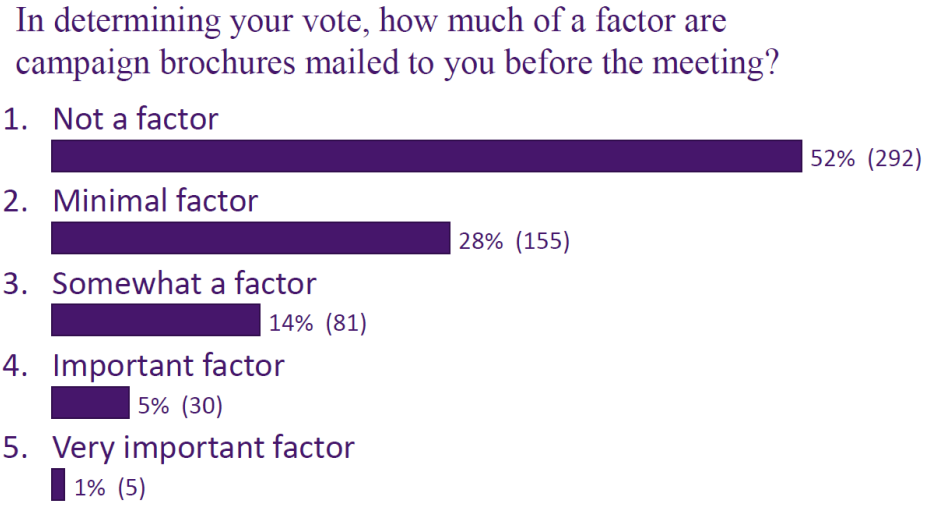
RESOLVED, That our AMA's speaker-appointed task force consideration should include addressing (favorably or unfavorably) the following ideas:

a. Elections being held on the Sunday morning of the annual and interim meetings of the House of Delegates.
b. Coordination of a large format interview session on Saturday by the Speakers to allow interview of candidates by all interested delegations simultaneously.
c. Separating the logistical election process based on the office (e.g. larger interview session for council candidates, more granular process for other offices)
d. An easily accessible system allowing voting members to either opt in or opt out of receiving AMA approved forms of election materials from candidates with respect to email and physical mail.
e. Electronic balloting potentially using delegates' personal devices as an option for initial elections and runoffs in order to facilitate timely results and minimal interruptions to the business.
f. Seeking process and logistics suggestions and feedback from HOD caucus leaders, non-HOD physicians (potentially more objective and less influenced by current politics in the HOD), and other constituent groups with a stake in the election process.
g. Address the propriety and/or recommended limits of the practice of delegates being directed on how to vote by other than their sponsoring society (e.g. vote trading, block voting, etc.) (Directive to Take Action); and be it further

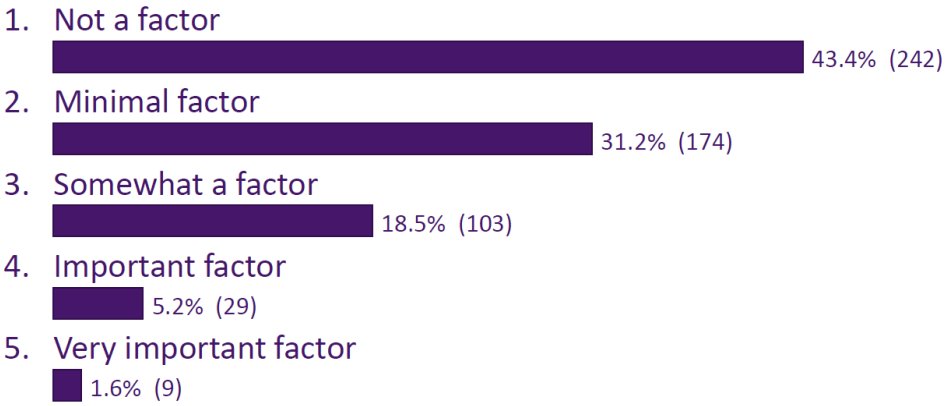
RESOLVED, That the task force report back to the HOD at the 2019 Interim Meeting.

APPENDIX D – Questions and responses from I-19 survey of the House of Delegates

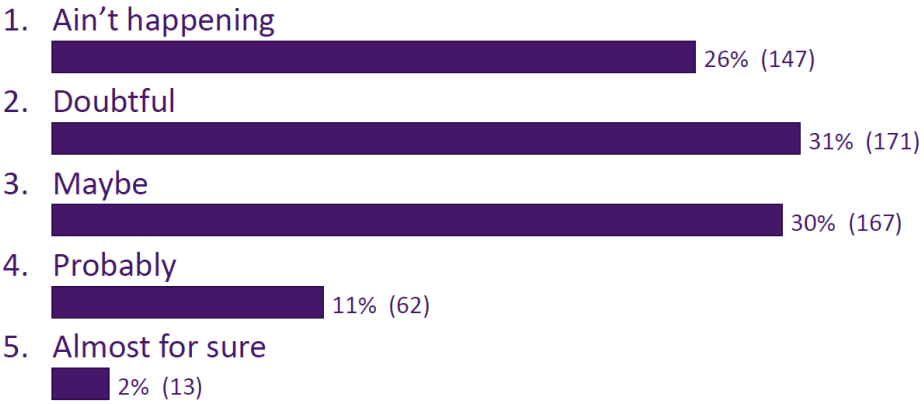




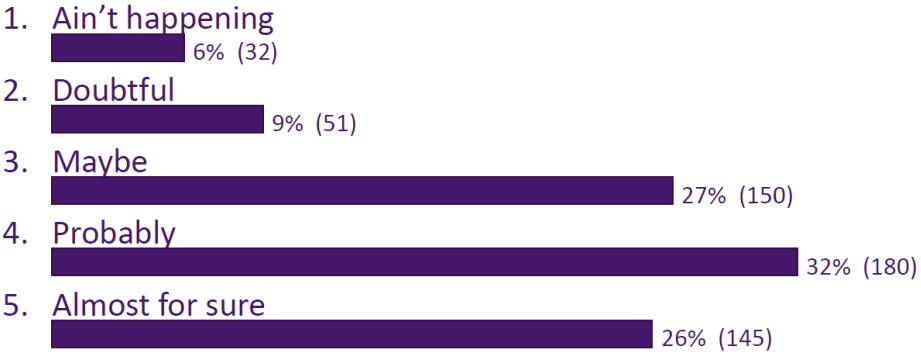
In determining your vote, how much of a factor are campaign materials emailed to you before the meeting?



How likely are you to look at candidates' websites?



How likely are you to look at an enhanced AMA Elections website that would include links to the candidates' website and answers to specific questions given to candidates in advance?



In determining your vote, how much of a factor is the interview process?

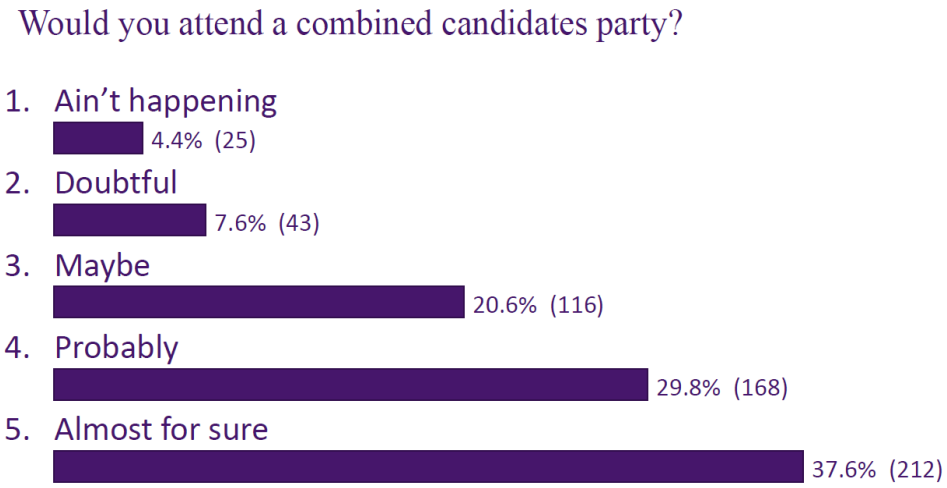
1. Not a factor
   3% (15)
2. Minimal factor
   5% (27)
3. Somewhat a factor
   16% (92)
4. Important factor
   33% (185)
5. Very important factor
   43% (242)

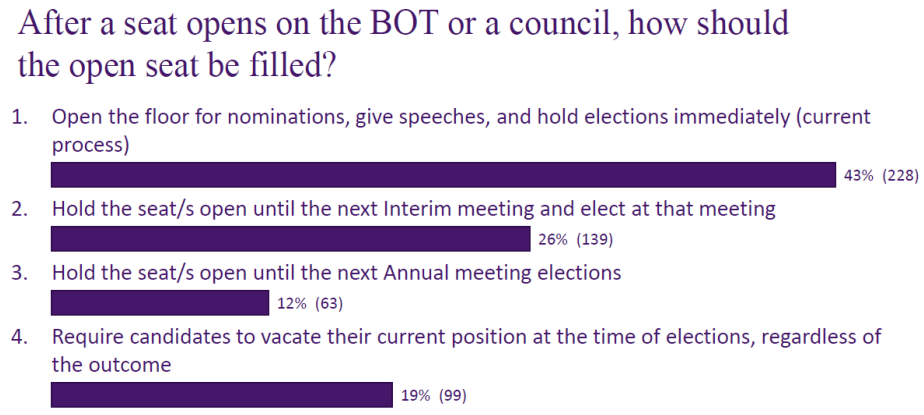
In determining your vote, how much of a factor are campaign receptions?

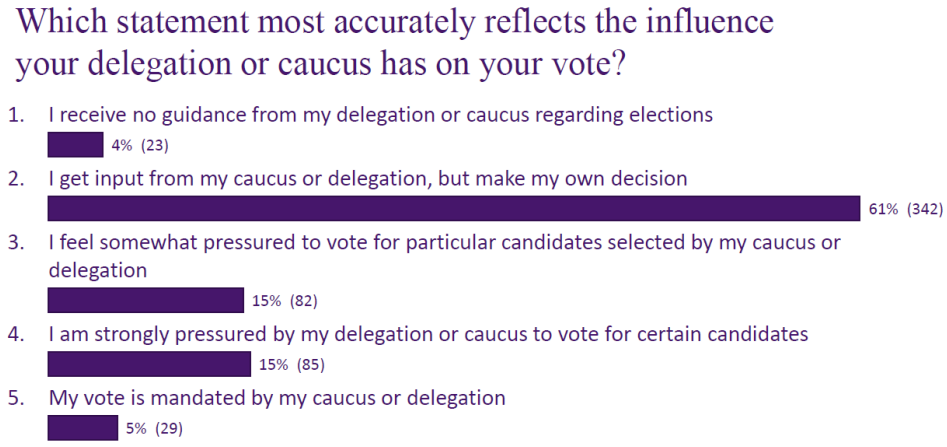
1. Not a factor
   33.3% (185)
2. Minimal factor
   27.5% (153)
3. Somewhat a factor
   21.8% (121)
4. Important factor
   9.7% (54)
5. Very important factor
   7.7% (43)

In determining your vote, how much of a factor are small group dinners and/or gatherings in suites at Interim, State Advocacy and NAC?

1. Not a factor
   27% (151)
2. Minimal factor
   23% (128)
3. Somewhat a factor
   27% (149)
4. Important factor
   18% (97)
5. Very important factor
   5% (25)







Appendix E - Newly Opened Positions - Options Considered

Three potential solutions for newly created vacancies ("pop-ups") were initially considered: requiring candidates seeking another office to resign their current position; leaving the open seat vacant until the following Annual Meeting; and modifying the

procedures for handling new vacancies. Each of these options were discussed at the I-19 Open Forum and were the subject of a question on the survey of the House. Each option received support and opposition, with no consensus reached, but a majority favored some change over the current process. The first two options would require bylaws changes. Ultimately the ETF developed a new fourth option based upon newly available voting technology that allows sequential voting with nearly instantaneous results and rapid ballot preparation which eliminates most of the problems associated with "pop-ups" without necessitating the more radical changes associated with any of the three options presented at I-19. Below is a discussion of each of the options that were considered, three of which are not recommended.

Requiring candidates to resign their current positions would address the problematic aspects of these "pop-up" elections. Because all vacancies would be known well in advance, elections could proceed as usual, without additional nominations or speeches, candidates would be known in advance to allow time for proper vetting through the usual interview process, and the possibility of opening a new seat on a council would no longer be a consideration in voting as the seat would be open regardless of the election outcome. To be clear, the incumbent seeking a new position would not resign until the close of the Annual Meeting at which the elections took place, which is when all newly elected officials take office. Questions about the fairness of such a requirement arose, particularly as some officer positions open relatively infrequently as is the case for the offices of Speaker and Vice Speaker, which while elected annually, tend to come open only every four years. In addition, this would potentially mean the tenure of some of our most talented council members (those that feel qualified to seek higher office) would be truncated or alternatively, council members would delay running for higher office until serving their full tenure thus reducing opportunities for new council members and reducing candidates running for higher office. In addition, at the trustee level, this would likely discourage current trustees from running for president-elect "early" and may lead to less contested races for the president-elect position. Some commented in favor of this option, but many found the idea of forcing candidates to resign from current positions in order to run unacceptable. Another concern is whether this requirement would just be implemented for current members of elected councils or would it also apply to members of appointed councils and the Board - either creating a disparity or forcing even more resignations. In the end, the ETF felt this option pressed an unacceptable dichotomy - of the loss of tenured leaders or elected members consistently staying for their full term with less opportunity for new leaders and fewer contested elections.

The second option, namely leaving the vacancy until the following meeting was supported by some during the Open Forum and on the survey. The bylaws treat vacancies arising from the resignation or death of an officeholder differently than election-related vacancies, which suggests it is not the vacancy per se that generates concerns. Twice in the past eleven years a member of the Board of Trustees resigned and created a vacancy lasting several months. For a vacancy that occurred in the spring, the Board did not feel it necessary to appoint a trustee as permitted under AMA's bylaws, and for a vacancy that arose in the fall, neither the Board nor the Committee on Rules and Credentials thought a special election was needed. Vacancies on the elected councils remain unfilled until elections are held at the next Annual Meeting (see Bylaw 6.9.3.1). As a practical matter none of the elected councils has experienced a vacancy in the last 13 years, so it is difficult to judge if a vacancy would undermine the council's effectiveness. Recently 2 members with unexpired terms on a single council ran for the Board. Would different rules be necessary to handle the situation where multiple seats were vacant vs. a single seat? It was unclear how to handle term and tenure of members elected at the half year and the ETF wanted to keep the Interim Meetings free of elections, so any vacancy would remain for a full year until the next Annual Meeting. Informal discussion with current and past council members suggested that vacancies while not untenable would be undesirable.

The third option discussed, altering the procedures for handling new vacancies, takes two forms. One possibility would be to take nominations immediately after the vacancy is announced, have the nominees make necessary speeches immediately and then move at once to voting. This would address concerns about electioneering and vote trading but further reduces opportunity to vet the candidates. The other possibility would be to call for nominations immediately but to delay voting to the next day, which would currently be Wednesday. This would permit the possibility of interviews, but Tuesday is a full day and the inauguration is Tuesday night, making it unlikely many would interview the candidates. It is also conceivable that a meeting that would otherwise adjourn on Tuesday because the business had been accomplished would have to carry over to the next morning solely for elections. (The task force believes that speedier elections might lead to a Tuesday adjournment; see "Technology" below.) The ETF did not favor moving the date of the main elections from Tuesday and even if moved to Monday with "pop-ups" on Tuesday this would mean elections would be the focus of two HOD sessions contrary to the goal to lessen the distraction from policy deliberation.

The ETF favored a process that encouraged or required candidates to announce their intention to run for potentially newly opened positions but avoided the negatives of the previously discussed options. To accomplish this, members would have to be alerted to potential openings and then allowed to join the campaign. Some would argue that candidates already "announce" that they intend to run if a seat opens just not officially. Formalizing this announcement process would provide greater transparency. Presumably, this would mean more interviews. Likely, these candidates would not go to the same expense and effort of a regular campaign (seen as one of the advantages of being a pop-up). In studying options for use of technology to expedite voting (another specific charge of the ETF), the ETF discovered a novel solution to this issue, as presented in the main body of this report and recommended.

Appendix F - Day of Elections - Options Considered

The following is the ETF discussion regarding moving the day of the elections to an alternative day/time. After the review detailed below, the ETF recommended continuing elections on Tuesday morning while instituting other reforms including electronic voting and the "Election Session."

One of the specific requests of Resolutions 603-A19 and 611-A19 which established the ETF, was to consider moving the day/date of the elections earlier, arguing that this would reduce the number of receptions, interviews, disruption of policy consideration and overall reduce the focus of the meeting away from elections to policy. Current rules specify elections will be on Tuesday (time is determined by Speaker) so a rule change would be required.

Options:

Move elections to Interim - fewer delegates attend. Shorter meeting. Geographic bias in any given year may affect attendance and outcome. Terms of office begin when? Councils and BOT use annual to annual as their planning cycle. This would politicize the interim meeting. Would not correct the concern regarding the "distraction from policy discussion" and may extend the length of Interim meeting.

Saturday voting – little time to meet candidates, particularly lesser known or from small delegations. Vetting process would be truncated or if in-person interviews are to continue, they would likely need to be moved to Friday morning or even Thursday (lengthening the meeting for candidates and interviewers). Would increase reliance on the 2-minute speech before HOD. Less opportunity for interaction with candidates. Potentially less informed voters. Seems to carry many of the disadvantages of "pop ups" which many have spoken against. Saturday is the first day the House convenes and nominations occur this day. Nominations "from the floor" are allowed by our rules - if a candidate is nominated on Saturday and then voting occurs there would be no opportunity to vet that candidate.

Sunday voting – already a very full day. Brief HOD session then reference committee hearings all day. Voting would lengthen the HOD session and delay the start of reference committees; thus, the reports which already take well into the early morning to prepare so they can be reviewed by the delegates would be delayed as well. Little time to vet candidates without moving interviews forward. Receptions would simply start a night earlier.

Monday voting – morning is filled with caucus meetings to review reference committee reports. Moving HOD session start time forward to allow time for elections would reduce time for policy discussion in and among delegations. Monday is already a short day of policy debate (typically 3.5 hrs or less) and provides some insight into remaining business. Some delegates prioritize the elections and might even go home if their candidate is unsuccessful. Would unsuccessful candidates awkwardly continue at the meeting? Would the afternoon be spent with congratulations to the winners (which often takes place at the President's reception Tuesday night), distracting from policy debate? If we move the President's inaugural and dinner to Monday, as has been suggested, the afternoon would need to end by 3 or so (likely meaning minimal or no policy discussion time that day).

Tuesday voting – keep current day but improve the process using technology and rules to expedite the voting including runoffs. Eliminate "pop-up" elections and the associated speeches. Designate an election session early morning with HOD resuming business afterwards lessening the concern for distraction and interruption of policy debate. Provides maximum time for vetting the candidates. Allows for the President's reception to continue as scheduled on Tuesday night.

Appendix G – Reconciliation of Policies Related to Elections

Policy G-610.010, Nominations
Guidelines for nominations for AMA elected offices include the following: (1) every effort should be made to nominate two or more eligible members for each Council vacancy; (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity; (3) the date for submission of ~~nominations to~~ applications for consideration by the Board of Trustees at their April meeting for the Council on Legislation, Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, Council on Science and Public Health, Council on Long Range Planning and Development, and Council on Ethical and Judicial Affairs is made uniform to March 15th of each year; (4) the announcement of the Council nominations and the official ballot should list candidates in alphabetical order by name only;

Policy G-610.020, Rules for AMA Elections
(1) The Speaker and Vice Speaker of the House of Delegates are responsible for overall administration of our AMA elections, although balloting is conducted under the supervision of the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker will advise candidates on allowable activities and when appropriate will ensure that clarification of these rules is provided to all known candidates. The Speaker, in consultation with the Vice Speaker and the Election Committee, is responsible for declaring a violation of the rules;

(2) Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers, generally by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and

no more: the candidate's name, photograph, email address, URL, the office sought and a list of endorsing societies. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed in the venue where the House of Delegates meets. Announcements sent by candidates to members of the House are considered campaigning and are specifically prohibited prior to the start of active campaigning. The Speakers may use additional means to make delegates aware of those members intending to seek election;

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

(4) An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual will provide a link to the AMA Candidates' Page, but links to personal, professional or campaign related websites will not be allowed. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates;

(5) A reduction in the volume of telephone calls and electronic communication from candidates~~, and literature and letters by or~~ and on behalf of candidates is encouraged. The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of electronic messages to contact electors should be minimized, and if used must include a simple mechanism to allow recipients to opt out of receiving future messages;

(6) At any AMA meeting convened prior to the time period for active campaigning ~~the Interim Meeting~~, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited ~~at the Interim Meeting~~. It is permissible ~~at the Interim Meeting~~ for candidates seeking election to engage in individual outreach~~, such as small group meetings, including informal dinners,~~ meant to familiarize others with a candidate's opinions and positions on issues;

(7) Our AMA believes that: (a) specialty society candidates for AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides; (b) elected specialty society members should be identified in that capacity while serving their term of office; and (c) nothing in the above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose;

(8) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside of the party venue~~, or (c) distributing stickers, buttons, etc. with the candidate's name on them~~. At these events, alcohol may be served only on a cash or no-host bar basis;

(9) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at a single campaign reception at which the candidate is featured ~~parties, and campaign literature may be distributed in the non official business bag for members of the House of Delegates~~. No campaign literature shall be distributed in the House of Delegates and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates;

(10) Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. ~~Campaign gifts can be distributed only at the Annual Meeting in the non-official business bag and at one campaign party. Campaign gifts should only be distributed during the Annual Meeting and not mailed to delegates and alternate delegates in advance of the meeting. The Speaker of the House of Delegates shall establish a limit on allowable expenditures for campaign-related gifts. In addition to these giveaway gifts, campaign memorabilia are allowed but are limited to a button, pin, or sticker. No other c~~Campaign memorabilia and giveaways that include a candidate's name or likeness may not ~~shall~~ be distributed at any time;

(14) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities; and

(15) Our AMA (a) requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election; and (b) will expand accessibility to completed conflict of interest information by posting such

information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.

Policy G-610.021, Guiding Principles for House Elections
The following principles provide guidance on how House elections should be conducted and how the selection of AMA leaders should occur:

(1) AMA delegates should: (a) avail themselves of all available background information about candidates for elected positions in the AMA; (b) determine which candidates are best qualified to help the AMA achieve its mission; and (c) make independent decisions about which candidates to vote for.

(2) Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable. This principle applies between as well as within caucuses and delegations.

(3) Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.

(4) Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for AMA leadership positions.

(5) Incumbency should not assure the re-election of an individual to an AMA leadership position.

(6) Service in any AMA leadership position should not assure ascendancy to another leadership position

(7) Delegations and caucuses when evaluating candidates may provide information to their members encouraging open discussion regarding the candidates but should refrain from rank order lists of candidates.

(8) Delegations and caucuses should be a source of encouragement and assistance to qualified candidates. Nomination and endorsement should be based upon selecting the most qualified individuals to lead our AMA regardless of the number of positions up for election in a given race. Delegations and caucuses are reminded that all potential candidates may choose to run for office, with or without their endorsement and support.

Policy G-610.030, Election Process
AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at each Annual Meeting; (2) ~~Poll hours will not be extended beyond the times posted.~~ All delegates eligible to vote must be seated within the House~~in line to vote~~ at the time appointed to cast their electronic votes~~for the close of polls~~; and (3) The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House.

REPORTS OF THE SPEAKERS

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

1. REPORT OF THE ELECTION TASK FORCE

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

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy G-610.020

At the June 2021 Special Meeting, the report of the Election Task Force (Speakers' Report 2) substantially revised the rules regarding nominations and elections. (See the updated policy in the appendix.) The following recommendation, dealing with interviews, was referred with a request for more detail.

> Delegations and caucuses may conduct interviews by virtual means in advance of the Annual Meeting of the House of Delegates during a period of time to be determined by the Speaker in lieu of in-person interviews at the meeting. Delegations and caucuses may choose either method, but not both for a given race. Groups electing to interview candidates for a given position must provide an equal opportunity for all candidates for that position who have announced their intention to be nominated at the time interviews are scheduled, to be interviewed using the same format and platform. An exception being that a group may elect to meet with a candidate who is from their own delegation without interviewing other candidates. Recording of virtual interviews must be disclosed to candidates prior to recording and may only be recorded with candidate consent. Interview recordings may only be shared with members of the interviewing caucus/group.

Testimony was generally supportive of continuing the option of virtual interviews and most of the details provided in the recommendation, but concerns were expressed regarding the lack of specificity of the interview time period. Such matters as excessive demands on candidates, time zone differences between interviewers and interviewees, and interference with clinical duties underlay the referral. This report provides recommendations for the conduct of virtual interviews, proposing limits and expectations for fairness.

BACKGROUND

Interviews are generally regarded as the best tool by which to measure candidates and select those for whom one will vote. As both the 2020 and 2021 Annual Meetings were cancelled due to COVID, the speakers recorded interviews with candidates and made them available through the AMA website. The speakers also laid out rules to facilitate virtual interviews with candidates that were conducted by various caucuses and delegations.

The virtual interviews were viewed favorably and not simply as substitutes for the in-person interviews typically conducted during the Annual Meeting. The Task Force report recommended continuation of the virtual interviews as an option even after return to in-person meetings, and comments during this past June's special meeting supported the use of virtual interviews by delegations provided a standard set of rules could be implemented.

PROPOSALS FOR VIRTUAL INTERVIEWS

The Task Force had proposed that all interviews by a delegation or caucus for a given office be conducted by the same means: either in-person (onsite at the Annual Meeting) or virtually, before arriving in Chicago for the Annual Meeting. This was done in the interest of fairness, and as no comments were heard on this topic, the recommendation will be retained. Delegations and caucuses should continue to be allowed to select the method of interviews that best suits their needs.

During testimony at the June 2021 Special Meeting concerns were raised regarding the days and times during which virtual interviews may be conducted. The referred recommendation stated that virtual interviews would be conducted "during a period of time to be determined by the Speaker." Comments were heard that virtual interviews conducted before the June 2020 and June 2021 Special Meetings were spread over too long a period of time, that the dates were

not known in advance and that some interview times interfered with clinical duties particularly for those in the Pacific and Eastern time zones. To address these concerns your speakers recommend a defined, relatively short window of dates for virtual interviews and interview times to be scheduled outside regular clinical hours. Meanwhile in-person interviews at the meeting will continue to be an option.

To allow candidates and delegations to plan, a specific window of dates should be defined. Both candidates and interviewers expressed a preference for interview dates relatively close to the opening of the Annual Meeting including the option of weekend interviews. Interviews should not be conducted the week immediately preceding the meeting which is typically busy with other responsibilities, including section and council meetings along with travel. Therefore, the window for virtual interviews is recommended to begin on the Friday evening of the second weekend immediately preceding the scheduled opening session of the House of Delegates meeting at which elections will take place and end on the Sunday evening of the weekend immediately preceding the meeting. Virtual interviews may only be scheduled during this defined period, beginning 15 days before and ending six days before the meeting opens. This window includes two weekends and six weeknights.[1] Should a planned in-person meeting be cancelled, the window could open a week earlier, effectively doubling the time available for interviews. Discretion should be granted to the speaker to address special situations such as this.

To avoid interfering with candidates' professional responsibilities, especially patient care and related clinical duties, interviews conducted on a weeknight (ie, Monday through Friday) must be scheduled between 5 pm and 10 pm based on the candidate's (ie, the person being interviewed) local time. Interviews conducted on weekends must be scheduled between 8 am and 10 pm based on the candidate's local time. Recognizing that physicians often have clinical duties outside of regular business hours, candidates and interviewers are encouraged to be flexible in scheduling interviews. Other times outside of these hours must be acceptable to both parties. Caucuses and delegations scheduling interviews for candidates within the parameters above are not obligated to offer alternatives but are encouraged to do so if possible. Candidates are encouraged to make themselves available for these interview windows to the extent possible but are entitled to decline any interview request.

The Office of House of Delegates Affairs compiles candidate contact information, including that for the candidate's campaign team. The information will be provided to groups wishing to interview candidates. Groups wishing to conduct interviews must designate their interviewing coordinator and provide the individual's contact information to the Office of House of Delegates Affairs. This list will then be shared with all declared candidates. It is incumbent on the candidates to schedule their individual interviews. The Office of House of Delegates Affairs will continue to create an interview schedule for officer candidates in opposed races for those regional caucuses and sections electing to interview in-person.

Policy G-610.020 sets clear guardrails around announcements of candidacy, meaning candidate contact information will be available well before the interviewing window opens. While interviews may not be conducted outside the window, interviewers will be allowed to contact candidates to set up interviews any time after the publication of the election manual, typically in mid-April.

Other relevant elements for interviews

The referred language includes additional elements that merit discussion, namely the format and platform used, the recording of interviews, and the sharing of those recordings. None of these items drew criticism at June's meeting.

A foundational concept for the Task Force was to provide a level playing field for all candidates. Seeking to ensure fairness, the Task Force recommended that all candidates for a given office be interviewed using the same format, so all candidates for a given office must be interviewed either in-person or virtually. Interviewers are free to use either modality, with candidates for some offices interviewed online and candidates for other offices interviewed onsite, but the chosen modality applies to all candidates for a given office. To be clear, an interviewing group is also free to use only virtual or only in-person interviews for all candidates. All virtual interviews for a given office must also be conducted on the same or similar platform, for example, all audio only or by video with audio. The choice of platform to be used should be confirmed when an interview is arranged; flexibility to accommodate availability of specific platforms (Teams, Zoom, etc.) is encouraged.

[1] For example, the 2021 Annual Meeting was scheduled to begin on Saturday, June 12, which means the interviewing window would have run from the evening of Friday, May 28 through Sunday, June 6.

Recognizing that delegations have a special relationship with their own members who may be candidates, the Task Force proposed an exception to the requirement to interview all candidates for a particular office. This exception allows the interviewing group to meet with a candidate who is a member of their group without interviewing other candidates for the same office. No objections were raised during testimony, and this exception is recommended to be retained.

Questions have been raised regarding what constitutes an interview and what does not. This arises from the fact that some campaigns request informal opportunities for their candidate to "stop by and introduce themselves" at a delegation or caucus meeting. This often evolves into a spontaneous interview which may not be offered to the other candidates in the same race or may occur when the same delegation has already conducted their interviews for that race. Your speakers believe further clarification is in order. For clarity, any appearance by a candidate before an organized meeting of a caucus or delegation, other than their own, would be considered an interview and fall under the rules for interviews as recommended below.

Notwithstanding various state laws that allow one party to record an interaction, the Task Force favored full transparency for these interviews and recommended that an interview be recorded only with the full knowledge and agreement of the candidate. No instances in which a candidate declined to be recorded have been reported, but nonetheless, the choice to be recorded should lie with the interviewee / candidate. In those cases where the interview is recorded, it may not be shared outside the group—whether a caucus or a delegation—that conducted the interview.

Late announcing candidates

Under the newly adopted election rules (G-610.020, ¶ 4) candidates are officially announced by the Office of House of Delegates Affairs at defined times. Individuals may make an independent announcement of candidacy only after active campaigning is allowed. As previously specified in the referred recommendation, groups conducting interviews with candidates for a given office are required to offer an interview to all individuals that have officially announced their candidacy at the time the group's interview schedule is finalized. Interviewing groups may, but are not required to, interview late announcing candidates. Should an interview be offered to the late candidate, all other announced candidates for the same office (even those previously interviewed) must be afforded the same opportunity. Offering a late announced candidate an opportunity to interview at a different time (perhaps closer to the election) or in a different format (in-person at the meeting itself) could be perceived as an unfair advantage. While our rules continue to allow for late announcements of candidacy, up to and including nomination at the opening session of the House, given the opportunities to announce one's candidacy in advance, late announcements should be extremely rare and should not provide an advantage to such candidates. Thus, the focus of this recommendation is on fairness for all candidates by encouraging transparency and facilitating full vetting of candidates and should be retained.

TECHNICAL CORRECTION TO POLICY G-610.020

While dealing with the election rules, your speakers have become aware of the need for a correction to language that was adopted in June. The rules previously required candidates to complete a conflict of interest (COI) disclosure before election, and that part of the policy was reaffirmed. Language in a different recommendation adopted in June would require individuals submitting an announcement of candidacy to include "their conflict of interest statement" along with the announcement. Insofar as the COI disclosure is collected in the year of the election and is not necessary for an announcement, that language should be stricken from paragraph 4 of the policy.

RECOMMENDATIONS

This report from your speakers spells out the expectations for interviews, particularly virtual interviews, conducted with those seeking election to leadership positions within our AMA. It is recommended that Policy G-610.020 be amended by addition and deletion to read as follows and the remainder of this report be filed. [Note: Paragraph numbers will be editorially corrected as required.]

(4) Candidates may notify the HOD Office of their intention to run for potential newly opened positions, as well as any scheduled open positions on any council or the Board of Trustees, at any time by submitting an announcement card ~~and their conflict of interest statement~~ to the House Office. They will then be included in all subsequent projections of announcements before the House, "Official Candidate Notifications," and in any campaign activity that had not yet been finalized. All previously announced candidates will continue to be

included on each Official Announcement Date. Any candidate may independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than at the specified times.

…

(11) The Speaker's Office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker). Groups wishing to conduct interviews must designate their interviewing coordinator and provide the individual's contact information to the Office of House of Delegates Affairs. The Speaker's Office will collect contact information for groups wishing to conduct interviews as well as for candidates and their campaign teams and will provide the information as requested.

(12) Interviews conducted with current candidates must comply with the following rules:

a. Interviews may be arranged between the parties once active campaigning is allowed.
b. Groups conducting interviews with candidates for a given office must offer an interview to all individuals that have officially announced their candidacy at the time the group's interview schedule is finalized.
    i. A group may meet with a candidate who is a member of their group without interviewing other candidates for the same office.
    ii. Interviewing groups may, but are not required to, interview late announcing candidates. Should an interview be offered to a late candidate, all other announced candidates for the same office (even those previously interviewed) must be afforded the same opportunity and medium.
    iii. Any appearance by a candidate before an organized meeting of a caucus or delegation, other than their own, will be considered an interview and fall under the rules for interviews.
c. Groups may elect to conduct interviews virtually or in-person.
d. In-person interviews may be conducted between Friday and Monday of the meeting at which elections will take place.
e. Virtual interviews are subject to the following constraints:
    i. Interviews may be conducted only during a window beginning on the Thursday evening two weeks prior to the scheduled Opening Session of the House of Delegates meeting at which elections will take place and must be concluded by that Sunday (four days later).
    ii. It is encouraged that interviews be conducted on weeknights between 5 pm and 10 pm or on weekends between 8 am and 10 pm based on the candidate's local time, unless another mutually acceptable time outside these hours is arranged.
    iii. Caucuses and delegations scheduling interviews for candidates within the parameters above must offer alternatives to those candidates who have conflicts with the scheduled time.
f. Recording of interviews is allowed only with the knowledge and consent of the candidate.
g. Recordings of interviews may be shared only among members of the group conducting the interview.
h. A candidate is free to decline any interview request.
i. In consultation with the Election Committee, the Speaker, or where the Speaker is in a contested election, the Vice Speaker, may issue special rules for interviews to address unexpected situations.

APPENDIX A – Policy G-610.020, Rules for AMA Elections

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

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

(3) Announcement cards of all known candidates will be projected on the last day of the Annual and Interim Meetings of our House of Delegates and posted on the AMA website as per Policy G 610.020, paragraph 2. Following each meeting, an "Official Candidate Notification" will be sent electronically to the House. It will include a list of all announced candidates and all potential

newly opened positions which may open as a result of the election of any announced candidate. Additional notices will also be sent out following the April Board meeting and on “Official Announcement Dates” to be established by the Speaker.

(4) Candidates may notify the HOD Office of their intention to run for potential newly opened positions, as well as any scheduled open positions on any council or the Board of Trustees, at any time by submitting an announcement card and their conflict of interest statement to the House Office. They will then be included in all subsequent projections of announcements before the House, “Official Candidate Notifications” and in any campaign activity that had not yet been finalized. All previously announced candidates will continue to be included on each Official Announcement Date. Any candidate may independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than at the specified times.

(5) The Federation and members of the House of Delegates will be notified of unscheduled potential newly opened positions that may become available as a result of the election of announced candidates. Candidates will be allowed to announce their intention to run for these positions.

(6) If a potential newly opened position on the Board or a specified council does not open but there are other open positions for the same council or the Board, an election will proceed for the existing open seats. Candidates will be offered the opportunity to withdraw their nomination prior to the vote. If there are no scheduled open seats on the Board or specified council for which a potential newly opened position is announced and if the potential newly opened position does not open (i.e., the individual with the unexpired term is not elected to the office they sought), no election for the position will be held. In the event that a prior election results in a newly opened position without a nominated candidate or more positions are open than nominated candidates, the unfilled position/s would remain unfilled until the next Annual Meeting.

(7) The AMA Office of House of Delegates Affairs will provide an opportunity for all announced candidates to submit material to the HOD office which will then be sent electronically by the HOD Office in a single communication to all delegates and alternates. Parameters regarding content and deadlines for submission will be established by the Speaker and communicated to all announced candidates.

(8) Our AMA believes that: (a) specialty society candidates for AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides; (b) elected specialty society members should be identified in that capacity while serving their term of office; and (c) nothing in the above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose.

(9) An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual will provide a link to the AMA Candidates’ Page, but links to personal, professional or campaign related websites will not be allowed. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates.

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

(11) The Speaker's Office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker).

(12) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities.

(13) Campaign memorabilia may not be distributed in the Not for Official Business (NFOB) bag.

(14) Campaign materials may not be distributed by postal mail or its equivalent. The AMA Office of House of Delegates Affairs will no longer furnish a file containing the names and mailing addresses of members of the AMA-HOD. Printed campaign materials will not be included in the “Not for Official Business” bag and may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials.

(15) A reduction in the volume of telephone calls and electronic communication from candidates and on behalf of candidates is encouraged. The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of electronic

messages to contact electors should be minimized, and if used must include a simple mechanism to allow recipients to opt out of receiving future messages.

(16) Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. Campaign memorabilia and giveaways that include a candidate's name or likeness may not be distributed at any time.

(17) Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies, state and regional delegations and health related causes that do not include any candidate identifier. These pins should be small, not worn on the badge and distributed only to members of the designated group. General distribution of any pin, button or sticker is disallowed.

(18) At any AMA meeting convened prior to the time period for active campaigning, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited. It is permissible for candidates seeking election to engage in individual outreach meant to familiarize others with a candidate's opinions and positions on issues.

(19) Candidates for AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society.

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

(21) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, OR (b) appearing by name or in a picture on a poster or notice in or outside of the party venue. At these events, alcohol may be served only on a cash or no-host bar basis.

(22) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at a single campaign reception at which the candidate is featured. No campaign literature shall be distributed in the House of Delegates and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates.

(23) At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place his or her name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker.

(24) Our AMA (a) requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election; and (b) will expand accessibility to completed conflict of interest information by posting such information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.

2. ESTABLISHING AN ELECTION COMMITTEE

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

HOUSE ACTION: REFERRED FOR DECISION

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

> In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 7 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime maximum tenure of 8 terms) to report to the Speaker. These individuals would agree not to be directly involved in a campaign during their tenure and would

be appointed from various regions, specialties, sections, and interest groups. The primary role of the committee would be to work with the Speakers to adjudicate any election complaint. Additional roles to be determined by the Speaker and could include monitoring election reforms, considering future campaign modifications and responding to requests from the Speaker for input on election issues that arise.

The recommendation is recorded as Paragraph 5 in Policy D-610.998, "Directives from the Election Task Force."

The Speakers determined that the term of each committee member should run from June to June, starting and ending with the adjournment of the HOD meeting, and initial appointments, including the chair, have been made. The seven members of the Committee are delegates or alternate delegates and have agreed to refrain from active participation in election campaigns through the following June, when their (initial) appointments will have concluded. Current members will be eligible for reappointment and other individuals willing to serve on the Committee are invited to complete the application form on the Speakers' page for positions that will begin in mid-2022.

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

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

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

This report is in response to Paragraph 6.

COMMITTEE ACTIVITIES AND PROPOSALS

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

Complaint reporting

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

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

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

Some discussion was had regarding the development of a list of potential rules violations and associated penalties, it quickly was recognized that this list would be limitless, necessarily qualified by nuance or exceptions. Furthermore, application of rigid penalties that do not take into account such nuances, would unnecessarily constrain the committee

and potentially disenfranchise members of our House with whom rests the ultimate decision regarding verified infractions. Rather, the Committee recommends that they be allowed flexibility to consider the circumstances surrounding reported violations and to determine the appropriate corrective action. To ensure consistency and fairness over time, a history of the details of each verified offense and the ensuing penalty will be retained by the Office of General Counsel.

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

Validation

Upon receiving a complaint, the Speaker will consult with the Committee chair to form a subcommittee of three members to investigate the allegation. The subcommittee members will be selected to avoid conflicts (e.g., being part of the same delegation as the alleged violator). Using necessary discretion, the subcommittee shall investigate the complaint and will report to the full Committee whether the complaint is founded. When necessary, the Office of General Counsel or the HOD Office will assist.

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

Resolution and potential penalties

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

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

RECOMMENDATIONS

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

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

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

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

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

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

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

[Editor's note: At the time of referral, the following amended language had been adopted:
Campaign violation complaints will be investigated by the Election Committee, which will recommend penalties to the Speaker of the House, who will validate complaints and actions as appropriate. Penalties may include an announcement of the violation by the Speaker to the House.

Appendix A – Members of the Election Committee

The following delegates and alternate delegates were selected for the initial election committee from among those who submitted applications. All have agreed to not be a candidate or to be directly involved in a campaign and will not seek reappointment for any year in which the individual intends to be a candidate or directly involved in a campaign:

- Lynda Young, MD, Chair, Delegate, Massachusetts Medical Society (pediatrics)
- Michael DellaVecchia, MD, PhD, Delegate, Pennsylvania Medical Society (ophthalmology)
- John Flores, MD, Delegate, Texas Medical Association (internal medicine)
- George Hruza, MD, Alternate Delegate, Missouri State Medical Association (dermatology)
- Josh Lesko, MD, Sectional Resident and Fellow Delegate (Medical Society of Virginia; emergency medicine)
- Ted Mazer, MD, Delegate, California Medical Association (otolaryngology)
- Nancy Mueller, MD, Delegate, Medical Society of New Jersey (neurology)

The Speakers serve ex officio, without vote, except to break ties.

Appendix B - Policies Relevant to this Report

D-610.998, Directives from the Election Task Force

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

Campaign literature
2. An AMA Candidates' Page will be created on the AMA website or other appropriate website to allow each candidate the opportunity to post campaign materials. Parameters for the site will be established by the Speaker and communicated to candidates.

Interviews
3. The Speakers are encouraged to continue recorded virtual interviews of announced candidates in contested races, to be posted on the AMA website.

Voting Process and Election Session
4. The Speaker is encouraged to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced, including collecting written personal points from candidates to be shared electronically with the House after the meeting or imposing time limits on such comments.

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

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

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

Policy G-610.020, Rules for AMA Elections

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

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

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

(4) Candidates may notify the HOD Office of their intention to run for potential newly opened positions, as well as any scheduled open positions on any council or the Board of Trustees, at any time by submitting an announcement card and their conflict of interest statement to the House Office. They will then be included in all subsequent projections of announcements before the House, "Official Candidate Notifications" and in any campaign activity that had not yet been finalized. All previously announced candidates will continue to be included on each Official Announcement Date. Any candidate may independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than at the specified times.

(5) The Federation and members of the House of Delegates will be notified of unscheduled potential newly opened positions that may become available as a result of the election of announced candidates. Candidates will be allowed to announce their intention to run for these positions.

(6) If a potential newly opened position on the Board or a specified council does not open but there are other open positions for the same council or the Board, an election will proceed for the existing open seats. Candidates will be offered the opportunity to withdraw their nomination prior to the vote. If there are no scheduled open seats on the Board or specified council for which a potential newly opened position is announced and if the potential newly opened position does not open (i.e., the individual with the unexpired term is not elected to the office they sought), no election for the position will be held. In the event that a prior election results in a newly opened position without a nominated candidate or more positions are open than nominated candidates, the unfilled position/s would remain unfilled until the next Annual Meeting.

(7) The AMA Office of House of Delegates Affairs will provide an opportunity for all announced candidates to submit material to the HOD office which will then be sent electronically by the HOD Office in a single communication to all delegates and alternates. Parameters regarding content and deadlines for submission will be established by the Speaker and communicated to all announced candidates.

(8) Our AMA believes that: (a) specialty society candidates for AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides; (b) elected specialty society members should be identified in that capacity while serving their term of office; and (c) nothing in the above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose.

(9) An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual will provide a link to the AMA Candidates' Page, but links to personal, professional or campaign related websites will not be allowed. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates.

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

(11) The Speaker's Office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker).

(12) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities.

(13) Campaign memorabilia may not be distributed in the Not for Official Business (NFOB) bag.

(14) Campaign materials may not be distributed by postal mail or its equivalent. The AMA Office of House of Delegates Affairs will no longer furnish a file containing the names and mailing addresses of members of the AMA-HOD. Printed campaign materials will not be included in the "Not for Official Business" bag and may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials.

(15) A reduction in the volume of telephone calls and electronic communication from candidates and on behalf of candidates is encouraged. The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of electronic messages to contact electors should be minimized, and if used must include a simple mechanism to allow recipients to opt out of receiving future messages.

(16) Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. Campaign memorabilia and giveaways that include a candidate's name or likeness may not be distributed at any time.

(17) Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies, state and regional delegations and health related causes that do not include any candidate identifier. These pins should be small, not worn on the badge and distributed only to members of the designated group. General distribution of any pin, button or sticker is disallowed.

(18) At any AMA meeting convened prior to the time period for active campaigning, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited. It is permissible for candidates seeking election to engage in individual outreach meant to familiarize others with a candidate's opinions and positions on issues.

(19) Candidates for AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society.

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

(21) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, OR (b) appearing by name or in a picture on a poster or notice in or outside of the party venue. At these events, alcohol may be served only on a cash or no-host bar basis.

(22) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at a single campaign reception at which the candidate is featured. No campaign literature shall be distributed in the House of Delegates and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates.

(23) At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place his or her name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker.

(24) Our AMA (a) requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election; and (b) will expand accessibility to completed conflict of interest information by posting such information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.

614. ALLOWING VIRTUAL INTERVIEWS ON NON-HOLIDAY WEEKENDS FOR CANDIDATES FOR AMA OFFICE
Introduced by Albert L. Hsu, MD, Delegate

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy G-610.020

RESOLVED, That our AMA amend Policy G-610.020, "Rules for AMA Elections," by addition and deletion to read as follows:

Interviews may be conducted only during a 4-7 day window designated by the Speaker beginning ~~on the Thursday~~ evening of a weekend at least two weeks but not more than 4 weeks prior to the scheduled Opening Session of the House of Delegates meeting at which elections will take place ~~and must be concluded by that Sunday (four~~ days later).

REPORT OF THE SPEAKERS

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

1. ELECTION COMMITTEE - INTERIM REPORT

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy D-610.998

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

BACKGROUND

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

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

> Recommendation 38: In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 7 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime maximum tenure of 8 terms) to report to the Speaker. These individuals would agree not to be directly involved in a campaign during their tenure and would be appointed from various regions, specialties, sections, and interest groups. The primary role of the committee would be to work with the Speakers to adjudicate any election complaint. Additional roles to be determined by the Speaker and could include monitoring election reforms, considering future campaign modifications and responding to requests from the Speaker for input on election issues that arise (New Policy).
>
> Recommendation 39: The Speaker in consultation with the Election Committee will consider a more defined process for complaint reporting, validation, resolution, and potential penalties. This process will be presented to the House for approval (New Policy).
>
> Recommendation 40: Policy G-610.020, Rules for AMA Elections, paragraph 1 be amended by addition to read as follows:
> (1) The Speaker and Vice Speaker of the House of Delegates are responsible for overall administration of our AMA elections, although balloting is conducted under the supervision of the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker will advise candidates on allowable activities and when appropriate will ensure that clarification of these rules is provided to all known candidates. The Speaker, in consultation with the Vice Speaker and the Election Committee, is responsible for declaring a violation of the rules.

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

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

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

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

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

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

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

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

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

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

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

Action by the Board of Trustees

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

1. That Paragraph 5 of Policy D-610.998, "Directives from the Election Task Force," be amended by addition to read as follows:

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

2. A Campaign Complaint Reporting, Validation and Resolution Process shall be established as follows:
   Campaign violation complaints should be directed to the Speaker, the Vice Speaker, or the AMA General Counsel and should include the following details:
   - The name of the person(s) thought to have violated the rules
   - The date of the alleged violation and the location if relevant
   - The specific violation being alleged (i.e., the way the rules were violated)
   - The materials, if any, that violate the rules; original materials are preferred over copies. Where necessary, arrangements for collection of these materials will be made.

3. Campaign violation complaints will be investigated by the Election Committee or a subcommittee thereof.
   a. The Committee will collectively determine whether a campaign violation has occurred.
   b. For validated complaints, the Committee will determine appropriate penalties, which may include an announcement of the violation by the Speaker to the House.
   c. Committee members with a conflict of interest may participate in discussions but must recuse themselves from decisions regarding the merits of the complaint or penalties.
   d. Deliberations of the Election Committee shall be confidential.
   e. The Speaker shall include a summary of the Election Committee's activities in "Official Candidate Notifications" sent to the House. Details may be provided at the discretion of the Election Committee and must be provided when the penalty includes an announcement about the violator to the House.

4. A record of all complaints and the results of the validation and the resolution processes, including penalties, shall be maintained by the AMA Office of General Counsel and kept confidential.

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

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

REVIEW OF ELECTION COMMITTEE ACTIVITY

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

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

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

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

DISCUSSION

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

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

RECOMMENDATIONS

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

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

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

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

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

3. That Policy D-610.998, Paragraph 7(a), be amended by addition to read as follows:

   7(a). The Committee will collectively determine whether a campaign violation has occurred. As part of the investigation process the Election Committee or its subcommittee shall inform the candidate of the complaint filed and give the candidate the opportunity to respond to the allegation.

4. That Paragraph 7 be amended by addition of a new sub point "b" to read as follows:

   7(b) If the complaint implicates a delegation or caucus, the Election Committee or its subcommittee shall inform the chair of the implicated delegation or caucus of the complaint filed and give the implicated delegation or caucus chair(s) the opportunity to answer to the allegation as a part of the investigative process.

5. That amended Policy D-610.998 be widely communicated, including being published in the Election Manual.

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

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

ELECTION COMMITTEE

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

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

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

APPENDIX B - Establishing an Election Committee (November 21)

HOUSE ACTION: REFERRED FOR DECISION

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

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

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

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

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

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

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

This report is in response to Paragraph 6.

COMMITTEE ACTIVITIES AND PROPOSALS

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

Complaint reporting

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

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

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

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

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

Validation

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

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

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

Resolution and potential penalties

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

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

RECOMMENDATIONS

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

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

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

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

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

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

3. Policy D-610.998, Paragraph 6 be rescinded.
[Editor's note: At the time of referral, the following amended language had been adopted:
Campaign violation complaints will be investigated by the Election Committee, which will recommend penalties to the Speaker of the House, who will validate complaints and actions as appropriate. Penalties may include an announcement of the violation by the Speaker to the House.

607. ACCOUNTABILITY FOR ELECTION RULES VIOLATIONS
Introduced by Texas

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: REFERRED

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

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

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

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

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

Directives from the Election Task Force D-610.998

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

Campaign literature
2. An AMA Candidates Page will be created on the AMA website or other appropriate website to allow each candidate the opportunity to post campaign materials. Parameters for the site will be established by the Speaker and communicated to candidates.

Interviews
3. The Speakers are encouraged to continue recorded virtual interviews of announced candidates in contested races, to be posted on the AMA website.

Voting Process and Election Session
4. The Speaker is encouraged to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced, including collecting written personal points from candidates to be shared electronically with the House after the meeting or imposing time limits on such comments.

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

6. A Campaign Complaint Reporting, Validation and Resolution Process shall be established as follows:
Campaign violation complaints should be directed to the Speaker, the Vice Speaker, or the AMA General Counsel and should include the following details:
The name of the person(s) thought to have violated the rules
The date of the alleged violation and the location if relevant
The specific violation being alleged (i.e., the way the rules were violated)

The materials, if any, that violate the rules; original materials are preferred over copies. Where necessary, arrangements for collection of these materials will be made.

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

8. A record of all complaints and the results of the validation and the resolution processes, including penalties, shall be maintained by the AMA Office of General Counsel and kept confidential.

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

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

11. Amended Policy D-610.998 will be widely communicated, including being published in the Election Manual.

Policy Timeline
Speakers Rep. 2, A-21 Modified: BOT Action in response to referred for decision: Speakers Rep. 2, I-21 Modified: Speakers Rep. 1, I-22

Nominations G-610.010

Guidelines for nominations for AMA elected offices include the following:
(1) every effort should be made to nominate two or more eligible members for each Council vacancy;
(2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity;
(3) the date for submission of applications for consideration by the Board of Trustees at its April meeting for the Council on Legislation, Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, Council on Science and Public Health, Council on Long Range Planning and Development, and Council on Ethical and Judicial Affairs is made uniform to March 15th of each year;
(4) the announcement of the Council nominations and the official ballot should list candidates in alphabetical order by name only; and
(5) nominating speeches for unopposed candidates for office, except for President-elect, should be eliminated.

Policy Timeline
CCB/CLRPD Rep. 3, A-12 Modified: Speakers Rep. 2, A-21

Rules for AMA Elections G-610.020

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

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

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

(4) Candidates may notify the HOD Office of their intention to run for potential newly opened positions, as well as any scheduled open positions on any council or the Board of Trustees, at any time by submitting an announcement card to the House Office. They will then be included in all subsequent projections of announcements before the House, Official Candidate Notifications, and in any campaign activity that had not yet been finalized. All previously announced candidates will continue to be included on each Official Announcement Date. Any candidate may independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than at the specified times.

(5) The Federation and members of the House of Delegates will be notified of unscheduled potential newly opened positions that may become available as a result of the election of announced candidates. Candidates will be allowed to announce their intention to run for these positions

(6) If a potential newly opened position on the Board or a specified council does not open but there are other open positions for the same council or the Board, an election will proceed for the

existing open seats. Candidates will be offered the opportunity to withdraw their nomination prior to the vote. If there are no scheduled open seats on the Board or specified council for which a potential newly opened position is announced and if the potential newly opened position does not open (ie., the individual with the unexpired term is not elected to the office they sought), no election for the position will be held. In the event that a prior election results in a newly opened position without a nominated candidate or more positions are open than nominated candidates, the unfilled position/s would remain unfilled until the next annual meeting.

(7) The AMA Office of House of Delegates Affairs will provide an opportunity for all announced candidates to submit material to the HOD office which will then be sent electronically by the HOD Office in a single communication to all delegates and alternates. Parameters regarding content and deadlines for submission will be established by the Speaker and communicated to all announced candidates.

(8) Our AMA believes that: (a) specialty society candidates for AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides; (b) elected specialty society members should be identified in that capacity while serving their term of office; and (c) nothing in the above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose.

(9) An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual will provide a link to the AMA Candidates Page, but links to personal, professional or campaign related websites will not be allowed. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates.

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

(11) The Speaker's Office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker). Groups wishing to conduct interviews must designate their interviewing coordinator and provide the individuals contact information to the Office of House of Delegates Affairs. The Speakers Office will collect contact information for groups wishing to conduct interviews as well as for candidates and their campaign teams and will provide the information as requested.

(12) Interviews conducted with current candidates must comply with the following rules:

a. Interviews may be arranged between the parties once active campaigning is allowed.

b. Groups conducting interviews with candidates for a given office must offer an interview to all individuals that have officially announced their candidacy at the time the groups interview schedule is finalized.

i. A group may meet with a candidate who is a member of their group without interviewing other candidates for the same office.

ii. Interviewing groups may, but are not required to, interview late announcing candidates. Should an interview be offered to a late candidate, all other announced candidates for the same office (even those previously interviewed) must be afforded the same opportunity and medium.

iii. Any appearance by a candidate before an organized meeting of a caucus or delegation, other than their own, will be considered an interview and fall under the rules for interviews.

c. Groups may elect to conduct interviews virtually or in-person.

d. In-person interviews may be conducted between Friday and Monday of the meeting at which elections will take place.

e. Virtual interviews are subject to the following constraints:

i. Interviews may be conducted only during a 4-7 day window designated by the Speaker beginning at least two weeks but not more than 4 weeks prior to the scheduled Opening Session of the House of Delegates meeting at which elections will take place.

ii. Interviews conducted on weeknights must be scheduled between 5 pm and 10 pm or on weekends between 8 am and 10 pm based on the candidates local time, unless another mutually acceptable time outside these hours is arranged.

iii. Caucuses and delegations scheduling interviews for candidates within the parameters above must offer alternatives to those candidates who have conflicts with the scheduled time.

f. Recording of interviews is allowed only with the knowledge and consent of the candidate.

g. Recordings of interviews may be shared only among members of the group conducting the interview.

h. A candidate is free to decline any interview request.

i. In consultation with the Election Committee, the Speaker, or where the Speaker is in a contested election, the Vice Speaker, may issue special rules for interviews to address unexpected situations.

(13) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities.

(14) Campaign memorabilia may not be distributed in the Not for Official Business (NFOB) bag.

(15) Campaign materials may not be distributed by postal mail or its equivalent. The AMA Office of House of Delegates Affairs will no longer furnish a file containing the names and mailing addresses of members of the AMA-HOD. Printed campaign materials will not be included in the Not for Official Business bag and may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials.

(16) A reduction in the volume of telephone calls and electronic communication from candidates and on behalf of candidates is encouraged. The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of electronic messages to contact electors should be minimized, and if used must include a simple mechanism to allow recipients to opt out of receiving future messages.

(17) Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. Campaign memorabilia and giveaways that include a candidates name or likeness may not be distributed at any time.

(18) Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies, state and regional delegations and health related causes that do not include any candidate identifier. These pins should be small, not worn on the badge and distributed only to members of the designated group. General distribution of any pin, button or sticker is disallowed.

(19) At any AMA meeting convened prior to the time period for active campaigning, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited. It is permissible for candidates seeking election to engage in individual outreach meant to familiarize others with a candidates opinions and positions on issues.

(20) Candidates for AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society.

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

(22) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a

receiving line, or (b) appearing by name or in a picture on a poster or notice in or outside of the party venue. At these events, alcohol may be served only on a cash or no-host bar basis.

(23) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at a single campaign reception at which the candidate is featured. No campaign literature shall be distributed in the House of Delegates and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates.

(24) At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place his or her name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker.

(25) Our AMA (a) requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election; and (b) will expand accessibility to completed conflict of interest information by posting such information on the Members Only section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.

Policy Timeline
CLRPD Rep. E, I-80 Res. 22, I-81 Reaffirmed: CLRPD Rep. B, I-90 Reaffirmed: CLRPD Rep. F, I-91 CCRC Special Report, I-92 CCRC Special Report I-93 Special Committee on Campaign and Elections and Reaffirmed Special Committee Report on Campaigns and Elections, I-96 Special Committee on Campaigns and Elections, A-97 Reaffirmed: Sunset Report, I-00 Consolidated: CLRPD Rep. 3, I-01 CC&B Rep. 3, I-08 Modified: Rules and Credentials Rep. 1, A-11 Modified: Rules and Credentials Rep. 1, I-13 Appended: BOT Rep. 5, I-13 Modified: Res. 602, A-14 Modified: Speakers Rep. 1, I-14 Modified: Res. 1, A-15 Modified: Speakers Rep. 2, A-21 Modified: Speakers Rep. 1, I-21 Modified: Res. 614, A-22

Guiding Principles for House Elections G-610.021

The following principles provide guidance on how House elections should be conducted and how the selection of AMA leaders should occur:
(1) AMA delegates should: (a) avail themselves of all available background information about candidates for elected positions in the AMA; (b) determine which candidates are best qualified to help the AMA achieve its mission; and (c) make independent decisions about which candidates to vote for.
(2) Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable. This principle applies between as well as within caucuses and delegations.
(3) Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.
(4) Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for AMA leadership positions.
(5) Incumbency should not assure the re-election of an individual to an AMA leadership position.
(6) Service in any AMA leadership position should not assure ascendancy to another leadership position.
(7) Delegations and caucuses when evaluating candidates may provide information to their members encouraging open discussion regarding the candidates.
(8) Delegations and caucuses should be a source of encouragement and assistance to qualified candidates. Nomination and endorsement should be based upon selecting the most qualified individuals to lead our AMA regardless of the number of positions up for election in a given race. Delegations and caucuses are reminded that all potential candidates may choose to run for office, with or without their endorsement and support.

Policy Timeline

CLRPD Rep. 4, I-01 Reaffirmed: CC&B Rep. 2, A-11 Modified: Speakers Rep. 2, A-21

Election Process G-610.030

AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at each Annual Meeting; (2) Voting for all elected positions including runoffs will be conducted electronically during an Election Session to be arranged by the Speaker; (3) All delegates eligible to vote must be seated within the House at the time appointed to cast their electronic votes; and (4) The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House.

Policy Timeline

Sub. Res. 3, I-74 Special Committee Report, A-86 Reaffirmed: CLRPD Rep. C, A-89 Amended: Sunset Report, I-96 Amended: Rep. of the Special Advisory Committee to the Speaker of the HOD, I-99 Reaffirmed: Sunset Report, A-00 BOT Report 23, A-01 Consolidated: CLRPD Rep. 3, I-01 Reaffirmed: CC&B Rep. 2, A-11 Modified: Speakers Rep. 2, A-21

3—Officers

3.1 Designations. The officers of the AMA shall be those specified in Article V of the Constitution.

3.2 Qualifications.

3.2.1 General. An officer, except the public trustee, must have been an active member of the AMA for at least 2 years immediately prior to election.

3.2.1.1 Resignation of AMA Position. Trustees, except the medical student trustee, shall resign all other positions held by them in the AMA upon their election. The medical student trustee shall resign all other positions held in the AMA upon assumption of office.

3.2.1.2 Delegate. Except for the Speaker and Vice Speaker, no person, while serving as an officer, shall be a delegate or an alternate delegate to the House of Delegates.

3.2.1.3 Restriction on Chair. The Chair of the Board of Trustees is not eligible for election as President-Elect until the Annual Meeting following completion of the term as Chair of the Board of Trustees.

3.2.2 Speaker and Vice Speaker. The Speaker and Vice Speaker of the House shall be elected from among the members of the House of Delegates.

3.2.3 Young Physician Trustee. The young physician trustee shall be an active physician member of the AMA under 40 years of age or within the first eight years of practice after residency and fellowship training programs, who is not a resident/fellow physician.

3.2.4 Resident/Fellow Physician Trustee. The resident/fellow physician trustee shall be an active physician member of the AMA who meets the definition of a resident/fellow physician.

3.2.5 Medical Student Trustee. The medical student trustee shall be an active medical student member of the AMA.

3.2.6 Public Trustee. The public trustee shall be an individual who does not possess the United States degree of doctor of medicine (MD) or doctor of osteopathic medicine (DO), or a recognized international equivalent, and who is not a medical student.

3.3 Nominations. Nominations for President-Elect, Speaker and Vice Speaker, shall be made from the floor by a member of the House of Delegates. Nominations for all other officers, except for Secretary, the medical student trustee, and the public trustee, shall be made from the floor by a member of the House of Delegates and may be announced by the Board of Trustees.

3.4 Elections.

3.4.1 Time of Election. Officers of the AMA, except the Secretary, the medical student trustee, and the public trustee, shall be elected by the House of Delegates at the Annual Meeting, except as provided in Bylaws 3.6 and 3.7. The public trustee may be elected at any meeting of the House of Delegates at which the Selection Committee for the Public Trustee submits a nomination for approval by the House of Delegates. On recommendation of the Committee on Rules and Credentials, the House of Delegates shall set the day and hour of such election. The Medical Student Section shall elect the medical student trustee in accordance with Bylaw 3.5.6.

3.4.2 Method of Election. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by ballot.

3.4.2.1 At-Large Trustees.

3.4.2.1.1 First Ballot. All nominees for the office of At-Large Trustee shall be listed alphabetically on a single ballot. Each elector shall have as many votes as the number of Trustees to be elected, and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer or more votes than the number of Trustees to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if they have received a vote on a majority of the legal ballots cast and are one of the nominees receiving the largest number of votes within the number of Trustees to be elected.

3.4.2.1.2 Runoff Ballot. A runoff election shall be held to fill any vacancy not filled because of a tie vote.

3.4.2.1.3 Subsequent Ballots. If all vacancies for Trustees are not filled on the first ballot and 3 or more Trustees are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. When 2 or fewer Trustees are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall

cast as many votes as there are Trustees yet to be elected, and must cast each vote for different nominees. This procedure shall be repeated until all vacancies have been filled.

3.4.2.2 All Other Officers, except the Medical Student Trustee and the Public Trustee. All other officers, except the medical student trustee and the public trustee, shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

3.4.2.3 Medical Student Trustee. The medical student trustee is elected by the Medical Student Section in accordance with Bylaw 3.5.6.

3.4.2.4 Public Trustee. The public trustee shall be elected separately. The nomination for the public trustee shall be submitted to the House of Delegates by the Selection Committee for the Public Trustee. Nominations from the floor shall not be accepted. A majority vote of delegates present and voting shall be necessary to elect.

3.5 Terms and Tenure.

3.5.1 President-Elect. The President-Elect shall be elected annually and shall serve as President-Elect until the next inauguration and shall become President upon installation at the inaugural ceremony, serving thereafter as President until the installation of a successor. The inauguration of the President may be held at any time during the meeting.

3.5.2 Speaker and Vice Speaker. The Speaker and Vice Speaker of the House of Delegates shall be elected annually, each to serve for one year or until their successors are elected and installed.

3.5.2.1 Limit on Total Tenure. An individual elected as Speaker may serve a maximum tenure of 4 years as Speaker. An individual elected as Vice Speaker may serve for a maximum tenure of 4 years as Vice Speaker.

3.5.3 Secretary. A Secretary shall be selected by the Board of Trustees from one of its members and shall serve for a term of one year.

3.5.4 At-Large Trustees. At-Large Trustees shall be elected to serve for a term of 4 years, and shall not serve for more than 2 terms.

3.5.4.1 Limit on Total Tenure. Trustees may serve for a maximum tenure of 8 years. Trustees elected at an Interim Meeting may serve for a maximum tenure of 8 years from the Annual Meeting following their election. The limitation on tenure shall take priority over a term length for which the Trustee was elected.

3.5.4.2 Prior Service as Young Physician Trustee. Periods of service as the young physician trustee shall count as part of the maximum Board of Trustees tenure.

3.5.4.3 Prior Service as Resident/Fellow Physician Trustee or Medical Student Trustee. Periods of service as the resident/fellow physician trustee or as the medical student trustee shall not count as part of the maximum Board of Trustees tenure.

3.5.5 Resident/Fellow Physician Trustee. The resident/fellow physician trustee shall serve a term of 2 years and shall not serve for more than 3 terms. If the resident/fellow physician trustee is unable, for any reason, to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected to a term to expire at the conclusion of the second Annual Meeting of the House of Delegates following the meeting at which the resident/fellow physician trustee was elected.

3.5.5.1 Cessation of Residency/Fellowship. The term of the resident/fellow physician trustee shall terminate and the position shall be declared vacant if the trustee should cease to be a resident/fellow physician. If the trustee completes residency or fellowship within 90 days prior to an Annual Meeting, the trustee shall be permitted to continue to serve on the Board of Trustees until the completion of the Annual Meeting.

3.5.6 Medical Student Trustee. The Medical Student Section shall elect the medical student trustee annually. The medical student trustee shall have all of the rights of a trustee to participate fully in meetings of the Board, including the right to make motions and to vote on policy issues, intra-Board elections or other elections, appointments or nominations conducted by the Board of Trustees.

3.5.6.1 Term. The medical student trustee shall be elected at the Business Meeting of the Medical Student Section prior to the Interim Meeting for a term of one year beginning at the close of the next Annual Meeting and concluding at the close of the second Annual Meeting following the meeting at which the trustee was elected.

3.5.6.2 Re-election. The medical student trustee shall be eligible for re-election as long as the trustee remains eligible for medical student membership in AMA.

3.5.6.3 Cessation of Enrollment. The term of the medical student trustee shall terminate and the position shall be declared vacant if the medical student trustee should cease to be eligible for medical student membership in the AMA by virtue of the termination of the trustee's enrollment in an educational program. If the medical student trustee graduates from an educational program within 90 days prior to an Annual Meeting, the trustee shall be permitted to continue to serve on the Board of Trustees until completion of the Annual Meeting.

3.5.7 Young Physician Trustee. The young physician trustee shall be elected for a term of 4 years, and shall not serve for more than 2 terms.

3.5.7.1 Limitations. No candidate shall be eligible for election or re-election as the young physician trustee unless, at the time of election, they are under 40 years of age or within the first eight years of practice after residency and fellowship training, and are not a resident/fellow physician. A young physician trustee shall be eligible to serve on the Board of Trustees for the full term for which elected, even if during that term the trustee reaches 40 years of age or completes the eighth year of practice after residency and fellowship training.

3.5.8 Public Trustee. A public trustee shall be elected for a term of 4 years, and shall not serve for more than one term. A public trustee shall have all of the rights of a trustee to participate fully in meetings of the Board, including the right to make motions and to vote on policy issues, except that a public trustee shall not have the right to vote on intra-Board elections. A public trustee shall not be eligible for election as an officer of the Board of Trustees.

6—Councils

6.0.1 Responsibilities.

6.0.1.1 Information and Recommendations. All Councils have a continuing duty to provide information and to submit recommendations to the House of Delegates, through the Board of Trustees, on matters relating to the areas of responsibility assigned to them under the provisions of these Bylaws.

6.0.1.1.1 Method of Reporting. Councils, except the Council on Ethical and Judicial Affairs and the Council on Legislation shall submit their reports to the House of Delegates through the Board of Trustees. The Board of Trustees may make such non-binding recommendations regarding the reports to the Councils as it deems appropriate, prior to transmitting the reports to the House of Delegates without delay or modification by the Board. The Board may also submit written recommendations regarding the reports to the House of Delegates.

6.0.1.1.2 Method of Referral. Referrals from the House of Delegates to a Council shall be made through the Board of Trustees. The Board may, in addition, refer the matter to such other councils as it deems appropriate.

6.0.1.2 Strategic Planning. All Councils have a responsibility to participate in the strategic planning process with the Board of Trustees, other Councils, and other organizational units as may be appropriate.

6.0.1.3 Communications and Working Relationships. All Councils have a responsibility to communicate and develop working relationships with the Board of Trustees, other Councils, the Sections, organizations represented within the House of Delegates and other organizational units as may be appropriate.

6.0.2 Rules and Regulations. Each Council shall select a Chair and Vice Chair or Chair-Elect and may adopt such rules and regulations as it deems necessary and appropriate for the conduct of its affairs, subject to approval by the Board of Trustees.

6.1 Council on Constitution and Bylaws.

6.1.1 Functions.

6.1.1.1 To review, advise and make recommendations on matters pertaining to the Constitution and Bylaws;

6.1.1.2 To recommend such changes in the Constitution and Bylaws as it deems appropriate for action by the House of Delegates;

6.1.1.3 To draft Constitution and Bylaws language as directed by the House of Delegates or Board of Trustees, or as recommended by the Council for consideration by the House of Delegates.

6.1.1.4 To serve as advisory to the Board of Trustees in reviewing the rules, regulations, and procedures of the AMA Councils and Sections.

6.1.2 Membership.

6.1.2.1 Eight active members of the AMA, one of whom shall be a resident/fellow physician, and one of whom shall be a medical student.

6.1.2.2 In addition, the Speaker and Vice Speaker of the House of Delegates shall be ex officio members of the Council without the right to vote.

6.2 Council on Medical Education.

6.2.1 Functions.

6.2.1.1 To study and evaluate all aspects of medical education continuum, including the development of programs approved by the House of Delegates, to ensure an adequate continuing supply of well-qualified physicians to meet the needs of the public;

6.2.1.2 To review and recommend policies for medical and allied health education, whereby the AMA may provide the highest education service to both the public and the profession;

6.2.1.3 To consider and recommend means by which the AMA may, on behalf of the public and the medical profession at-large, continue to provide information, leadership, and direction to the existing inter-organizational bodies dealing with medical and allied health education; and

6.2.1.4 To consider and recommend the means and methods whereby physicians may be assisted in maintaining their professional competence and the development of means and criteria for recognition of such achievement.

6.2.2 Membership.

6.2.2.1 Twelve active members of the AMA, one of whom shall be a resident/fellow physician, and one of whom shall be a medical student.

6.3 Council on Medical Service.

6.3.1 Functions.

6.3.1.1 To study and evaluate the social and economic aspects of health care; and, on behalf of the public and the profession, to recommend relevant policy changes to improve health care delivery in a changing socioeconomic environment;

6.3.1.2 To investigate social and economic factors influencing the practice of medicine;

6.3.1.3 To confer with state associations, component societies and national medical specialty societies regarding changing conditions and anticipated proposals that would affect medical care; and

6.3.1.4 To assist medical service committees established by state associations, component societies, and the national medical specialty societies.

6.3.2 Membership.

6.3.2.1 Twelve active members of the AMA, one of whom shall be a resident/fellow physician, and one of whom shall be a medical student.

6.4 Council on Science and Public Health.

6.4.1 Functions.

6.4.1.1 To advise on substantial and promising developments in the scientific aspects of medicine, public health, and biomedical research that warrant public attention;

6.4.1.2 To advise on professional and public information activities that might be undertaken by the AMA in the fields of scientific medicine and public health;

6.4.1.3 To assist in the preparation of policy positions on scientific issues in medicine and public health raised by the public media;

6.4.1.4 To advise on policy positions on aspects of government support, involvement in, or control of biomedical and public health research;

6.4.1.5 To advise on opportunities to coordinate or cooperate with national medical specialty societies, voluntary health agencies, other professional organizations and governmental agencies on scientific activities in medicine and public health;

6.4.1.6 To consider and evaluate the benefits that might be derived from joint development of domestic and international programs on scientific issues in medicine and public health; and

6.4.1.7 To propose and evaluate activities that might be undertaken by the AMA as major scientific projects in medicine or public health, either individually or jointly with state associations and component societies.

6.4.2 Membership.

6.4.2.1 Twelve active members of the AMA, one of whom shall be a resident/fellow physician, and one of whom shall be a medical student.

6.5 Council on Ethical and Judicial Affairs.

6.5.1 Authority. The Council on Ethical and Judicial Affairs is the judicial authority of the AMA, and its decision shall be final.

6.5.2 Functions.

6.5.2.1 To interpret the Principles of Medical Ethics of the AMA through the issuance of Opinions;

6.5.2.2 To interpret the Constitution, Bylaws and rules of the AMA;

6.5.2.3 To investigate general ethical conditions and all matters pertaining to the relations of physicians to one another or to the public, and make recommendations to the House of Delegates or the constituent associations through the issuance of Reports or Opinions;

6.5.2.4 To receive appeals filed by applicants who allege that they, because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any other reason unrelated to character or competence have been unfairly denied membership in a constituent association and/or component society, to determine the facts in the case, and to report the findings to the House of Delegates. If the Council determines that the allegations are indeed true, it shall admonish, censure, or in the event of repeated violations, recommend to the House of Delegates that the constituent association and/or component society involved be declared to be no longer a constituent association and/or component society member of the AMA;

6.5.2.5 To request that the President appoint investigating juries to which it may refer complaints or evidence of unethical conduct which in its judgment are of greater than local concern. Such investigative juries, if probable

cause for action be shown, shall submit formal charges to the President, who shall appoint a prosecutor to prosecute such charges against the accused before the Council on Ethical and Judicial Affairs in the name and on behalf of the AMA. The Council may acquit, admonish, suspend, expel, or place on probation the accused; and

6.5.2.6 To approve applications and nominate candidates for affiliate membership as otherwise provided for in Bylaw 1.1.2.

6.5.3 Original Jurisdiction. The Council on Ethical and Judicial Affairs shall have original jurisdiction in:

6.5.3.1 All questions involving membership as provided in Bylaws 1.1.1.1, 1.1.1.2, 1.1.2, 1.1.4, and 1.5.

6.5.3.2 All controversies arising under this Constitution and Bylaws and under the Principles of Medical Ethics to which the AMA is a party.

6.5.3.3 Controversies between two or more constituent associations or their members and between a constituent association and a component society or societies of another constituent association or associations or their members.

6.5.4 Appellate Jurisdiction. The Council on Ethical and Judicial Affairs shall have appellate jurisdiction in questions of law and procedure but not of fact in all cases which arise:

a. Between a constituent association and one or more of its component societies.

b. Between component societies of the same constituent association.

c. Between a member or members and the component society to which the member or members belong following an appeal to the member's constituent association.

d. Between a member and the component society or the constituent association to which the member belongs regarding disciplinary action taken against the member by the society or association.

e. Between members of different component societies of the same constituent association following a decision by the constituent association.

6.5.4.1 Appeal Mechanisms. Notice of appeal shall be filed with the Council on Ethical and Judicial Affairs within 30 days of the date of the decision by the component society or the constituent association and the appeal shall be perfected within 60 days thereof; provided, however, that the Council on Ethical and Judicial Affairs, for what it considers good and sufficient cause, may grant an additional 30 days for perfecting the appeal.

6.5.5 Membership.

6.5.5.1 Nine active members of the AMA, one of whom shall be a resident/fellow physician and one of whom shall be a medical student. Members elected to the Council on Ethical and Judicial Affairs shall resign all other positions held by them in the AMA upon their election to the Council. No member, while serving on the Council on Ethical and Judicial Affairs, shall be a delegate or an alternate delegate to the House of Delegates, or an Officer of the AMA, or serve on any other council, committee, or as representative to or Governing Council member of an AMA Section, with the exception of service on the Committee on Conduct at AMA Meetings (CCAM) as specified in AMA Policy.

6.5.5.2 Limit on Medical Student Participation. The medical student member of the Council shall have the right to participate fully in the work of the Council, including the right to make motions and vote on policy issues, elections, appointments, or nominations conducted by the Council, except that in disciplinary matters and in matters relating to membership the medical elected student member shall participate only if a medical student is the subject of the disciplinary matter or is the applicant for membership.

6.5.6 Nomination and Election. The members of the Council shall be elected by the House of Delegates on nomination by the President-Elect who assumes the office of President at the conclusion of the meeting. State associations, national medical specialty societies, Sections, and other organizations represented in the House of Delegates, and members of the Board of Trustees may submit the names and qualifications of candidates for consideration by the President-Elect.

6.5.7 Term.

6.5.7.1 The medical student member of the Council shall be elected for a term of 2 years. Except as provided in Bylaw 6.11, if the medical student member ceases to be enrolled in an educational program at any time prior to the expiration of the term for which the medical student member was elected, the service of such medical student member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.5.7.2 Except as provided in Bylaw 6.5.7.2 and Bylaw 6.11, the resident/fellow physician member of the Council shall be elected for a term of 2 years provided that if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.5.7.3 All other members of the Council shall be elected for a term of 7 years, so arranged that at each Annual Meeting the term of one member shall expire.

6.5.8 Tenure. Members of the Council may serve only one term, except that the resident/fellow physician member shall be eligible to serve for 3 terms and the medical student member shall be eligible to serve for 2 terms. A member elected to serve an unexpired term shall not be regarded as having served a term unless such member has served at least half of the term.

6.5.9 Vacancies.

6.5.9.1 Members other than the Resident/Fellow Physician Member. Any vacancy among the members of the Council other than the resident/fellow physician member shall be filled at the next meeting of the House of Delegates. The new member shall be elected by the House of Delegates, on nomination by the President, for the remainder of the unexpired term.

6.5.9.2 Resident/Fellow Physician Member. If the resident/fellow physician member of the Council ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates at the next Annual Meeting, on nomination by the President, for a 2-year term.

6.6 Council on Long Range Planning and Development.

6.6.1 Functions.

6.6.1.1 To study and make recommendations concerning the long-range objectives of the AMA;

6.6.1.2 To study, make recommendations, and serve in an advisory role to the Board of Trustees concerning strategies by which the AMA attempts to reach its long-range objectives;

6.6.1.3 To study, or cause to be studied, anticipated changes in the environment in which medicine and the AMA must function, collect relevant data and transmit interpretations of these studies and data to the Board of Trustees for distribution to decision making centers throughout the AMA, and submit reports to the House of Delegates at appropriate times;

6.6.1.4 To identify and evaluate ways to enhance the AMA's policy development processes and to make information on AMA policy positions readily accessible by providing support to the AMA's outreach, communications, and advocacy activities; and

6.6.1.5 To evaluate and make recommendations to the House of Delegates, through the Board of Trustees, with respect to the formation and/or change in status of any Section. The Council will apply criteria adopted by the House of Delegates.

6.6.2 Membership.

6.6.2.1 Ten active members of the AMA. Five members shall be appointed by the Speaker of the House of Delegates as follows: Two members shall be appointed from the membership of the House of Delegates, 2 members shall be appointed from the membership of the House of Delegates or from the AMA membership at-large, and one member appointed shall be a resident/fellow physician. Four members shall be appointed by the Board of Trustees from the membership of the House of Delegates or from the AMA membership at-large. One member appointed shall be a medical student member appointed by the Governing Council of the Medical Student Section with the concurrence of the Board of Trustees.

6.6.3 Term.

6.6.3.1 Members other than the Resident/Fellow Physician Member and Medical Student Member. Members of the Council other than the resident/fellow physician and medical student member shall be appointed for terms of 4 years beginning at the conclusion of the Annual Meeting.

6.6.3.2 Resident/Fellow Physician Member. The resident/fellow physician member of the Council shall be appointed for a term of 2 years beginning at the conclusion of the Annual Meeting provided that if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which appointed except as provided in Bylaw 6.11, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.6.3.3 Medical Student Member. Except as provided in Bylaw 6.11, the medical student member of the Council shall be appointed for a term of one year beginning at the conclusion of the Annual Meeting. If the medical student member ceases to be enrolled in an educational program at any time prior to the expiration of the term for which appointed, the service of such medical student member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.6.4 Tenure. Members of the Council may serve for no more than 8 years. The limitation on tenure shall take priority over a term length for which the member was appointed.

6.6.5 Vacancies.

6.6.5.1 Members Other than the Resident/Fellow Physician and Medical Student Member. Any vacancy among the members of the Council other than the resident/fellow physician and the medical student member shall be filled by appointment by either the Speaker of the House of Delegates or by the Board of Trustees as provided in Bylaw 6.6.2. The new member shall be appointed for a 4-year term.

6.6.5.2 Resident/Fellow Physician Member. If the resident/fellow physician member of the Council ceases to complete the term for which appointed, the remainder of the term shall be deemed to have expired. The successor shall be appointed by the Speaker of the House of Delegates for a 2-year term.

6.7 Council on Legislation.

6.7.1 Functions.

6.7.1.1 To review proposed federal legislation and recommend appropriate action in accordance with AMA policy;

6.7.1.2 To recommend changes in existing AMA policy when necessary to accomplish effective legislative goals;

6.7.1.3 To serve as a reference council through which all legislative issues of the AMA are channeled prior to final consideration by the Board of Trustees;

6.7.1.4 To maintain constant surveillance over legislation and to anticipate future legislative needs;

6.7.1.5 To recommend to the Board of Trustees new federal legislation and legislation to modify existing laws of interest to the AMA;

6.7.1.6 To monitor the development and issuance of federal regulations and to make recommendations to the Board of Trustees concerning action on such regulations; and

6.7.1.7 To develop and recommend to the Board of Trustees models for state legislation.

6.7.2 Membership.

6.7.2.1 Twelve active members of the AMA, one of whom shall be a resident/fellow physician, and one of whom shall be a medical student. These members of the Council shall be appointed by the Board of Trustees. The medical student member shall be appointed from nominations submitted by the Medical Student Section.

6.7.3 Term.

6.7.3.1 Members of the Council on Legislation shall be appointed for terms of one year, beginning at the conclusion of the Annual Meeting. Except as provided in Bylaw 6.11, if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which appointed, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant. Except as provided in Bylaw 6.11, if the medical student member ceases to be enrolled in an educational program the

service of such medical student member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.7.4 Tenure. Members of the Council on Legislation may serve no more than eight terms.

6.7.5 Vacancies. Any vacancy occurring on the Council shall be filled for the remainder of the unexpired term at the next meeting of the Board of Trustees. Completion of an unexpired term shall not count toward maximum tenure on the Council.

6.8 Election - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.

6.8.1 Nomination and Election. Members of these Councils, except the medical student member, shall be elected by the House of Delegates. Nominations shall be made by the Board of Trustees and may also be made from the floor by a member of the House of Delegates.

6.8.1.1 Separate Election. The resident/fellow physician member of these Councils shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

6.8.1.2 Other Council Members. With reference to each such Council, all nominees for election shall be listed alphabetically on a single ballot. Each elector shall have as many votes as there are members to be elected, and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer votes or more votes than the number of members to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if they have received a vote on a majority of the legal ballots cast and are one of the nominees receiving the largest number of votes within the number of members to be elected.

6.8.1.3 Run-Off Ballot. A run-off election shall be held to fill any vacancy that cannot be filled because of a tie vote.

6.8.1.4 Subsequent Ballots. If all vacancies are not filled on the first ballot and 3 or more members of the Council are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating the

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

6.8.2 Medical Student Member. Medical student members of these Councils shall be appointed by the Governing Council of the Medical Student Section with the concurrence of the Board of Trustees.

6.9 Term and Tenure - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.

6.9.1 Term.

6.9.1.1 Members other than the Resident/Fellow Physician Member and Medical Student Member. Members of these Councils other than the resident/fellow physician and medical student member shall be elected for terms of 4 years.

6.9.1.2 Resident/Fellow Physician Member. The resident/fellow physician member of these Councils shall be elected for a term of 2 years. Except as provided in Bylaw 6.11, if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.9.1.3 Medical Student Member. The medical student member of these Councils shall be appointed for a term of one year. Except as provided in Bylaw 6.11, if the medical student member ceases to be enrolled in an educational program at any time prior to the expiration of the term for which elected, the service of such medical student member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.9.2 Tenure. Members of these Councils may serve no more than 8 years. The limitation on tenure shall take priority over a term length for which the member was elected. Medical student members who are appointed shall assume office at the close of the Annual Meeting.

6.9.3 Vacancies.

6.9.3.1 Members other than the Resident/Fellow Physician and Medical Student Member. Any vacancy among the members of these Councils other than the resident/fellow physician and medical student member shall be filled at the next Annual Meeting of the House of Delegates. The successor shall be elected by the House of Delegates for a 4-year term.

6.9.3.2 Resident/Fellow Physician Member. If the resident/fellow physician member of these Councils ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates for a 2-year term.

6.10 Commencement of Term. Members of Councils who are elected by the House of Delegates shall assume office at the close of the meeting at which they are elected.

6.11 Term of Resident/Fellow Physician or Medical Student Member. A resident/fellow physician or medical student member of a Council who completes residency or fellowship or who graduates from an educational program within 90 days prior to an Annual Meeting shall be permitted to serve on the Council until the completion of the Annual Meeting. Service on a Council as a resident/fellow physician and/or medical student member shall not be counted in determining maximum Council tenure.

A note from your speakers

We are pleased to provide this edition of the American Medical Association Election Manual. It includes write-ups from announced candidates for election in June 2023, along with a description of our AMA election process and the current rules governing the conduct of campaigns.

In soliciting this information your speakers suggested that candidates list their sponsoring and endorsing societies, and include relevant biographical information and, if desired, a personal statement. Candidates and their sponsoring societies prepared the text and submitted the copy for publication, and responsibility for the content properly rests with the candidates.

AMA House of Delegates policy requires that each candidate's conflict-of-interest information be available for review. You can find this information posted on our password-protected web page. We trust you will find this manual user-friendly and robust, but suggestions for future editions are welcome; just send your comments to hod@ama-assn.org. Nominations will be accepted at the Opening Session of the House of Delegates. Elections for all contested races will be held on Tuesday morning, June 13, during the Election Session.

Sincerely,

Bruce A. Scott, MD
Speaker

Lisa Bohman Egbert, MD
Vice speaker

Table of contents

AMA election process

Return to
Table of contents

Introduction

Officers and four councils are elected by the American Medical Association House of Delegates (HOD) at the June Meeting. Candidates for these offices are widely solicited throughout the Federation. Campaigns are often spirited and are conducted under rules established by the AMA-HOD, rules that may be modified from time to time. This democratic process allows delegates ample opportunity to become acquainted with the candidates and their views. The elections are conducted during a special Election Session under the supervision of the Committee on Rules and Credentials and the chief teller, who are appointed by the speakers. The speaker and the vice speaker are responsible for overall administration of the elections. Voting is conducted by secret ballot.

Announcements of candidacy

Individuals intending to seek election should make their intentions known to the speakers, generally by providing the speakers' office (hod@ama-assn.org) with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, email address, URL, the office sought and a list of endorsing societies. The speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume or a slogan) will not be posted to the website as they are in violation of the rules. Printed announcements may not be distributed. The speakers may use additional means to make delegates aware of members intending to seek election. (G-610.020[2])

Following each meeting, an "Official Candidate Notification" will be sent electronically to the House. It will include a list of all announced candidates and all potential newly opened positions which may open as a result of the election of any announced candidate. Additional notices will also be sent out following the April Board meeting and on "Official Announcement Dates" to be established by the speaker. (G-610.020[3])

This rule provides a standard mechanism by which individuals can make known their intention to seek office, including positions that are contingent on prior election results. Printed announcements may not be distributed at an AMA-HOD meeting under any circumstance.

Endorsements

Any communication or activity undertaken to seek endorsement from groups of which the candidate is not a current member after the announcement of candidacy and prior to the April Board meeting (active campaign period) would be considered active campaigning and, therefore, a violation of the election rules. Any formal questioning of an announced candidate, including written questions, would be considered an interview, and, therefore, subject to the rules for interviews. (See below.)

Nominations

The AMA-BOT solicits candidates for four elected councils: the Council on Constitution and Bylaws, the Council on Medical Education, the Council on Medical Service, and the Council on Science and Public Health. The AMA-BOT announces council candidates after its April meeting. Council candidates who have announced their intent to seek election, including those seeking re-election, must submit the necessary materials to the AMA-BOT Office by the deadline to be included in the announcement by the BOT. Council candidates are officially nominated by the BOT during the Opening Session of the HOD.

Officer candidates announce their candidacy via an electronic announcement "card" sent to the HOD Office as described above. They are nominated during the Opening Session of the HOD. Under AMA bylaws, any delegate may nominate additional candidates for council and officer vacancies from the floor until nominations are closed at the Opening Session of the House.

Conflict-of-interest disclosures
Under AMA-HOD policy, all candidates for election are required to complete a conflict-of-interest/disclosure of affiliations form prior to their election. Candidates should contact the Office of General Counsel (ogc@ama-assn.org) for information on completing the form. Forms must be submitted by March 15 of the year in which the individual is seeking election to appear in this election manual. Completed forms are posted in the "Members-only" section of our AMA website. Completion of this form is required of all candidates for election, including those nominated from the floor. (G-610.020[25])

Campaigns

Active campaigns for AMA elective office may not begin until the AMA-BOT has officially announced the candidates for council seats after its April meeting. Active campaigning includes mass outreach activities such as emails directed to all or a significant portion of the members of the AMA-HOD, communicated by or on behalf of the candidate. (G-610.020[10])

At the Opening Session of the House of Delegates, each officer candidate in a contested election will give a two-minute speech. The order of the speeches will be determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place his or her name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the speaker will schedule a debate in front of the AMA-HOD to be conducted by rules established by the speaker or, in the event of a conflict, the vice speaker. (G-610.020[24])

There are no nominating speeches for council candidates; the names of council nominees are announced at the Opening Session of the AMA-HOD, after which the speaker will call for additional nominations from the floor. Candidates who are unopposed will be elected by acclamation.

Guiding principles for AMA-HOD elections

Policy G-610.021 lays out the guiding principles for AMA-HOD elections, and delegates are encouraged to consider its tenets carefully. The policy reads as follows:

The following principles provide guidance on how House elections should be conducted and how the selection of AMA leaders should occur:

1. AMA delegates should: (a) avail themselves of all available background information about candidates for elected positions in the AMA; (b) determine which candidates are best qualified to help the AMA achieve its mission; and (c) make independent decisions about which candidates to vote for.

2. Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable. This principle applies between as well as within caucuses and delegations.

3. Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.

4. Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for AMA leadership positions.

5. Incumbency should not assure the re-election of an individual to an AMA leadership position.

6. Service in any AMA leadership position should not assure ascendancy to another leadership position.

7. Delegations and caucuses when evaluating candidates may provide information to their members encouraging open discussion regarding the candidates.

8. Delegations and caucuses should be a source of encouragement and assistance to qualified candidates. Nomination and endorsement should be based upon selecting the most qualified individuals to lead our AMA regardless of the number of positions up for election in a given race. Delegations and caucuses are reminded that all potential candidates may choose to run for office, with or without their endorsement and support.

Campaign rules

This listing of campaign rules reflects policies adopted by the AMA-HOD and procedures developed by the speakers to comply with AMA-HOD actions. Where AMA-HOD policies are listed, the relevant AMA policy number is listed in parentheses following the policy. The rules are listed in general categories. Questions and concerns may be directed to the speakers at hod@ama-assn.org.

Expenses, events, parties and other activities

1. Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. Campaign memorabilia and giveaways that include a candidate's name or likeness may not be distributed at any time. (G-610.020[17]) Campaign memorabilia may not be distributed in the Not for Official Business (NFOB) bag. (G-610.020[14])

2. Group dinners, if attended by an announced candidate in a currently contested election, must be "Dutch treat"—each participant pays their own share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. Gatherings of four or fewer delegates or alternates are exempt from this rule. (G-610.020[21])

3. Campaign parties are allowed only at the Annual Meeting. A state, specialty society, caucus, coalition, etc., may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, or (b) appearing by name or in a picture on a poster or notice in or outside of the party venue. At these events, alcohol may be served only on a cash or no-host bar basis. (G-610.020[22])

   In 2023 our AMA will again host an AMA Candidate Reception. Candidates may be featured at the AMA reception or at another reception, but not both. The reception is scheduled from 5:30 to 7:30 p.m. Sunday, June 11.

4. Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies, state and regional delegations and health related causes that do not include any candidate identifier. These pins should be small, not worn on the badge and distributed only to members of the designated group. General distribution of any pin, button or sticker is disallowed. (G-610.020[18])

5. Candidates for AMA office should not attend meetings of the state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society. (G-610.020[20])

Campaigning, literature and publicity

1. At any AMA meeting convened prior to the time period for active campaigning, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited. It is permissible for candidates seeking election to engage in individual outreach meant to familiarize others with a candidate's opinions and positions on issues. (G-610.020[19])

   This rule prohibits campaign parties as well as the distribution of campaign literature and gifts at the Interim Meeting. Announcements of candidacy (see above) may occur at the Interim Meeting.

2. Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at a single campaign reception at which the candidate is featured. (G-610.020[23])

3. Campaign materials may not be distributed by postal mail or its equivalent (e.g., UPS or FedEx). Printed campaign materials will not be included in the "Not for Official Business" bag and may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials. (G-610.020[15])

4. An AMA Candidates' Page will be created on the AMA website or other appropriate website to allow each candidate the opportunity to post campaign materials. Parameters for the site will be established by the speaker and communicated to candidates. (D-610.998[2]) Candidates will be allowed to customize their individual pages within the template, but other layouts will not be possible. The pages are meant to supplement, not repeat, material from the election manual, but the content is up to the candidate.

5. An election manual containing information on candidates for election who have announced their intentions to seek office by March 15 shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the web pages associated with the meeting at which elections will occur. The election manual will provide a link to the AMA Candidates' Page, but links to personal, professional or campaign related websites will not be allowed. The election manual provides an equal opportunity for each candidate to present the material they consider important to bring before the members of the AMA-HOD. The election manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates. (G-610.020[9])

6. A reduction in the volume of telephone calls from candidates, and literature and letters by or on behalf of candidates is encouraged. The use of electronic messages to contact electors should also be minimized, and if used, must allow recipients to opt out of receiving future messages. (G-610.020[16])

   The HOD Office will send one email on behalf of all candidates. Candidates have been invited to submit materials of their choosing for inclusion in the email.

7. No campaign literature shall be distributed in the House of Delegates, and no mass outreach electronic messages shall be transmitted after the Opening Session of the House of Delegates Meeting. (G-610.020[23])

Interviews

Caucuses and delegations may choose to conduct virtual or in-person interviews. Groups are not required to interview candidates for all contests, and they may choose different methods for different contests. Per the rules in Policy G-610.020, the speakers' office will schedule in-person interviews with officer candidates in contested elections for regional caucuses and the Specialty and Service Society if requested. Any group that wishes to conduct in-person or virtual interviews must submit contact information for an individual responsible for scheduling the interviews and specify which contests for which they wish to interview. Deadlines for submission of this information to the HOD Office (hod@ama-assn.org) will be announced for in-person and virtual interviews.

The HOD Office will compile the list of groups wishing to interview for each position and send it to the candidates to schedule directly with the designated contact persons. It is the responsibility of the candidates to contact the group's designated person to arrange an interview. Candidates may not schedule interviews with groups that are not on the official list.

A centralized official list of groups wishing to conduct interview and candidates, as recommended by the Election Task Force, affords transparency to all candidates seeking interviews, while allowing groups to decide if, when, how, and for which contests they wish to interview.

Interviews conducted with current candidates must comply with the following rules:

1. Interviews may be arranged between the parties once active campaigning is allowed.

2. Groups conducting interviews with candidates for a given office must offer an interview to all individuals that have officially announced their candidacy at the time the group's interview schedule is finalized.

    a. A group may meet with a candidate who is a member of their group without interviewing other candidates for the same office.

    b. Interviewing groups may, but are not required to, interview late announcing candidates. Should an interview be offered to a late candidate, all other announced candidates for the same office (even those previously interviewed) must be afforded the same opportunity and medium.

    c. Any appearance by a candidate before an organized meeting of a caucus or delegation, other than their own, will be considered an interview and fall under the rules for interviews.

3. Groups may elect to conduct interviews virtually or in-person.

4. In-person interviews may be conducted between Friday and Monday of the meeting at which elections will take place.

5. Virtual interviews are subject to the following constraints:

    a. Interviews may be conducted only during a four to seven day window designated by the speaker beginning at least two weeks but not more than four weeks prior to the scheduled Opening Session of the House of Delegates meeting at which elections will take place.

    b. Interviews conducted on weeknights must be scheduled between 5 p.m. and 10 p.m. or on weekends between 8 a.m. and 10 p.m. based on the candidate's local time, unless another mutually acceptable time outside these hours is arranged.

c. Caucuses and delegations scheduling interviews for candidates within the parameters above must offer alternatives to those candidates who have conflicts with the scheduled time.

6. Recording of interviews is allowed only with the knowledge and consent of the candidate.

7. Recordings of interviews may be shared only among members of the group conducting the interview.

8. A candidate is free to decline any interview request.

9. In consultation with the Election Committee, the speaker, or where the speaker is in a contested election, the vice speaker, may issue special rules for interviews to address unexpected situations.

(G-610.020[12])

Policy also encourages the speakers to conduct and record virtual interviews with candidates and post those interviews on the AMA website.

Campaign complaint reporting, validation and resolution

AMA Policy D-610.998 specifies the process for how campaign violation complaints will be handled. Per policy, the speaker has appointed an Election Committee whose primary role is to work with the speakers to adjudicate any election complaints, but may also include monitoring election reforms, reviewing future campaign modifications and responding to requests from the speaker for input on election issues that arise.

1. Campaign violation complaints should be directed to the speaker, the vice speaker, or the AMA General Counsel and should include the following details:

   a. The name of the person(s) thought to have violated the rules

   b. The date of the alleged violation and the location if relevant

   c. The specific violation being alleged (i.e., the way the rules were violated)

   d. The materials, if any, that violate the rules; original materials are preferred over copies (where necessary, arrangements for collection of these materials will be made)

   (D-610.998[6])

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

   a. The Election Committee will collectively determine whether a campaign violation has occurred. As part of the investigation process the Election Committee or its subcommittee shall inform the candidate of the complaint filed and give the candidate the opportunity to respond to the allegation.

   b. If the complaint implicates a delegation or caucus, the Election Committee or its subcommittee shall inform the chair of the implicated delegation or caucus of the complaint filed and give the implicated delegation or caucus chair(s) the opportunity to answer to the allegation as a part of the investigative process.

c. For validated complaints, the Election Committee will determine appropriate penalties, which may include an announcement of the violation by the speaker to the House.

d. Committee members with a conflict of interest may participate in discussions but must recuse themselves from decisions regarding the merits of the complaint or penalties.

e. Deliberations of the Election Committee shall be confidential.

f. The speaker shall include a summary of the Election Committee's activities in "Official Candidate Notifications" sent to the House. Details may be provided at the discretion of the Election Committee and must be provided when the penalty includes an announcement about the violator to the House.

(D-610.998[7])

3. A record of all complaints and the results of the validation and the resolution processes, including penalties, shall be maintained by the AMA Office of General Counsel and kept confidential. (D-610.998[8])

Elections

Nominations will be accepted on Friday, June 10, 2023, during the Opening Session of the AMA-HOD. Uncontested candidates will be elected by acclamation at that time. Voting for contested elections will be held during the Election Session to be held on Tuesday morning, June 13, 2023. All delegates should be seated in the House at least 10 minutes prior to the Election Session.

Only credentialed delegates are permitted to cast a ballot. If a delegate cannot participate in the Election Session, they may designate a substitute delegate who must be properly credentialed by Monday, June 12, 2023, at 6 p.m. Central time.

Candidates are listed on the ballot in alphabetical order by name only. AMA bylaws require ballots that call for the exact number of votes for each vacancy. Each ballot clearly states the number of votes that should be cast, and our voting system will ensure that only appropriately completed ballots will be counted. A majority vote of the legal ballots cast is required for election.

If all vacancies are not filled on the first ballot, a runoff election(s) will be held. AMA bylaws dictate that if three or more members of the AMA-BOT or any council are still to be elected, the number of nominees in the runoff election shall be no more than twice the number of remaining vacancies less one. If two or fewer members of the AMA-BOT or council are still to be elected, the number of nominees in the runoff shall be no more than twice the number of remaining vacancies. In either case, the nominees in runoff elections are determined by retaining those who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. This process will continue until all the vacancies are filled.

Those candidates who are elected officially take office at the conclusion of the AMA-HOD meeting.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(I-23)

Introduced by: Medical Student Section

Subject: Support for International Aid for Reproductive Healthcare

Referred to: Reference Committee on Amendments to Constitution and Bylaws

---

Whereas, in 2020, the World Health Organization recognized comprehensive abortion care as a human right and an essential health service[1]; and

Whereas, the United Nations Humans Rights Council and American Public Health Association state that abortion is necessary to ensure the right to life for women and girls by preventing maternal morbidity and mortality[2,3]; and

Whereas, abortion is one of the most common medical procedures globally, and delayed care increases risk of complications, interpersonal violence, poverty, and death[4-7]; and

Whereas, unsafe abortions result in 13% of maternal deaths worldwide, with disproportionately high rates in low- and middle-income countries (LMICs)[8-9]; and

Whereas, the US is the largest contributor to contraceptive and reproductive care globally, particularly in LMICs, contributing $600 million in 2022[10-12]; and

Whereas, since 1973, the Helms Amendment has prohibited the use of federal funds for abortion in other countries, including in cases of rape, incest, and risk of death[13]; and

Whereas, of the 56 countries receiving U.S. financial health assistance, 86% legally allow abortion in at least one circumstance, but are unable to offer this care due to the dependence on US aid and Helms Amendment restrictions[14]; and

Whereas, the Mexico City Policy (MCP) and its 2017 expansion (the “global gag rule”) prohibit the provision of US aid to international non-governmental organizations (NGOs) using non-US funds to provide abortion information, referrals, or services[14-15]; and

Whereas, many NGOs that do not comply with the global gag rule but rely heavily on US aid lack the local infrastructure and funds necessary to otherwise provide services[16]; and

Whereas, the MCP has been repeatedly rescinded and reinstated by presidents since 1984, with President Biden rescinding the MCP and the global gag rule in 2021, but the Helms amendment still restricts US funds for global abortion care[17]; therefore be it

RESOLVED, that our American Medical Association oppose restrictions on U.S. funding to non-governmental organizations which provide reproductive health care internationally, including but not limited to contraception and abortion care (New HOD Policy); and it be further

RESOLVED, that our AMA supports global humanitarian assistance for maternal healthcare and comprehensive reproductive health services, including but not limited to contraception and abortion care. (New HOD Policy)

Fiscal Note: Modest – Between $1,000 - $5,000

Received: 09/11/2023

REFERENCES

1. Abortion. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/abortion. Accessed March 8, 2023.
2. United Nations Human Rights Committee (HRC). General comment no. 36, Article 6 (Right to Life). Published online September 3, 2019. Accessed April 14, 2022. https://www.refworld.org/docid/5e5e75e04.html
3. American Public Health Association. Restricted Access to Abortion Violates Human Rights, Precludes Reproductive Justice, and Demands Public Health Intervention.; 2015. Accessed April 14, 2022.
4. Bearak JM;Popinchalk A;Beavin C;Ganatra B;Moller AB;Tunçalp Ö;Alkema L; Country-specific estimates of unintended pregnancy and abortion incidence: A global comparative analysis of levels in 2015-2019. BMJ global health. https://pubmed.ncbi.nlm.nih.gov/35332057. Accessed April 9, 2023.
5. Jerman J, Frohwirth L, Kavanaugh ML, Blades N. Barriers to abortion care and their consequences for patients traveling for services. Perspectives on sexual and reproductive health. 2017;49(2):95-102. https://www.jstor.org/stable/48576863. doi: 10.1363/psrh.12024.
6. Espey E, Dennis A, Landy U. The importance of access to comprehensive reproductive health care, including abortion: A statement from women's health professional organizations. American journal of obstetrics and gynecology. 2019;220(1):67-70. https://dx.doi.org/10.1016/j.ajog.2018.09.008. doi: 10.1016/j.ajog.2018.09.008.
7. Haddad LB, Nour NM. Unsafe abortion: unnecessary maternal mortality. Rev Obstet Gynecol. 2009 Spring;2(2):122-6. PMID: 19609407; PMCID: PMC2709326.
8. Gebremedhin, M., Semahegn, A., Usmael, T. et al. Unsafe abortion and associated factors among reproductive aged women in Sub-Saharan Africa: a protocol for a systematic review and meta-analysis. Syst Rev 7, 130 (2018). https://doi.org/10.1186/s13643-018-0775-9
9. Abortion law: Global comparisons. Council on Foreign Relations. https://www.cfr.org/article/abortion-law-global-comparisons. Accessed March 8, 2023.
10. The U.S. Government and International Family Planning & Reproductive Health Efforts. KFF. Published November 11, 2021. Accessed March 5, 2023. https://www.kff.org/global-health-policy/fact-sheet/the-u-s-government-and-international-family-planning-reproductive-health-efforts/
11. Countries | Family Planning | Global Health | U.S. Agency for International Development. Accessed March 5, 2023. https://www.usaid.gov/global-health/health-areas/family-planning/countries
12. DAC List of ODA Recipients - OECD. Accessed March 5, 2023. https://www.oecd.org/dac/financing-sustainable-development/development-finance-standards/daclist.htm
13. The helms amendment and abortion laws in countries receiving U.S. Global Health Assistance. KFF. https://www.kff.org/global-health-policy/issue-brief/the-helms-amendment-and-abortion-laws-in-countries-receiving-u-s-global-health-assistance/. Published January 18, 2022. Accessed March 8, 2023.
14. Assessing the global gag rule. Planned Parenthood. https://www.plannedparenthood.org/uploads/filer_public/81/9d/819d9000-5350-4ea3-b699-1f12d59ec67f/181231-ggr-d09.pdf. Accessed March 9, 2023.
15. Plgha Review Feb 6 final for web site - 2017-2021.state.gov. https://2017-2021.state.gov/wp-content/uploads/2019/06/PLGHA-6-month-review-final-for-posting.pdf. Accessed March 9, 2023.
16. Impact of Mexico City policy on PEPFAR. The Foundation for AIDS Research. https://www.amfar.org/wp-content/uploads/2022/04/IB-Mexico-City-Policy-PEP-B-071818.pdf. Published July 2018. Accessed March 9, 2023.
17. Federal Register. Memorandum of January 28, 2021: Protecting Women's Health at Home and Abroad. 24 January 2021. GPO-18-119. Accessed 29 Aug 2023. https://www.govinfo.gov/content/pkg/FR-2021-06-24/pdf/2021-13638.pdf

RELEVANT AMA POLICY

D-5.996 Expanding Support for Access to Abortion Care

1. Our AMA will advocate for: (a) broad and equitable access to abortion services, public and private coverage of abortion services, and funding of abortion services in public programs; (b) explicit codification of legal protections to ensure broad, equitable access to abortion services; and (c) equitable participation by physicians who provide abortion care in insurance plans and public programs.
2. Our AMA opposes the use of false or inaccurate terminology and disinformation in policymaking to impose restrictions and bans on evidence-based health care, including reproductive health care. [Res. 229, I-22]

D-5.999 Preserving Access to Reproductive Health Services

Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state

medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage or clinical privileges against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion. [Res. 028, A-22; Reaffirmed: Res. 224, I-22; Modified: BOT Rep. 4, I-22; Appended: Res. 317, I-22; Reaffirmation: A-23; Appended: Res. 711, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(I-23)

Introduced by: Medical Student Section

Subject: Reconsideration of Medical Aid in Dying (MAID)

Referred to: Reference Committee on Amendments to Constitution and Bylaws

---

Whereas, the practice that our AMA calls “physician-assisted suicide” (PAS) is often referred to by many other terms, including “medical aid in dying” (MAID)[1]; and

Whereas, the American Psychological Association and the American Association of Suicidology recognize that “suicide” is distinct from MAID, and the use of “suicide” to describe MAID may misrepresent and stigmatize patients’ rationale and choices[2]; and

Whereas, in jurisdictions where it is legal, MAID allows adults with terminal illness and preserved decision-making capacity to request a prescription for self-administered medications to end their life, while retaining the autonomy to decide if and when to fill the prescription and if and when to self-administer the medication[1]; and

Whereas, medical aid in dying (MAID) is legal by legislation, judicial action, or referendum in eleven US jurisdictions, covering 1 in 4 US adults: California (2015), Colorado (2016), Hawaii (2018), Montana (2009), Maine (2019), New Jersey (2019), New Mexico (2021), Oregon (1994), Vermont (2013), Washington state (2008), and Washington, DC (2016)[3-4]; and

Whereas, our American Medical Association House of Delegates last debated neutrality on MAID at A-18, I-18, and A-19, and after extensive debate ultimately retained our existing Code of Medical Ethics opinion that “physician-assisted suicide is fundamentally incompatible with the physician’s role as healer”; and

Whereas, in a 2020 Medscape Survey, 55% of physicians (including 51% of primary care and 57% of specialists) supported legalization of MAID[5], indicating that neutrality may more accurately represent the views of the medical profession, rather than opposition; and

Whereas, withholding or withdrawing life-sustaining treatment (including intubation, feeding tubes, medications such as antibiotics or chemotherapy, procedures, and dialysis) is a legal and common end-of-life medical decision in the US and is considered ethical by our AMA[6]; and

Whereas, cancer patients who decide to forgo treatment and accept death may experience considerable pain as they wait for their disease to end their life, and caregivers often report feeling burdened with managing end-of-life pain[7-9]; and

Whereas, death after removal of a feeding tube may take over ten days, resulting in dramatic physical alterations due to starvation and causing anxiety caregivers[10]; and

Whereas, leading ethical scholars have concluded that letting patients die (by waiting to succumb to their disease after withholding or withdrawing treatment) may in many circumstances be less ethical than allowing a patient to actively end their own life[11]; and

Whereas, many medical societies have recently taken variations of neutral positions on MAID, ranging from "studied neutrality" while maintaining concerns over routine use and appropriate safeguards to "engaged neutrality" to "leav[ing] the decision…to the conscientious judgment of its members acting on behalf of their patients"; and

Whereas, despite concerns that MAID may be misused for patients of color, racial inequities in end-of-life care actually indicate that patients of color are less likely to complete advance directives or be asked their end-of-life preferences, that white patients are more likely to use MAID where legal, and that existing safeguards make possible abuse of MAID difficult[8]; and

Whereas, while financial concerns may exist regarding patients choosing MAID over continuation of care, patients already choose between hospice and continuation of care, which may already hold similar financial considerations[16]; and

Whereas, Gideonse v Brown (2022) found that patients can legally travel to Oregon to receive MAID even if they reside in a state where MAID is illegal, so physicians across the US may potentially encounter patients intending to travel for MAID[17]; therefore be it

RESOLVED, that our American Medical Association oppose criminalization of physicians and health professionals who engage in medical aid in dying at a patient's request and with their informed consent, and oppose civil or criminal legal action against patients who engage or attempt to engage in medical aid in dying (New HOD Policy); and be it further

RESOLVED, that our AMA use the term "medical aid in dying" instead of the term "physician-assisted suicide" and accordingly amend HOD policies and directives, excluding Code of Medical Ethics opinions (New HOD Policy); and be it further

RESOLVED, that our AMA rescind our HOD policies on physician-assisted suicide, H-270.965 "Physician-Assisted Suicide" and H-140.952 "Physician Assisted Suicide," while retaining our Code of Medical Ethics opinion on this issue (Rescind HOD Policy); and be it further

RESOLVED, that our AMA amend H-140.966 "Decisions Near the End of Life" by deletion as follows, while retaining our Code of Medical Ethics opinions on these issues:

> Decisions Near the End of Life, H-140.966
> Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.
> (2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment.
> (3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may

foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.

~~(4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time.~~

(5) Our AMA supports continued research into and education concerning pain management. (Modify Current HOD Policy)

and be it further

RESOLVED, that our AMA study changing our existing position on medical aid in dying, including reviewing government data, health services research, and clinical practices in domestic and international jurisdictions where it is legal. (Directive to Take Action)

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

Received: 09/19/2023

REFERENCES

1. Nowels D, VandeKieft G, Ballentine JM. Medical Aid in Dying. *Am Fam Physician*. 2018;97(5):339-343.
2. American Association of Suicidology. “Suicide” Is Not the Same as “Physician Aid in Dying.” Published October 30, 2017. Accessed March 8, 2023. https://ohiooptions.org/wp-content/uploads/2016/02/AAS-PAD-Statement-Approved-10.30.17-ed-10-30-17.pdf
3. States with Legal Medical Aid in Dying. Brittanica ProCon. Updated December 19, 2022. Accessed March 8, 2023. https://euthanasia.procon.org/states-with-legal-physician-assisted-suicide
4. US Census Bureau. Updated 2022. Accessed March 8, 2023. https://www.census.gov/quickfacts/fact/table/US/PST045222
5. Kane L. Life, Death, and Painful Dilemmas: Ethics 2020 Medscape Survey. Published November 13, 2020. Accessed March 8, 2023. https://www.medscape.com/slideshow/2020-ethics-report-life-death-6013311.
6. Mueller PS. Ethical and Legal Concerns Associated With Withdrawing Mechanical Circulatory Support: A U.S. Perspective. Front Cardiovasc Med. 2022 Jul 26;9:897955. doi: 10.3389/fcvm.2022.897955.
7. Parast L, Tolpadi AA, Teno JM, Elliott MN, Price RA. Hospice Care Experiences Among Cancer Patients and Their Caregivers. J Gen Intern Med. 2021 Apr;36(4):961-969. doi: 10.1007/s11606-020-06490-x. Epub 2021 Jan 19.
8. Al Rabadi L, LeBlanc M, Bucy T, Ellis LM, Hershman DL, Meyskens FL Jr, Taylor L, Blanke CD. Trends in Medical Aid in Dying in Oregon and Washington. JAMA Netw Open. 2019 Aug 2;2(8):e198648. doi: 10.1001/jamanetworkopen.2019.8648.
9. Chi NC, Demiris G. Family Caregivers' Pain Management in End-of-Life Care: A Systematic Review. Am J Hosp Palliat Care. 2017 Jun;34(5):470-485. doi: 10.1177/1049909116637359. Epub 2016 Mar 14.
10. Kitzinger J, Kitzinger C. Deaths after feeding-tube withdrawal from patients in vegetative and minimally conscious states: A qualitative study of family experience. Palliat Med. 2018 Jul;32(7):1180-1188. doi: 10.1177/0269216318766430. Epub 2018 Mar 23.
11. Rachels J. Active and passive euthanasia. N Engl J Med. 1975 Jan 9;292(2):78-80. doi: 10.1056/NEJM197501092920206.
12. Mayeda DP, Ward KT. Methods for overcoming barriers in palliative care for ethnic/racial minorities: a systematic review. *Palliat Support Care*. 2019;17(6):697-706. doi:10.1017/S1478951519000403
13. Ashana DC, D'Arcangelo N, Gazarian PK, Gupta A, Perez S, Reich AJ, Tjia J, Halpern SD, Weissman JS, Ladin K. "Don't Talk to Them About Goals of Care": Understanding Disparities in Advance Care Planning. *J Gerontol A Biol Sci Med Sci*. 2022 Feb 3;77(2):339-346. doi: 10.1093/gerona/glab091. PMID: 33780534; PMCID: PMC8824574.
14. Jones T, Luth EA, Lin SY, Brody AA. Advance Care Planning, Palliative Care, and End-of-life Care Interventions for Racial and Ethnic Underrepresented Groups: A Systematic Review. J Pain Symptom Manage. 2021 Sep;62(3):e248-e260. doi: 10.1016/j.jpainsymman.2021.04.025. Epub 2021 May 11. PMID: 33984460; PMCID: PMC8419069.
15. Lenko R, Voepel-Lewis T, Robinson-Lane SG, Silveira MJ, Hoffman GJ. Racial and Ethnic Differences in Informal and Formal Advance Care Planning Among U.S. Older Adults. J Aging Health. 2022 Dec;34(9-10):1281-1290. doi: 10.1177/08982643221104926. Epub 2022 May 27. PMID: 35621163; PMCID: PMC9633341.
16. Obermeyer Z, Makar M, Abujaber S, Dominici F, Block S, Cutler DM. Association Between the Medicare Hospice Benefit and Health Care Utilization and Costs for Patients With Poor-Prognosis Cancer. JAMA. 2014;312(18):1888–1896. doi:10.1001/jama.2014.14950

17. Templeton A. What Oregon's Death with Dignity settlement means for terminally ill patients from out of state. Oregon Public Broadcasting. Published March 31, 2022. Accessed March 8, 2023. https://www.opb.org/article/2022/03/31/what-oregons-death-with-dignity-settlement-means-for-terminally-ill-patients-from-out-of-state.

RELEVANT AMA POLICY

Code of Medical Ethics Opinion 5.7 Physician-Assisted Suicide

Thoughtful, morally admirable individuals hold diverging, yet equally deeply held, and well-considered perspectives about physician-assisted suicide. Nonetheless, at the core of public and professional debate about physician-assisted suicide is the aspiration that every patient come to the end of life as free as possible from suffering that does not serve the patient's deepest self-defining beliefs. Supporters and opponents share a fundamental commitment to values of care, compassion, respect, and dignity; they diverge in drawing different moral conclusions from those underlying values in equally good faith.

Guidance in the AMA Code of Medical Ethics encompasses the irreducible moral tension at stake for physicians with respect to participating in assisted suicide. Opinion E-5.7 powerfully expresses the perspective of those who oppose physician-assisted suicide. Opinion 1.1.7 articulates the thoughtful moral basis for those who support assisted suicide.

Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians:

(a) Should not abandon a patient once it is determined that cure is impossible.

(b) Must respect patient autonomy.

(c) Must provide good communication and emotional support.

(d) Must provide appropriate comfort care and adequate pain control.

AMA Principles of Medical Ethics: I,IV; Issued: 2016

Code of Medical Ethics Opinion 5.7 Euthanasia

Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering.

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life.

However, permitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations.

The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life.

Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Physicians:

(a) Should not abandon a patient once it is determined that a cure is impossible.

(b) Must respect patient autonomy.

(c) Must provide good communication and emotional support.

(d) Must provide appropriate comfort care and adequate pain control.

AMA Principles of Medical Ethics: I,IV; Issued: 2016

H-270.965 Physician-Assisted Suicide
Our AMA strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician's role as healer. [Sub. Res, 5, I-98; Reaffirmed: CEJA Rep. 11, A-08; Reaffirmed: BOT Rep. 09, A-18]

H-140.952 Physician Assisted Suicide
It is the policy of the AMA that: (1) Physician assisted suicide is fundamentally inconsistent with the physician's professional role.
(2) It is critical that the medical profession redouble its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. The use of more aggressive comfort care measures, including greater reliance on hospice care, can alleviate the physical and emotional suffering that dying patients experience. Evaluation and treatment by a health professional with expertise in the psychiatric aspects of terminal illness can often alleviate the suffering that leads a patient to desire assisted suicide.
(3) Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease.
(4) Requests for physician assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary. Multidisciplinary intervention, including specialty consultation, pastoral care, family counseling and other modalities, should be sought as clinically indicated.
(5) Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area. Physicians should recognize that courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations. [CEJA Rep. 8, I-93; Reaffirmed by BOT Rep. 59, A-96; Reaffirm: Res. 237, A-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmed: CEJA Rep. 03, A-19]

H-140.966 Decisions Near the End of Life
Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.
(2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment.
(3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.
(4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time.
(5) Our AMA supports continued research into and education concerning pain management.
[CEJA Rep. B, A-91; Reaffirmed by BOT Rep. 59, A-96; Reaffirmation A-97; Appended: Sub. Res. 514, I-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed in lieu of Res. 211, I-13; Reaffirmed: BOT Rep. 05, I-16]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(I-23)

Introduced by: Resident and Fellow Section

Subject: Adopting a Neutral Stance on Medical Aid in Dying

Referred to: Reference Committee on Amendments to Constitution and Bylaws

---

Whereas, medical aid in dying is an end-of-life care option that allows a competent adult with a terminal illness to obtain a prescription to self-administer medication to hasten death in a peaceful and dignified manner[1]; and

Whereas, the American Medical Association has long held strong opposition to the practice of medical aid in dying; and

Whereas, medical aid in dying is being legalized in an increasing number of states, with 1 in 5 Americans living in a state where it is legal[2]; and

Whereas, medical aid in dying is a matter of personal autonomy and the right to self-determination; and

Whereas, 61% of US adults support allowing medical assistance in dying[3]; and

Whereas, medical aid in dying can provide comfort and dignity for terminally ill patients who are suffering and have exhausted all other treatment options; and

Whereas, when state laws do not support a terminally ill person's ability to make their own end-of-life decisions based on their own preferences and desires, there can be moral conflicts with the existing ethical principles that can contribute to additional distress and anxiety in the terminally ill patient[4]; and

Whereas, our AMA's opposition to medical aid in dying further creates conflict in the ethical obligations of physicians who may be asked to provide guidance or participate in the process; therefore be it

RESOLVED, that our American Medical Association adopt a neutral stance on medical aid in dying and respect the autonomy and right of self-determination of patients and physicians in this matter. (New HOD Policy)

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

Received: 9/26/23

REFERENCES
1. Buchbinder M. Access to Aid-in-Dying in the United States: Shifting the Debate From Rights to Justice. Am J Public Health. 2018 Jun;108(6):754-759. doi: 10.2105/AJPH.2018.304352. Epub 2018 Apr 19. PMID: 29672149; PMCID: PMC5944872.
2. Campbell EG, Kini V, Ressalam J, Mosley BS, Bolcic-Jankovic D, Lum HD, Kessler ER, DeCamp M. Physicians' Attitudes and Experiences with Medical Aid in Dying in Colorado: a "Hidden Population" Survey. J Gen Intern Med. 2022 Oct;37(13):3310-3317. doi: 10.1007/s11606-021-07300-8. Epub 2022 Jan 11. PMID: 35018562; PMCID: PMC8751472.
3. The Gallup Organization. (2022, November 29). Prevalence of living wills in U.S. up slightly. Gallup.com. Retrieved April 10, 2023, from https://news.gallup.com/poll/312209/prevalence-living-wills-slightly.aspx
4. Atkinson Smith, Mary DNP, MSL, APRN, FAANP; Torres, Lisa DNP, MSN, FNP, PNP; Burton, Terry C.. Patient Rights at the End of Life: The Ethics of Aid-in-Dying. Professional Case Management 25(2):p 77-84, March/April 2020. | DOI: 10.1097/NCM.0000000000000392

RELEVANT AMA POLICY

Decisions Near the End of Life H-140.966
Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.
(2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment.
(3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.
(4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time.
(5) Our AMA supports continued research into and education concerning pain management.
Citation: [CEJA Rep. B, A-91; Reaffirmed by BOT Rep. 59, A-96; Reaffirmation A-97; Appended: Sub. Res. 514, I-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed in lieu of Res. 211, I-13; Reaffirmed: BOT Rep. 05, I-16]

Physician-Assisted Suicide H-270.965
Our AMA strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician's role as healer.
Citation: [Sub. Res, 5, I-98; Reaffirmed: CEJA Rep. 11, A-08; Reaffirmed: BOT Rep. 09, A-18]

Code of Medical Ethics: 5.8 Euthanasia
Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient’s intolerable and incurable suffering.
It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life.
However, permitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations.
The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient’s life. Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Physicians:
(a) Should not abandon a patient once it is determined that a cure is impossible.
(b) Must respect patient autonomy.
(c) Must provide good communication and emotional support.
(d) Must provide appropriate comfort care and adequate pain control.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(I-23)

Introduced by: Medical Student Section

Subject: Inappropriate Use of Health Records in Criminal Proceedings

Referred to: Reference Committee on Amendments to Constitution and Bylaws

---

Whereas, every US state has a higher incarceration rate than any other high-income country, and patients experience high rates of chronic disease and psychiatric illness in prison[1-5]; and

Whereas, 34 states use discretionary parole, where a panel of individuals may grant an individual release from prison based on criminal history, program participation, and behavior while incarcerated, but irrelevant factors such as time of day of parole review and age and race of the individual may inappropriately affect interpretations and decisions[6-8]; and

Whereas, patients with extensive medical management, including psychotherapy, may have their health documentation inappropriately included in their parole portfolios even when not pertinent to a case, inflating the size of portfolios, increasing the workload perceived by parole boards, and negatively impacting chances of a fair parole decision[9-11]; therefore be it

RESOLVED, that our American Medical Association encourage collaboration with relevant parties, including state and county medical societies, the American College of Correctional Physicians, and the American Bar Association, on efforts to preserve patients' rights to privacy regarding medical care while incarcerated while ensuring appropriate use of medical records in parole and other legal proceedings to protect incarcerated individuals from punitive actions related to their medical care. (New HOD Policy)

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

Received: 09/27/2023

REFERENCES

1. Maruschak LM. Medical problems of prisoners: (448112008-001). Published online 2008. doi:10.1037/e448112008-0013.
2. Reingle Gonzalez JM, Connell NM. Mental Health of Prisoners: Identifying Barriers to Mental Health Treatment and Medication Continuity. American Journal for Public Health. 2014;104(12):2328-2333. doi:10.2105/AJPH.2014.3020434.
3. Wallace D, Wang X. Does in-prison physical and mental health impact recidivism? SSM - Popul Health. 2020;11:100569. doi:10.1016/j.ssmph.2020.100569
4. "Laura M. Maruschak, Bjs Statistician - Bureau of Justice Statistics." Accessed March 9, 2023.
5. Wilper AP, Woolhandler S, Boyd JW, Lasser, KE, McCormick D, Bor DH, et al. The health and health care of US prisoners: results of a nationwide survey. American Journal of Public Health. 2009; 99(4):666-72.
6. Frankel, Allison. "Revoked." Human Rights Watch, September 6, 2021.
7. Beth Schwartzapfel | The Marshall Project. "How Parole Boards Keep Prisoners in the Dark and behind Bars." The Washington Post. WP Company, July 11, 2015.
8. "Extraneous Factors in Judicial Decisions | PNAS." https://www.pnas.org/doi/10.1073/pnas.1018033108.
9. Profiles in Parole Release and Revocation: Examining the Legal Framework in the United States. St. Paul, MN: University of Minnesota, Robina Institute of Criminal Law and Criminal Justice; February 2022. Accessed March 8, 2023.https://robinainstitute.umn.edu/sites/robinainstitute.umn.edu/files/2022-02/louisiana_parole_profile.pdf

10. Lewis v. Cain, No. 06-15022, 2015 WL 1602976 (E.D. La. Apr. 8, 2015) (Order granting conditional habeas relief). Accessed March 9, 2023. https://www.laaclu.org/sites/default/files/field_documents/2015_Lewis_v_Cain_Doc3_1.pdf
11. "Medical History - Statpearls - NCBI Bookshelf." Accessed March 9, 2023. https://www.ncbi.nlm.nih.gov/books/NBK534249/.

RELEVANT AMA POLICY

D-430.993 Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections

1. Our AMA supports the development of: (1) best practices for acute care of patients in the custody of law enforcement or corrections, (2) clearly defined and consistently implemented processes between health care professionals and law enforcement that (a) can best protect patient confidentiality, privacy, and dignity while meeting the needs of patients, health professionals, and law enforcement and (b) ensures security measures do not interfere with the capacity to provide medical, mental health, pregnancy, end of life care, palliative care, and substance use care, especially in emergency situations, and (3) if conflict arises during an incarcerated individual's hospitalization that the hospital's bioethics committee should convene to address the issue and not a law enforcement liaison.
2. Our AMA affirms that: (1) the adoption of best practices in the acute care of patients in the custody of law enforcement or corrections is an important effort in achieving overall health equity for the U.S. as a whole, and (2) it is the responsibility of the medical staff to ensure quality and safe delivery of care for incarcerated patients.
3. Our AMA supports universal coverage of essential health benefits for all individuals in the custody of law enforcement or corrections and who are
incarcerated.
4. Our AMA will work with interested parties, including but not limited to, the American College of Emergency Physicians and the American College of Correctional Physicians, to develop model federal legislation requiring health care facilities to inform patients in custody about their rights as a patient under applicable federal and state law. [Res. 407, A-22; Modified: CSAPH Rep. 06, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(I-23)

Introduced by: Medical Student Section

Subject: Improving Access to Forensic Medical Evaluations and Legal Representation for Asylum Seekers

Referred to: Reference Committee on Amendments to Constitution and Bylaws

---

Whereas, asylum seekers are people fleeing conflict, violence, human rights violations, extreme poverty, or persecution, who enter a country and request sanctuary[1-3]; and

Whereas, in the US, 842,000 asylum cases are currently pending, with the backlog projected to increase to 1 million by 2025, demonstrating a need for physicians trained in forensic medical and psychiatric evaluations and immigration lawyers to represent asylum seekers[4,5]; and

Whereas, children are especially impacted by lengthy and traumatic migration and asylum processes, in some cases experiencing resignation syndrome, a catatonic state of reduced consciousness typically relieved by being granted asylum[6-8]; and

Whereas, only 9 states publicly fund legal representation for all asylum seekers, and barriers in access to immigration lawyers result in 40% of asylum seekers being unrepresented[9]; and

Whereas, lack of representation reduces probability of asylum, as 49% of represented asylum seekers are successful compared to only 18% of unrepresented asylum seekers[4,8,10]; and

Whereas, physicians play a critical role in asylum cases by providing medical evidence of well-founded fear of persecution for immigration judges determining asylum[11]; and

Whereas, physician forensic medical evaluations greatly improve success rates in asylum cases, with 74% of cases with evaluations granted asylum compared to only 42% overall, but demand for evaluations far exceeds physician supply[13,14]; and

Whereas, the Asylum Medicine Training Initiative offers free, self-paced, standardized education on forensic evaluations to any physician, requiring 5 to 7 hours[16]; therefore be it

RESOLVED, that our American Medical Association support public funding of legal representation for people seeking legal asylum (New HOD Policy); and be it further

RESOLVED, that our AMA support efforts to train and recruit physicians to conduct medical and psychiatric forensic evaluations for all asylum seekers through existing training resources, including, but not limited to, the Asylum Medicine Training Initiative. (New HOD Policy)

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

Received: 09/27/2023

REFERENCES

1. United Nations High Commissioner for Refugees (no date) Asylum-seekers, UNHCR. UNHCR, The UN Refugee Agency. Available at: https://www.unhcr.org/en-us/asylum-seekers.html (Accessed: March 8, 2023).
2. An overview of U.S. refugee law and policy (2022) American Immigration Council. Available at: https://www.americanimmigrationcouncil.org/research/overview-us-refugee-law-and-policy#:~:text=Of%20the%2011%2C814%20refugees%20who,%2C%20and%20Latin%20America%2FCaribbean.
3. Who is a refugee, a migrant or an asylum seeker? (2022) Amnesty International. Available at: https://www.amnesty.org/en/what-we-do/refugees-asylum-seekers-and-migrants/#definitions (Accessed: March 8, 2023).
4. A Sober Assessment of the Growing U.S. Asylum Backlog (2022) TRAC Immigration. Available at: https://trac.syr.edu/reports/705 (Accessed: March 8, 2023).
5. President of the United States (2022) Report to Congress on proposed refugee admissions for Fiscal Year 2023 - United States Department of State, U.S. Department of State. U.S. Department of State. Available at: https://www.state.gov/report-to-congress-on-proposed-refugee-admissions-for-fiscal-year-2023/#overview (Accessed: March 8, 2023).
6. Robjant, K., Hassan, R., & Katona, C. (2009). Mental health implications of detaining asylum seekers: Systematic review. The British Journal of Psychiatry, 194(4), 306-312. doi:10.1192/bjp.bp.108.053223
7. Sallin K, Lagercrantz H, Evers K, Engström I, Hjern A, Petrovic P. Resignation Syndrome: Catatonia? Culture-Bound? Front Behav Neurosci. 2016 Jan 29;10:7. doi: 10.3389/fnbeh.2016.00007. PMID: 26858615; PMCID: PMC4731541.
8. Asylum Denial Rates Continue to Climb (2020) TRAC Immigration. Available at: https://trac.syr.edu/immigration/reports/630/ (Accessed: March 8, 2023).
9. Advancing Universal Representation initiative (no date) Vera Institute of Justice. Available at: https://www.vera.org/ending-mass-incarceration/reducing-incarceration/detention-of-immigrants/advancing-universal-representation-initiative (Accessed: March 8, 2023).
10. Asylum Decisions (2023) TRAC Immigration. Available at: https://trac.syr.edu/phptools/immigration/asylum/ (April 8, 2023)
11. Disla de Jesus V, Appel J. A Call for Asylum Evaluation and Advocacy in Forensic Psychiatry. Journal of the American Academy of Psychiatry and the Law Online Sep 2022, 50 (3) 342-345; DOI: 10.29158/JAAPL.220050-22
12. Atkinson HG, Wyka K, Hampton K, Seno CL, Yim ET, Ottenheimer D, Arastu NS. Impact of forensic medical evaluations on immigration relief grant rates and correlates of outcomes in the United States. J Forensic Leg Med. 2021 Nov;84:102272. doi: 10.1016/j.jflm.2021.102272. Epub 2021 Oct 28. PMID: 34743036.
13. Ferdowsian H, McKenzie K, Zeidan A. Asylum Medicine: Standard and Best Practices. Health Hum Rights. 2019 Jun;21(1):215-225. PMID: 31239628; PMCID: PMC6586957.
14. Asylum Medicine Training Initiative https://asylummedtraining.org/ (Accessed: April 8, 2023)

RELEVANT AMA POLICY

H-350.957 Addressing Immigrant Health Disparities

1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin. [Res. 804, I-09; Appended: Res. 409, A-15; Reaffirmation: A-19; Appended: Res. 423, A-19; Reaffirmation: I-19]

D-350.983 Improving Medical Care in Immigrant Detention Centers

1. Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention. [Res. 017, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(I-23)

Introduced by: Academic Physicians Section (AMA-APS)

Subject: Physicians Arrested for Non-Violent Crimes While Engaged in Public Protests

Referred to: Reference Committee on Amendments to Constitution and Bylaws

---

Whereas, the killing of Mr. George Floyd, while he was being restrained in police custody, has resulted in widespread social activism, including but not limited to protest marches and demonstrations that have included participation by physicians in many areas of the United States; and

Whereas, medical care for individuals in the transgender community has been affected through politically motivated legislation in a number of states to limit gender-affirming care and other procedures, leading to public protests in many states; and

Whereas, the 2022 Supreme Court decision rendered in "*Dobbs v. Jackson Women's Health Organization*" *("Dobbs")*, which removed the constitutional protections regarding access to certain health care services (elective abortion of a pregnancy), has also been met with numerous public protests, which have included participation by physicians; and

Whereas, the *New England Journal of Medicine* published a perspective on August 24, 2022, reminding physicians, in the wake of *Dobbs*, of the appropriate role of professional participation in civil disobedience in light of this decision; and

Whereas, the right to speak freely and to petition the government for redress of grievances is enshrined in the First Amendment of the Constitution of the United States as part of the Bill of Rights; and

Whereas, there exists in the United States a long history of peaceful protest marches, many of which involved peaceful acts of civil disobedience while petitioning for grievances regarding issues such as the right to join a union, civil rights, and other causes; and

Whereas, participation in events in which "civil disobedience" occurs often carries with such participation a significant risk for arrest by members of the police, because many of these marches have been met by forceful police responses, including the use of force disproportionate to any potential threat to public safety; and

Whereas, police departments and public safety agencies nationwide have responded to some large protests with techniques such as "kettling," in which police surround peaceful protesters in a manner that precludes their dispersal and results in an arrest of them all—a technique that has subsequently resulted in arrests of citizens who have been non-violently expressing their right to free speech; and

Whereas, other circumstances may also ensue in which physicians are arrested during peaceful expressions of protest, in which they cannot credibly be accused of having committed any crime of violence upon public safety personnel or others involved in or responding to such protests; and

Whereas, some jurisdictions have escalated arrests for some non-violent acts of civil disobedience to potentially be charged as a “felony” offense; and

Whereas, such arrests, whether alleged misdemeanors or alleged felonies, typically must be reported on credentialing or re-credentialing applications to state licensure boards, hospital organizations and insurers or governmental agencies that provide payment to physicians for their provision of health care goods and services; and

Whereas, physicians who are arrested in circumstances as described above may reasonably fear that such arrests (and their reporting) may complicate their re-credentialing with state licensure boards, hospital organizations and/or insurers or governmental agencies that provide payment to physicians for their provision of health care goods and services; and

Whereas, such arrests are typically viewed by these credentialing organizations as unrelated to fitness to practice medicine; and

Whereas, failure to report such arrests can result in sanctions related to the physician’s failure to meet the obligation to truthfully provide answers to the questions posed by the credentialing organization(s); therefore be it

RESOLVED, that our American Medical Association advocate to appropriate credentialing organizations and payers—including the Federation of State Medical Boards, state and territorial licensing boards, hospital and hospital system accrediting boards, and organizations that compensate physicians for provision of health care goods and services—that misdemeanor or felony arrests of physicians as a result of exercising their First Amendment rights of protest through nonviolent civil disobedience should not be deemed germane to the ability to safely and effectively practice medicine. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 10/11/23

Reference Committee B

Report(s) of the Board of Trustees

06 Universal Good Samaritan Statute
07 Obtaining Professional Recognition for Medical Service Professionals

Resolution(s)

201 Opposition to the Restriction and Criminalization of Appropriate Use of Psychotropics in Long Term Care
202 Protecting the Health of Patients Incarcerated in For-Profit Prisons
203 Anti-Discrimination Protections for Housing Vouchers
204 Improving PrEP & PEP Access
205 Cannabis Product Safety
206 The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice
207 On-Site Physician Requirement for Emergency Departments
208 Non-Physician Practitioners Oversight and Training
210 Immigration Status in Medicaid and CHIP
213 Health Technology Accessibility for Aging Patients
215 A Public Health-Centered Criminal Justice System
216 Saving Traditional Medicare
217 Addressing Work Requirements for J-1 Visa Waiver Physicians
218 Youth Residential Treatment Program Regulation
219 Improving Access to Post-Acute Medical Care for Patients with Substance Use Disorder (SUD)
220 Merit-Based Process for the Selection of all Federal Administrative Law Judges
222 Expansion of Remote Digital Laboratory Access Under CLIA
223 Initial Consultation for Clinical Trials Under Medicare Advantage
224 ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers

REPORT OF THE BOARD OF TRUSTEES

B of T Report 06-I-23

Subject: Universal Good Samaritan Statute (Res. 214-I-22)

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

Referred to: Reference Committee B

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

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

BACKGROUND

Origin of Good Samaritan Laws

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

Good Samaritan laws provide liability protection against claims of "ordinary negligence." Ordinary negligence is the failure to act as a reasonably prudent person; that is, the failure to exercise such

care as a reasonably acting person would ordinarily apply under the same or similar circumstances.[4] These laws typically do not protect against "gross negligence" or willful actions. Gross negligence is a conscious and voluntary disregard of the need to use reasonable care that is likely to cause foreseeable grave injury or harm to persons, property, or both.[5]

Applicability of Good Samaritan Laws to Physicians

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

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

AMA POLICY

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

AMA policy supports Good Samaritan protections for medical professionals responding to emergencies as "bystander physicians" (Policy H-130.937, Delivery of Health Care by Good Samaritans), and to medical professionals during in-flight medical emergencies (Policy H-45.997, In-Flight Emergency Care). In addition, AMA policy supports protections for callers or witnesses seeking medical help for overdose victims (Policy H-45.997, 911 Good Samaritan Laws). Thus, while the AMA has strong policy supporting the protection of physicians acting as a Good Samaritan in certain circumstances, and has advocated that Good Samaritan protections be extended to health care professionals when volunteering during a federally declared disaster,[8] such policy does not directly ask for the alignment and harmonization of disparate state laws into a universal minimum standard of conduct.

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

DISCUSSION

The AMA has strong policy in support of general Good Samaritan liability protections, primarily at the state level, as well as strong policy in support of medical liability reform. AMA policy in

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

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

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

Policy H-130.937, Delivery of Health Care by Good Samaritans

1. Our AMA will work with state medical societies to educate physicians about the Good Samaritan laws in their states and the extent of liability immunity for physicians when they act as Good Samaritans.
2. Our AMA encourages state medical societies in states without "Good Samaritan laws," which protect qualified medical personnel, to develop and support such legislation.
3. Where there is no conflict with state or local jurisdiction protocol, policy, or regulation on this topic, the AMA supports the following basic guidelines to apply in those instances where a bystander physician happens upon the scene of an emergency and desires to assist and render medical assistance. For the purpose of this policy, "bystander physicians" shall refer to those physicians rendering assistance voluntarily, in the absence of pre-existing patient-physician

relationships, to those in need of medical assistance, in a service area in which the physician would not ordinarily respond to requests for emergency assistance. (a) Bystander physicians should recognize that prehospital EMS systems operate under the authority and direction of a licensed EMS physician, who has both ultimate medical and legal responsibility for the system. (b) A reasonable policy should be established whereby a bystander physician may assist in an emergency situation, while working within area-wide EMS protocols. Since EMS providers (non-physicians) are responsible for the patient, bystander physicians should work collaboratively, and not attempt to wrest control of the situation from EMS providers. (c) It is the obligation of the bystander physician to provide reasonable self-identification. (d) Where voice communication with the medical oversight facility is available, and the EMS provider and the bystander physician are collaborating to provide care on the scene, both should interact with the local medical oversight authority, where practicable. (e) Where voice communication is not available, the bystander physician may sign appropriate documentation indicating that he/she will take responsibility for the patient(s), including provision of care during transportation to a medical facility. Medical oversight systems lacking voice communications capability should consider the addition of such communication linkages to further strengthen their potential in this area. (f) The bystander physician should avoid involvement in resuscitative measures that exceed his or her level of training or experience. (g) Except in extraordinary circumstances or where requested by the EMS providers, the bystander physician should refrain from providing medical oversight of EMS that results in deviation from existing EMS protocols and standing orders.

4. Our AMA urges the International Civil Aviation Organization to make explicit recommendations to its member countries for the enactment of regulations providing "Good Samaritan" relief for those rendering emergency medical assistance aboard air carriers and in the immediate vicinity of air carrier operations.

RECOMMENDATION

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

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

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

Fiscal Note: $10,000.

---

[1] Good Samaritan Laws, B. West and M. Varacallo National Institutes of Health National Library of Medicine, National Center for Biotechnology Information, September 2022.

[2] Good Samaritan Law States [Updated March 2023], WorldPopulationReview.com; See also, What does the law say to Good Samaritans?: A review of Good Samaritan statutes in 50 states and on US airlines, Stewart PH, W.S. Agin WS and S.P. Douglas, 2013: cited in VeryWellHealth, R. Brouhard, September 2020, https://www.verywellhealth.com/do-all-states-have-good-samaritan-laws-1298836#citation-2.

[3] See footnote 1, *supra.*

[4] *Ibid*

[5] *Ibid*

[6] *Ibid*

[7] *See,* (1) Statement of the American Medical Association to the Committee on Energy & Commerce Subcommittee on Oversight and Investigations, United States House of Representatives, Re: "Combatting the Opioid Abuse Epidemic: Professional and Academic Perspectives," Presented by Patrice A. Harris, MD,

MA, Secretary, Board of Trustees April 23, 2015, available at: https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fopioid-abuse-testimony-23april2015.pdf;
(2) Testimony of the American Medical Association before the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health, Re: Examining Legislative Proposals to Combat our Nation's Drug Abuse Crisis, October 8, 2015, available at: https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fopioid-house-energy-commerce-testimony-08oct2015.pdf;
(3) Letter to Speaker Pelosi, Leader McConnell, Leader McCarthy, and Leader Schumer, March 19, 2020, available at: https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-3-19-Letter-to-Congress-re-Financial-Assistance.pdf;
(4) Letter to Representative Garner, February 7, 2016, available at: https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2FAMA-letter-supporting-MT-Naloxone-Bill-FINAL.pdf
(5) *Strengthening partnerships to end the nation's opioid crisis,* National Governors Association Health and Human Services Committee February 20, 2016 Statement for the record Patrice A. Harris, MD, MA Chair-elect American Medical Association Board of Trustees, available at: https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fharris-statement-nga-feb2016.pdf;
(6) Letter to the Honorable Chris Christie, Chair, President's Commission on Combating Drug Addiction and the Opioid Crisis, Office of National Drug Control Policy, May 18, 2017, available at: https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2017-5-18-Letter-to-Christie-re-White-House-Commission-on-Opioids.pdf;
(7) Letter to National Governors Association on State policies to preserve and expand the COVID-19 workforce by adopting civil immunity protections, April 20, 2020, available at: https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-4-20-Mc-Bride-Letter-to-NGA-FINAL.pdf.

[8] Letters in support of the Good Samaritan Health Professionals Act: https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2FGSHPA-support-ltr-to-Ruiz-Bucshon-final-9-28-21.pdf; https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-3-19-Letter-to-Congress-re-Financial-Assistance.pdf; https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-7-2-Letter-to-Walden-Pallone-re-Good-Samaritan.pdf.

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

REPORT OF THE BOARD OF TRUSTEES

B of T Report 07-I-23

Subject: Obtaining Professional Recognition for Medical Service Professionals (Res. 232-I-22)

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

Referred to: Reference Committee B

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

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

BACKGROUND

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

Currently, there is no unique SOC for MSPs. The BLS instead categorizes MSPs as human resources professionals. The National Association Medical Staff Services (NAMSS)—which is a membership organization that includes medical staff and credentialing services professionals from medical group

practices, hospitals, managed care organizations, and credentials verification organizations—petitioned the BLS to obtain a unique SOC for MSPs during the last revision period, but their petition was denied. NAMSS intends to submit a revised petition to the BLS and is seeking stakeholder support.

DISCUSSION

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

As mentioned above, BLS does not currently have an SOC for MSPs as a distinct category. Instead, BLS provides SOC codes for various specific occupations within the health care industry. Some of the occupations that may encompass roles related to MSPs include medical records and human information technicians, medical secretaries and administrative assistants, medical transcriptionists, and billing and posting clerks. MSPs, however, perform more specialized duties. For example, the Centers for Medicare & Medicaid Services (CMS) requirements to onboard medical staff members are distinct from other hospital employees because of the direct effects on patient safety. CMS sets rigorous standards for medical staff that MSPs oversee to minimize patient and hospital risks. Credentialing and privileging physicians and other clinicians require MSPs' unique skillset to ensure compliance with policies and procedures that are not required of human resources personnel. The following chart (provided by NAMSS) lists some of the differences between MSPs and human resources personnel.

MSPs	**HR Personnel**
Supports Medical Staff Services Office Members	**Supports Hospital Employees**
• Exclusively serves the Medical Staff, a self-governing body separate from HR. • Does not participate in hiring processes. • Focuses on practitioners, who are often contracted, not employed. • Enrolls practitioners in payer networks, provides documentation to treat patients, and tracks approvals for claims reimbursement. • Provides Medical Staff leadership support (e.g., meeting, financial, election, committee, credentialing-software management). • Manages development of bylaws, process and procedures, federal/state/organizational rules and regulations, privileging forms, peer review, and fair hearings/appeals. *Responsibilities*: Primary-source verification, credentialing, privileging, provider enrollment, continuous practitioner monitoring, reappointment, committee management, CME coordination, accreditation/regulatory compliance, Medical Staff governance, and National Provider Data Bank reports.	• Posts and fills open employee positions. • Oversees payroll, I-9 verification, tax information, employment rules, compensation, and benefits. • Manages private personnel information and employee-related issues. Enforces federal and state employment laws. • Focuses on organizational employee policies. • Counsels employees. • Ensures facility safety, security, and compliance. • Implements and facilitates employee professional-growth programs. *Responsibilities*: Staffing, employee support, employee policies, compensation/benefits, retention, safety/security, training/development, legal and worker protection.

Credentials and Privileges	Recruits, Hires, Onboards
• Credentials and privileges practitioners that HR hires. • Obtains and primary-source verifies practitioner education, training, affiliation history, malpractice claims, peer references, certifications, licensure, DEA registration, federal/state sanctions.	• Develops and oversees employed-staff structure, posts job descriptions, recruits, matches candidates with positions, develops benefits packages, onboards employees. • Reviews self-reported applicant data. • Does not assess clinical competencies.
Continuously Evaluates Performance	**Oversees Staffing and Working Conditions**
• Continuously monitors medical staff. • Uses understanding of medical procedures to match qualifications with privileges. • Reappoints practitioners every 2-3 years through vigorous recredentialing process.	• Focuses on staffing, interpersonal relations, and workplace conditions. • Oversees growth and retention initiatives. • Does not review Medical Staff members quality performance.
Medical Staff Compliance Experts	**Employment Law Experts**
• Experts in bylaws, policies, and procedures, regulatory standards related to practitioners. • Ensures compliance with, and awareness of, accrediting-body standards; federal and state regulatory standards.	• Abides by labor laws, regulations relating to employment, and HR-specific accreditation regulations. • Reports and maintains federal employment information.
Credentials	**Credentials**
• Certified Provider Credentialing Specialist (CPCS) • Certified Professional Medical Services Management (CPMSM)	• Certified in Healthcare Human Resources (CHHR) • Certified Professional in Healthcare Risk Management (CPHRM)

AMA POLICY

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

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

CONCLUSION

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

recommends that an Alternate Resolution 232-I-22 be adopted that would establish policy in support of an SOC for MSPs in lieu of an active collaboration with the leadership of NAMSS.

RECOMMENDATION

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

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

Fiscal Note: Less than $500.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(I-23)

Introduced by: American Association for Geriatric Psychiatry, American Academy of Addiction Psychiatry, American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Psychiatric Association

Subject: Opposition to the Restriction and Criminalization of Appropriate Use of Psychotropics in Long Term Care

Referred to: Reference Committee B

Whereas, major neurocognitive disorders, including Alzheimer's disease and other dementias, have become increasingly common as our population is aging; and

Whereas, behavioral and psychological symptoms of dementia are behavioral changes (i.e. paranoia, delusions, auditory/visual hallucinations, physical and verbal aggression) that impact the majority of patients with major neurocognitive disorders and are typically treated with a combination of medications (i.e., antidepressants and antipsychotic medications) and behavioral interventions; and

Whereas, despite the 2007 FDA warning advising increased risk of death in older adults with dementia taking antipsychotics, these medications are still used following discussion of the risks and benefits as supported by the American Psychiatric Association clinical practice guidelines (2020) which noted: "Aggression, agitation, and psychosis are highly prevalent in patients with Major Neurocognitive Disorder and cause great suffering. Their presence is associated with a worse prognosis. While non-pharmacological approaches are generally recommended as first-line treatments, they are often ineffective in the treatment of aggression, agitation and psychosis, and the judicious use of antipsychotic medications may be appropriate"[1]; and

Whereas, the Centers for Medicaid and Medicare Services (CMS) initiated a 2012 policy reducing all psychotropic treatments with a focus on antipsychotic medications[2] and imposing strict penalties for antipsychotic use without a diagnosis of schizophrenia, Tourette's, or Huntington's disease[3]. As a result of this policy, psychiatrists report medically inappropriate tapers and discontinuation of long-term stable antipsychotic regimens often leading to behavioral decompensation, unanticipated nursing home discharge to community hospitals where the patient is boarded for weeks to months before a new placement is identified; and

Whereas, despite efforts since 2013 to encourage CMS measure adjustment and in light of the 2021 OIG report highlighting measure deficiencies[4], CMS has not agreed to policy changes that would differentiate appropriate and inappropriate antipsychotic prescribing based on accepted clinical guidelines; and

Whereas, state legislatures have taken up the mantle of this overly restrictive CMS policy by proposing laws[5] that further incentivize nursing homes to discriminate against people living with mental illness by promoting reduced access to psychotropics and criminalizing potential errors in the medical record documentation specific to the use of psychotropics; and

Whereas, our AMA has established substantial policy on the importance of the patient-physician relationship in clinical decision-making being free from legislative interference and criminalization as outlined in AMA Policies H-160.954, H-160.946, H160.999, and H-80.992, yet the specific wording only references federal efforts, where broader language would allow our advocacy teams more flexibility when relevant state issues occur; therefore be it

RESOLVED, that our American Medical Association work with key partners to advocate that CMS revise the existing measure for psychotropic prescribing in nursing homes to ensure nursing home residents have access to all medically appropriate care (Directive to Take Action); and be it further

RESOLVED, that our AMA amend policy H-160.954 by insertion as follows: (1) Our AMA continues to take all reasonable and necessary steps to ensure that errors in medical decision-making and medical records documentation, exercised in good faith, do not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal, state, and local government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 9/25/2023

REFERENCES

1. American Psychiatric Association. (2020, July). APA Official Action: Position Statement on the Use of Antipsychotic Medication in Patients with Major Neurocognitive Disorder. Position-Antipsychotic-Medication-Major-Neurocognitive-Disorder.pdf (psychiatry.org)
2. Lucas JA and Bowblis JR. (2017) "CMS Strategies To Reduce Antipsychotic Drug Use In Nursing Home Patients With Dementia Show Some Progress" Health Affaris 36(7). https://doi.org/10.1377/hlthaff.2016.1439
3. Centers for Medicare and Medicaid Services. (2023, Jan 18). *Updates to the Nursing Home Care Compare Website and Five Star Quality Rating System: Adjusting Quality Measure Ratings Based on Erroneous Schizophrenia Coding, and Posting Citations Under Dispute.* US Department of Health and Human Services. QSO-23-05-NH (cms.gov)
4. Office of Inspector General (2021 May). *OEI-07-19-00490 - CMS Could Improve the Data It Uses To Monitor Antipsychotic Drugs in Nursing Homes.* U.S. Department of Health and Human Services
5. California Legislative Information (2023 March 16). AB-48 Nursing Facility Resident Informed Consent Protection Act of 2023. Bill Text - AB-48 Nursing Facility Resident Informed Consent Protection Act of 2023. (ca.gov)

RELEVANT AMA POLICY

Criminalization of Medical Judgment H-160.954
(1) Our AMA continues to take all reasonable and necessary steps to ensure that errors in medical decision-making and medical records documentation, exercised in good faith, do not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties. [Sub. Res. 223, I-93; Reaffirmed: Res. 227, I-98; Reaffirmed: Res. 237, A-99; Reaffirmed and Appended: Sub. Res. 215, I-99; Reaffirmation A-09; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation: I-12Modified: Sub. Res. 716, A-13; Reaffirmed in lieu of Res. 605, I-13; Reaffirmed: Res. 250, A-22; Reaffirmed: Res. 252, A-22]

The Criminalization of Health Care Decision Making H-160.946
The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion

leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making. [Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07; Reaffirmation A-09; Reaffirmation: I-12; Reaffirmed: BOT Rep. 9, A-22; Reaffirmed: Res. 250, A-22; Reaffirmed: Res. 252, A-22; Reaffirmed: Res. 224, I-22]

Opposition to Criminalizing Health Care Decisions D-160.999
Our AMA will educate physicians regarding the continuing threat posed by the criminalization of healthcare decision-making and the existence of our model legislation "An Act to Prohibit the Criminalization of Healthcare Decision-Making." [Res. 228, I-98; Reaffirmed: BOT Rep. 5, A-08; Reaffirmation: I-12; Reaffirmed: BOT Rep. 9, A-22]

Report Regarding the Criminalization of Providing Medical Care H-80.992
Our American Medical Association will 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. [Res. 015, A-23]

Appropriate Use of Antipsychotic Medications in Nursing Home Patients D-120.951
Our AMA will: (1) meet with the Centers for Medicare & Medicaid Services (CMS) for a determination that acknowledges that antipsychotics can be an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed and will ask CMS to cease and desist in issuing citations or financial penalties for medically necessary and appropriate use of antipsychotics for the treatment of dementia-related psychosis; and (2) ask CMS to discontinue the use of antipsychotic medication as a factor contributing to the Nursing Home Compare rankings, unless the data utilized is limited to medically inappropriate administration of these medications. [Res. 523, A-12; Appended: Res. 708, A-19]

Long-Term Care Prescribing of Atypical Antipsychotic Medications H-25.989
Our AMA: (1) will collaborate with appropriate national medical specialty societies to create educational tools and programs to promote the broad and appropriate implementation of non-pharmacological techniques to manage behavioral and psychological symptoms of dementia in nursing home residents and the cautious use of medications; (2) supports efforts to provide additional research on other medications and non-drug alternatives to address behavioral problems and other issues with patients with dementia; and (3) opposes the proposed requirement that physicians who prescribe medications with "black box warnings on an off-label basis certify in writing that the drug meets the minimum criteria for coverage and reimbursement by virtue of being listed in at least one of the authorized drug compendia used by Medicare." [Res. 819, I-11; Reaffirmed: CMS Rep. 1, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(I-23)

Introduced by: Medical Student Section

Subject: Protecting the Health of Patients Incarcerated in For-Profit Prisons

Referred to: Reference Committee B

Whereas, the federal government and 26 states currently contract with for-profit prisons owned by private third-party companies, with the population incarcerated in for-profit prisons disproportionately rising at least 5 to 10 times faster than the overall incarcerated population from 2000 to 2016[1-3]; and

Whereas, contracts with for-profit prisons raise ethical concerns, since facilities profit from larger incarcerated populations and longer sentences[1,4]; and

Whereas, for-profit prisons maximize profits by cutting funding for payment, training, and retention of staff, resulting in inexperienced personnel with high turnover and increased risk to the safety and quality of life of incarcerated individuals[3,7-8]; and

Whereas, for-profit prisons spend under 10% of their funds on healthcare compared to 15% in public prisons, offer less access to mental health, addiction, and HIV care, and demonstrate greater rates of delayed interventions for serious mental illness, denial or delay of medically necessary hospitalization, inappropriate use of non-physicians, overcrowding, assaults, injuries due to riots, use of force and solitary confinement, and due process violations[7-11]; and

Whereas, while public prisons are obligated to release data on operations, safety conditions, healthcare use, and parole and probation services and can be held publicly accountable, for-profit prisons are not subject to this level of oversight[1,6,13-14]; and

Whereas, in 2021, the Biden-Harris Administration announced that they would not renew federal contracts with for-profit prisons, but these corporations continue to contract with counties who in turn contract with the federal government for criminal and immigration detention[15-16]; and

Whereas, California, Nevada, New York, Illinois, and Washington state all ban or limit state use of for-profit prisons, and 22 states do not use for-profit prisons at all[17-18]; therefore be it

RESOLVED, that our American Medical Association advocate against the use of for-profit prisons (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for for-profit prisons, public prisons with privatized medical services, and detention centers to be held to the same standards as prisons with public medical services, especially with respect to oversight, reporting of health-related outcomes, and quality of healthcare. (Directive to Take Action)

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

Received: 09/11/2023

REFERENCES

1. Private prisons vs. public prisons. Criminal Justice Programs. https://www.criminaljusticeprograms.com/articles/private-prisons-vs-public-prisons/. Published May 4, 2021. Accessed March 20, 2022.
2. Fettig A, Nellis A. Private prisons in the United States. The Sentencing Project. https://www.sentencingproject.org/publications/private-prisons-united-states/. Published March 30, 2021. Accessed April 8, 2023.
3. Gotsch K, Basti V. Capitalizing on mass incarceration: U.S. growth in private prisons. The Sentencing Project. https://www.sentencingproject.org/publications/capitalizing-on-mass-incarceration-u-s-growth-in-private-prisons/. Published August 2, 2018. Accessed March 20, 2022.
4. Cert examples. Human Resources. https://in.nau.edu/human-resources/cert-examples/. Accessed March 20, 2022.
5. Burkhardt BC. Who is in private prisons? demographic profiles of prisoners and workers in American private prisons. *Int Journal of Law, Crime and Justice*. 2017;51:24-33. doi:10.1016/j.ijlcj.2017.04.004
6. Kim C. Private prisons face an uncertain future as states turn their backs on the industry. Vox. https://www.vox.com/policy-and-politics/2019/12/1/20989336/private-prisons-states-bans-califonia-nevada-colorado. Published December 1, 2019. Accessed March 20, 2022.
7. Wagner P, Rabuy B. Following the money of mass incarceration. Prison Policy Initiative. https://www.prisonpolicy.org/reports/money.html. Published January 25, 2017. Accessed March 20, 2022.
8. Risko R. Budget Briefing: Corrections. House Fiscal Agency. https://www.house.mi.gov/hfa/PDF/Briefings/Corrections_BudgetBriefing_fy22-23.pdf. Published December 2022. Accessed April 9, 2023.
9. Review of Federal Bureau of Prisons' monitoring of ... Office of the Inspector General. https://oig.justice.gov/reports/2016/e1606.pdf. Published August 2016. Accessed March 20, 2022.
10. Thompson C. Everything you ever wanted to know about private prisons... https://www.themarshallproject.org/2014/12/18/everything-you-ever-wanted-to-know-about-private-prisons. Published December 18, 2014. Accessed March 20, 2022.
11. Wessler S. Federal officials ignored years of internal warnings about deaths at private prisons. The Nation. https://www.thenation.com/article/archive/federal-officials-ignored-years-of-internal-warnings-about-deaths-at-private-prisons/. Published December 14, 2017. Accessed March 20, 2022.
12. Nowotny KM, Rogers RG, Boardman JD. Racial disparities in health conditions among prisoners compared with the general population. SSM - Population Health. https://www.sciencedirect.com/science/article/pii/S235282731730037X?via%3Dihub. Published May 22, 2017. Accessed March 20, 2022.
13. Montes AN, Mears DP, Stewart EA. Racial and ethnic divides in privatized punishment: Examining disparities in private prison placements. Justice Quarterly. 2019;37(5):930-954. doi:10.1080/07418825.2019.1675747
14. Kim D-Y. Prison privatization: An Empirical Literature Review and path forward. *Int Crim Justice Rev*. 2019;32(1):24-47. doi:10.1177/1057567719875791
15. Executive order on reforming our incarceration system to eliminate the use of privately operated criminal detention facilities. The White House. https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/26/executive-order-reforming-our-incarceration-system-to-eliminate-the-use-of-privately-operated-criminal-detention-facilities/. Published January 26, 2021. Accessed March 20, 2022.
16. Eisen L-B. Breaking down Biden's order to eliminate DOJ private prison contracts. Brennan Center for Justice. https://www.brennancenter.org/our-work/research-reports/breaking-down-bidens-order-eliminate-doj-private-prison-contracts. Published November 15, 2021. Accessed March 20, 2022.
17. La Corte R. Washington State governor Oks Bill banning for-profit jails. AP NEWS. https://apnews.com/article/legislature-prisons-washington-legislation-immigration-ceda36fec7dfc3a56c8fe8f7a66d3d76. Published April 14, 2021. Accessed March 8, 2023.
18. Buday M, Nellis A. The Sentencing Project; 2022. https://www.sentencingproject.org/app/uploads/2022/10/Private-Prisons-in-the-United-States-2.pdf. Accessed March 8, 2023.

RELEVANT AMA POLICY

H-430.986 Health Care While Incarcerated

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system, including correctional settings having sufficient resources to assist incarcerated persons' timely access to mental health, drug and residential rehabilitation facilities upon release.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and

adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the “inmate exclusion” of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7.Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community; (c) the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and (d) collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.
11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children’s Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.
13. Our AMA encourages the following qualifications for the Director and Assistant Director of the Health Services Division within the Federal Bureau of Prisons: (a) MD or DO, or an international equivalent degree with at least five years of clinical experience at a Bureau of Prisons medical facility or a community clinical setting; (b) knowledge of health disparities among Black, American Indian and Alaska Native, and people of color, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities; (c) knowledge of the health disparities among individuals who are involved with the criminal justice system.
14. Our AMA will collaborate with interested parties to promote the highest quality of health care and oversight for those who are involved in the criminal justice system by advocating for health administrators and executive staff to possess credentials and experience comparable to individuals in the community in similar professional roles. [CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Modified: Res. 503, A-21; Reaffirmed: Res. 229, A-21; Modified: Res. 127, A-22; Appended: Res. 244, A-23; Appended: Res. 429, A-23]

H-430.997 Standards of Care for Inmates of Correctional Facilities
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance use disorder care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism. [Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation I-09 Modified in lieu of Res. 502, A-12; Reaffirmation: I-12; Modified: CSAPH Rep. 1, A-22]

D-350.983 Improving Medical Care in Immigrant Detention Centers
Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental,

and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention. [Res. 017, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(I-23)

Introduced by: Medical Student Section

Subject: Anti-Discrimination Protections for Housing Vouchers

Referred to: Reference Committee B

Whereas, adequate, safe, and affordable housing is an important social determinant of health, yet studies on subsidized housing and health are limited in number and scope[1]; and

Whereas, individuals in need of federal housing assistance and subsidized housing may bear a greater burden of mental and physical illness, physical violence and economic hardship than the general population[1-2;] and

Whereas, the US Department of Health and Human Services and Housing Urban Development (HUD) entered into a partnership in 2021 to expand affordable housing access, along with services that address social determinants of health among vulnerable populations[3]; and

Whereas, the federal housing choice voucher program, commonly referred to as “Section 8” is a federal housing program for tenants experiencing economic and related hardships[2,4]; and

Whereas, 2 in 3 voucher households are not protected by anti-discrimination laws at the local, state, or federal level, allowing for landlords to discriminate against and refuse the use of the Section 8 vouchers by prospective tenants[5]; and

Whereas, over two-thirds of HUD beneficiaries (Section 8 or related program) are racial and ethnic minorities, with 45% identifying as Black or African American[7]; and

Whereas, racial and ethnic minorities are less likely to be homeowners due to disparate intergenerational wealth compared to the non-Hispanic white population[8-9]; and

Whereas, our American Medical Association recognizes that generational wealth gaps experienced by Black or African American, American Indian or Alaska Native, and Hispanic families are a consequence of structural racism and a barrier to achieving racial health equity (D-60.965); and

Whereas, families’ length of stay in the Section 8 Housing Choice Voucher program is increasing and rate of success in finding suitable low-income housing to utilize the voucher has been decreasing since the 1980s, both largely due to rising housing costs, stagnant incomes, and insufficient federal funding10; and

Whereas, the increasing wait times in Section 8 reinforce existing housing insecurity and homelessness that track among disparities in race, especially in the difficulty of finding and maintaining employment, and increasing childhood adverse events, leading to cognitive and mental health problems, respiratory diseases, accidental and intentional injuries, and diminished educational outcomes[11]; therefore be it

RESOLVED, that our American Medical Association support local, state, and federal policies requiring landlords to accept Section 8 and related housing vouchers as valid sources of individual and family income (New HOD Policy); and be it further

RESOLVED, that our AMA support local, state, and federal policies preventing landlords from discriminating against individuals and families who utilize public assistance. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 09/11/2023

REFERENCES

1. Pomeroy ML, Johnson E, Weinstein AA. Subsidized Housing and Health: An Exploratory Study Examining Resident Perspectives on Community Health and Access to Care. J Health Care Poor Underserved. 2021;32(3):1415-1432. doi:10.1353/hpu.2021.0141
2. Jayasundara DS, Legerski EM, Danis FS, Ruddell R. Oil Development and Intimate Partner Violence: Implementation of Section 8 Housing Policies in the Bakken Region of North Dakota and Montana. J Interpers Violence. 2018;33(21):3388-3416. doi:10.1177/0886260518798359
3. HHS and HUD announce expanded partnership, new housing and services resource center. Published December 8, 2021. Accessed September 22, 2022. https://www.hud.gov/press/press_releases_media_advisories/hud_no_21_201
4. Housing Choice Vouchers Fact Sheet. U.S. Department of Housing and Urban Development. Accessed September 22, 2022. https://www.hud.gov/topics/housing_choice_voucher_program_section_8
5. Bell, A., Sard, B., Koepnick, B. Prohibiting Discrimination Against Renters Using Housing Vouchers Improves Results. Center on Budget and Policy Priorities. Last Updated December 20, 2018. Accessed September 22, 2022. https://www.cbpp.org/research/housing/prohibiting-discrimination-against-renters-using-housing-vouchers-improves-results
6. Ellen, I., O'Regan, K., Harwood, K. Advancing Choice in the Housing Choice Voucher Program: Source of Income Protections and Locational Outcomes. *Housing Policy Debate*. 2022. DOI: 10.1080/10511482.2022.2089196
7. Public Housing Statistics. *iProperty Management*. Last Updated May 9, 2022. Accessed September 22, 2022. https://ipropertymanagement.com/research/public-housing-statistics
8. Fenton, R. Unaffordable housing: cost-burdened housing estimates for South Carolina's minority population. *South Carolina State Library*. Published August 9, 2022. Accessed September 22, 2022. https://dc.statelibrary.sc.gov/handle/10827/45438
9. Eldemire, A., Luchtenberg, K., Wynter, M. Does Homeownership Reduce Wealth Disparities for Low-Income and Minority Households? *The Review of Corporate Finance Studies*. Volume 11, Issue 3. August 2022: Pages 465–510, https://doi.org/10.1093/rcfs/cfac016
10. Section 8 Family Data. *Section 8 Information*. Published March 24, 2020. Accessed August 28, 2022. https://section8-information.org/section-8-statistics/
11. Acosta S, Gartland E. Families Wait Years for Housing Vouchers Due to Inadequate Funding. Center on Budget and Policy Priorities. https://www.cbpp.org/research/housing/families-wait-years-for-housing-vouchers-due-to-inadequate-funding. Published July 22, 2021. Accessed September 18, 2022.

RELEVANT AMA POLICY

H-350.953 Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data
Our AMA will: (1) oppose policies that enable racial housing segregation; and (2) advocate for continued federal funding of publicly-accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education, and healthcare, including but not limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool. [Res. 405, A-18]

H-160.903 Eradicating Homelessness
Our AMA:
(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
(4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;

(5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
(7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods. [Res. 401, A-15, Appended: Res. 416, A-18, Modified: BOT Rep. 11, A-18, Appended: BOT Rep. 16, A-19, Appended: BOT Rep. 28, A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(I-23)

Introduced by: Medical Student Section

Subject: Improving PrEP & PEP Access

Referred to: Reference Committee B

Whereas, pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) are antiretroviral treatments that prevent human immunodeficiency virus (HIV) infection in high-risk populations[1]; and

Whereas, the Centers for Disease Control and Prevention (CDC) recommends PrEP for: (1) people without HIV who have had anal or vaginal sex in the past six months without a condom, with an STI history in that period, or with a partner with HIV, and (2) for people without HIV who use injection drugs with a partner with HIV or who share injection equipment[1]; and

Whereas, the CDC recommends PEP for people without HIV or with unknown HIV status with possible HIV exposure in the past 72 hours[2]; and

Whereas, HIV disproportionately affects men who have sex with men (MSM) and minoritized racial and ethnic groups, especially Black and Latine communities[3-4]; and

Whereas, under 25% of patients who meet PrEP criteria actually take PrEP, with disproportionate inequities among Black and Latine patients[5-6]; and

Whereas, 52% of new HIV diagnoses occur in Southern states, but only 27% of PrEP users reside in these states[6]; and

Whereas, various state laws increase PrEP and PEP access by creating collaborative practice agreements between physicians and pharmacists, allowing patients to seek prophylaxis at community pharmacies while being monitored by physicians[5,7-14]; and

Whereas, a systematic review found that allowing patients to seek prophylaxis at pharmacies can result in found that 74-96% of patients filling a prescription within a week of evaluation, and multiple other studies demonstrate increased access for patients who may otherwise forgo PrEP due to logistical, financial, or travel barriers finding a clinic for initial HIV evaluation[14-23]; and

Whereas, AMA Policy H-95.932 already supports the use of collaborative practice agreements with pharmacists for naloxone; and

Whereas, as multiple states are considering laws to increase access to PrEP and PEP at pharmacies, our AMA should take a position on this issue to bolster advocacy[24-25]; therefore be it

RESOLVED, that our American Medical Association support efforts to increase access to HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) through the establishment of collaborative practice agreements with physicians. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 09/19/2023

REFERENCES

1. PreExposure Prophylaxis for the Prevention of HIV Infection in the United States - 2021 Update.; 2021. https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf
2. Dominguez KL, Smith DK, Thomas V, et al. Updated guidelines for antiretroviral postexposure prophylaxis after sexual, injection drug use, or other nonoccupational exposure to HIV—United States, 2016. Cdc.gov. Published 2016. https://stacks.cdc.gov/view/cdc/38856
3. HIV.gov. HIV & AIDS Trends and U.S. Statistics Overview. HIV.gov. Published October 27, 2022. https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics/
4. National Profile | Volume 33 | HIV Surveillance | Reports | Resource Library | HIV/AIDS | CDC. www.cdc.gov. Published May 23, 2022. https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-33/content/national-profile.html
5. *Pharmacist- Initiated PrEP and PEP*. National Alliance of State and Territorial AIDS Directors https://nastad.org/sites/default/files/2021-11/PDF-Pharmacist-Initiated-PrEP-PEP.pdf
6. Smith D, Van Handel M, Grey J. By Race/ethnicity, Blacks Have Highest Number Needing PrEP in the United States, 2015. www.natap.org. Published March 2018. Accessed April 10, 2023. https://www.natap.org/2018/CROI/croi_147.htm
7. Mayer KH, Agwu A, Malebranche D. Barriers to the Wider Use of Pre-exposure Prophylaxis in the United States: A Narrative Review. *Advances in Therapy*. 2020;37(5):1778-1811. doi:https://doi.org/10.1007/s12325-020-01295-0
8. Cohen S, Lubega S, Peters P, Wong S. Quick Clinical Guide: HIV PrEP Pre-Exposure Prophylaxis. www.cdph.ca.gov. https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/QuickClinicalGuide_PrEP_ADA.pdf
9. Stevens L. Post-Exposure Prophylaxis in NYS. Published June 13, 2017. www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/webinars/docs/2017/hh_pep_in_nys.pdf
10. Bill Text - SB-159 HIV: preexposure and postexposure prophylaxis. Ca.gov. Published 2019. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB159
11. SB325 Establishes provisions relating to preventing the acquisition of human immunodeficiency virus. www.leg.state.nv.us. Published March 22, 2021. Accessed April 10, 2023. https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/7959/Text#
12. House Bill 2958. Published 2021. https://olis.oregonlegislature.gov/liz/2021r1/Measures/Overview/HB2958
13. SB79. Published 2021. https://www.senate.mo.gov/21info/pdf-bill/intro/SB79.pdf
14. Weidle PJ, Lecher S, Botts LW, et al. HIV testing in community pharmacies and retail clinics: A model to expand access to screening for HIV infection. *Journal of the American Pharmacists Association*. 2014;54(5):486-492. doi:https://doi.org/10.1331/japha.2014.14045
15. Human Immunodeficiency Virus Infection Prevention Medications | Colorado General Assembly. leg.colorado.gov. Published 2020. https://leg.colorado.gov/bills/hb20-1061
16. Kennedy CE, Yeh PT, Atkins K, Ferguson L, Baggaley R, Narasimhan M. PrEP distribution in pharmacies: a systematic review. *BMJ Open*. 2022;12(2):e054121. doi:https://doi.org/10.1136/bmjopen-2021-054121
17. Crawford ND, Josma D, Morris J, Hopkins R, Young HN. Pharmacy-based pre-exposure prophylaxis support among pharmacists and men who have sex with men. *Journal of the American Pharmacists Association*. 2020;60(4):602-608. doi:https://doi.org/10.1016/j.japh.2019.12.003
18. Zhao A, Dangerfield DT, Nunn A, et al. Pharmacy-Based Interventions to Increase Use of HIV Pre-exposure Prophylaxis in the United States: A Scoping Review. *AIDS and Behavior*. 2021;26(5):1377-1392. doi:https://doi.org/10.1007/s10461-021-03494-4
19. Klepser DG, Klepser ME, Peters PJ, Hoover KW, Weidle PJ. Implementation and Evaluation of a Collaborative, Pharmacy-Based Hepatitis C and HIV Screening Program. *Preventing Chronic Disease*. 2022;19. doi:https://doi.org/10.5888/pcd19.220129
20. Havens JP, Scarsi KK, Sayles H, Klepser DG, Swindells S, Bares SH. Acceptability and Feasibility of a Pharmacist-Led Human Immunodeficiency Virus Pre-Exposure Prophylaxis Program in the Midwestern United States. *Open Forum Infectious Diseases*. 2019;6(10). doi:https://doi.org/10.1093/ofid/ofz365
21. Mayer KH, Chan PA, R. Patel R, Flash CA, Krakower DS. Evolving Models and Ongoing Challenges for HIV Preexposure Prophylaxis Implementation in the United States. *JAIDS Journal of Acquired Immune Deficiency Syndromes*. 2018;77(2):119-127. doi:https://doi.org/10.1097/qai.0000000000001579
22. Select Features of State Pharmacist Collaborative Practice Laws. Published 2012. https://www.cdc.gov/dhdsp/pubs/docs/pharmacist_state_law.pdf
23. Figueira I, Teixeira I, Rodrigues AT, Gama A, Dias S. Point-of-care HIV and hepatitis screening in community pharmacies: a quantitative and qualitative study. *International Journal of Clinical Pharmacy*. 2022;44(5):1158-1168. doi:https://doi.org/10.1007/s11096-022-01444-1
24. Collins B, Bronson H, Elamin F, Yerkes L, Martin E. The “No Wrong Door” Approach to HIV Testing: Results From a Statewide Retail Pharmacy–Based HIV Testing Program in Virginia, 2014-2016. *Public Health Reports*. 2018;133(2_suppl):34S42S. doi:https://doi.org/10.1177/0033354918801026
25. https://www.nprillinois.org/people/maureen-foertsch-mckinney. New law will allow pharmacists to prescribe HIV prevention medications. NPR Illinois. Published June 10, 2022. Accessed July 6, 2023. https://www.nprillinois.org/health-harvest/2022-06-10/new-law-will-allow-pharmacists-to-prescribe-hiv-prevention-medications

RELEVANT AMA POLICY

H-95.932 Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications

1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone and other safe and effective overdose reversal medications, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone and other safe and effective overdose reversal medications delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone and other safe and effective overdose reversal medications .
3. Our AMA encourages physicians to co-prescribe naloxone and other safe and effective overdose reversal medications to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone and other safe and effective overdose reversal medications on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other healthcare professionals and others who are authorized to prescribe, dispense and/or administer naloxone and other safe and effective overdose reversal medications pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone and other safe and effective overdose reversal medications to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone and other safe and effective overdose reversal medications with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible naloxone and other safe and effective overdose reversal medications rescue stations (public availability of naloxone and other safe and effective overdose reversal medications through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone and other safe and effective overdose reversal medications in all public spaces regardless of whether the individual holds a prescription.
10. Our AMA supports efforts to increase the availability, delivery, possession and use of mail-order overdose reversal medications, including naloxone, to help prevent opioid-related overdose, especially in vulnerable populations, including but not limited to underserved communities and American Indian reservation populations. [BOT Rep. 22, A-16; Modified: Res. 231, A-17; Modified: Speakers Rep. 01, A-17; Appended: Res. 909, I-17; Reaffirmed: BOT Rep. 17, A-18; Modified: Res. 524, A-19; Reaffirmed: BOT 09, I-19; Reaffirmed: Res. 219, A-21; Modified: Res. 505, A-23]

H-20.895 Pre-Exposure Prophylaxis (PrEP) for HIV

1. Our AMA will educate physicians, physicians-in-training, and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of all approved PrEP regimens in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for all approved PrEP regimens, such as prior authorization, mandatory consultation with an infectious disease specialist, and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.
5. Our AMA encourages the discussion of and education about PrEP during routine sexual health counseling. [Res. 106, A-16; Modified: Res. 916, I-16; Appended: Res. 101, A-17; Modified: Res. 933, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(I-23)

Introduced by: Oklahoma

Subject: Cannabis Product Safety

Referred to: Reference Committee B

Whereas, physicians prioritize patient safety, and the American Medical Association Code of Medical Ethics underscores its commitment "to promote the art of medicine and the betterment of public health"; and

Whereas, there are many legal implications due to the passage of state cannabis laws and the associated regulations; and

Whereas, current AMA policy, Cannabis Legalization for Medicinal Use, D-95.969 states: Our AMA (3) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process."; and

Whereas, existing AMA policy, Cannabis Legalization for Adult Use (commonly referred to as recreational use), H-95.924 and Cannabis Warnings for Pregnant and Breastfeeding Women, H-95.936, do not contain any such call for model legislation; and

Whereas, as the legalization of both medicinal and recreational cannabis use spreads across the country, it becomes increasingly important that states be able to properly regulate the production, marketing and sales of cannabis products; therefore be it

RESOLVED, that our American Medical Association draft state model legislation to help states implement the provisions of AMA policies H-95.924, Cannabis Legalization for Adult Use and H-95.936, Cannabis Warnings for Pregnant and Breastfeeding Women that currently do not have such model language, including regulation of retail sales, marketing and promotion (especially those aimed at children), misleading health claims, and product labeling regarding dangers of use during pregnancy and breastfeeding. (Directive to Take Action)

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

Received: 9/26/23

RELEVANT AMA POLICY

CBD Oil Use and the Marketing of CBD Oil H-95.911
Our AMA supports: (1) banning the advertising of cannabidiol (CBD) as a component of marijuana in places that children frequent; and (2) legislation and regulatory actions at the federal and state level to prohibit companies from selling CBD products if they make any unproven health and therapeutic claims.

Cannabis Legalization for Medicinal Use D-95.969
Our AMA: (1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use; (2) believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process; (3) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process."; (4) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws; (5) believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions; (6) will, when necessary and prudent, seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians; and (7) encourages hospitals and health systems to: (a) not recommend patient use of non-FDA approved cannabis or cannabis derived products within healthcare facilities until such time as federal laws or regulations permit its use; and (b) educate medical staffs on cannabis use, effects and cannabis withdrawal syndrome.

Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924
Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older); (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) believes states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth; (5) laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (6) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis, especially emergency department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder; (7) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (8) encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (9) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (10) will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among women who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving; (11) supports social equity programs to address the impacts of cannabis prohibition and enforcement policies that have disproportionately impacted marginalized and minoritized communities; and (12) will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids.

Cannabis Warnings for Pregnant and Breastfeeding Women H-95.936
Our AMA advocates for regulations requiring point-of-sale warnings and product labeling for cannabis and

cannabis-based products regarding the potential dangers of use during pregnancy and breastfeeding wherever these products are sold or distributed.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(I-23)

Introduced by: American Academy of Ophthalmology

Subject: The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice

Referred to: Reference Committee B

Whereas, recent research suggests that large language models (LLMs) such as, generative pretrained transformers (GPTs), and other augmented intelligence exhibit political biases1,2,3; and

Whereas, recent research suggests that the reliability of LLMs in its question-answering (QA) capability is variable4; and

Whereas, an AI Chatbot when asked the same questions included in the 2018 AMA Truth in Advertising Survey5 answered that both MDs or DOs and Other Health Care Professionals equally or either one should be allowed to perform the following specific activities: Treat chronic pain by prescribing drugs or other substances that have a higher potential for addiction or abuse, Write prescriptions for medication to treat mental health conditions such as schizophrenia and bipolar disorder, Order and interpret diagnostic imaging studies like X-rays and MRIs, and Administer and monitor anesthesia levels and patient condition before and during surgery and also answered that that it did not know whether a Doctor of Medical Science or a Doctor of Nursing Practice was a Physician; and

Whereas, when given a choice, an AI chatbot agreed with the statement that “patients would benefit from scope of practice changes”; and

Whereas, an AI Chatbot misidentified states with and without expanded optometric scope of practice laws that authorized optometrists to perform laser surgery and provided misinformation on training requirements for optometrists to perform laser surgery; and

Whereas, misinformation, misleading information and biased information from LLMs may be relied upon for policy advice and information by legislators and regulators when formulating opinions on health policy; and

Whereas, our AMA has policy concerning false or misleading AI-generated medical advice (Assessing the Potentially Dangerous Intersection Between AI and Misinformation H-480.935); and

Whereas, existing AMA policy does not directly address false, biased or misleading AI-generated content on health policy, physician truth in advertising, and scope of practice; and

Whereas, the First Amendment of the US Constitution does not allow the government to regulate political bias and protects free speech; therefore be it

RESOLVED, that our American Medical Association encourage physicians to educate our patients, the public, and policymakers about the benefits and risks of facing LLMs including GPTs for advice on health policy, information on healthcare issues influencing the legislative and regulatory process, and for information on scope of practice that may influence decisions by patients and policymakers. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 9/26/23

REFERENCES

1. Hartmann, Jochen, Jasper Schwenzow, and Maximilian Witte. "The political ideology of conversational AI: Converging evidence on ChatGPT's pro-environmental, left-libertarian orientation." arXiv preprint arXiv:2301.01768 (2023). https://arxiv.org/pdf/2301.01768.pdf
2. Suguri Motoki, Fabio Yoshio and Pinho Neto, Valdemar and Rodrigues, Victor. “More Human than Human: Measuring ChatGPT Political Bias.” (July 18, 2023). Motoki, F., Neto, V. P., & Rodrigues, V. (2023). More human than human: Measuring ChatGPT political bias. Public Choice. https://www.researchgate.net/publication/373188439_More_human_than_human_measuring_ChatGPT_political_bias
3. Rystrøm, Jonathan H. "Apolitical Intelligence? Auditing Delphi's responses on controversial political issues in the US." *arXiv preprint arXiv:2306.13000* (2023) https://arxiv.org/pdf/2306.13000.pdf
4. Shen, Xinyue, et al. "In chatgpt we trust? measuring and characterizing the reliability of chatgpt." *arXiv preprint arXiv:2304.08979* (2023) https://arxiv.org/pdf/2304.08979.pdf
5. Truth in Advertising Survey Results, AMA Resource Center https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/arc/tia-survey_0.pdf

RELEVANT AMA POLICY

Assessing the Potentially Dangerous Intersection Between AI and Misinformation H-480.935
Our American Medical Association will: (1) study and develop recommendations on the benefits and unforeseen consequences to the medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content, and that our AMA propose appropriate state and federal regulations with a report back at A-24; (2) work with the federal government and other appropriate organizations to protect patients from false or misleading AI-generated medical advice; (3) encourage physicians to educate our patients about the benefits and risks of consumers facing LLMs including GPTs; and (4) 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, exclusion of augmented intelligence systems as authors, and the responsibility of authors to validate the veracity of any text generated by augmented intelligence. [Res. 247, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(I-23)

Introduced by: Michigan

Subject: On-Site Physician Requirement for Emergency Departments

Referred to: Reference Committee B

Whereas, patients seeking emergency medical care should seek care at facilities prepared to offer evaluation and medical diagnosis of undifferentiated acute symptoms, recognition and stabilization of emergency conditions, appropriate emergency treatment when available and/or transfer to a higher level of care for emergency conditions when appropriate; and

Whereas, facility designations using the term “emergency” within their title may be assumed by laypersons or medical professionals to imply the ability to offer all of the above emergency duties and services; and

Whereas, the shift from “supervision” to “collaboration” of non-physician practitioners (NPPs) (e.g., APRNs, PAs, and CRNAs), may imply a lower degree of physician involvement in the care of the patient in as much as, collaboration may imply mere consultation of the physician only when deemed necessary by the NPP which is inadequate in the setting of acute medical care because NPPs have not been trained in the great breadth of medicine, as have physicians, and cannot consistently recognize all acute emergency situations in which immediate physician care is required; and

Whereas, every patient presenting to a facility which represents itself as a place where patients can seek emergency medical care should be under the direct and real-time care of a licensed physician including the on-site and real-time supervision of NPPs; and

Whereas, despite an overall physician deficit, there is not a lack of emergency medicine (EM) physician workforce as there is a predicted surplus of EM physicians by the year 2030; therefore be it

RESOLVED, that our American Medical Association develop model state legislation and support federal and state legislation or regulation requiring all facilities that imply the provision of emergency medical care have the real-time, on-site presence of a physician, and on-site supervision of non-physician practitioners (e.g., physician assistants and advanced practice nurses) by a licensed physician with training and experience in emergency medical care whose primary duty is dedicated to patients seeking emergency medical care in that emergency department. (Directive to Take Action)

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

Received: 9/26/23

RELEVANT AMA POLICY

Physician and NonPhysician Licensure and Scope of Practice D-160.995
1. Our AMA will: (a) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (b) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; and (c) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.
2. Our AMA will: (a) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience; (b) advocate for the inclusion of non-physician scope of practice characteristics in various analyses of practice location attributes and desirability; (c) advocate for the inclusion of scope of practice expansion into measurements of physician well-being; and (d) study the impact of scope of practice expansion on medical student choice of specialty.
3. Our AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation. [CME Rep. 1, I-00; Reaffirmed: CME Rep. 2, A-10; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 251, A-18; Appended: Res. 222, I-19]

Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice H-360.987
Our AMA endorses the following principles: (1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care.
(2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team.
(3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians.
(4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team.
(5) Certified nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists shall be licensed and regulated jointly by the state medical and nursing boards.
(6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices. [BOT Rep. 23, A-96; Reaffirmation A-99; Reaffirmed: Res. 240, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-12; Reaffirmed: BOT Rep. 16, A-13; Modified: BOT Rep. 12, A-23 Reaffirmed: BOT Rep. 09, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(I-23)

Introduced by: Young Physicians Section

Subject: Non-Physician Practitioners Oversight and Training

Referred to: Reference Committee B

Whereas, the number and utilization of non-physician providers (NPPs) is increasing; and

Whereas, there is increasing scope of practice for NPPs in many states; and

Whereas, patient safety should remain one of the main priorities in providing high quality healthcare; and

Whereas, the number of clinical hours required for physician board certification exceeds that of NPPs by over 10,000 hours; and

Whereas, data are limited in regards to competence, cost and quality of NPPs practicing without any type of physician supervision; and

Whereas, NPPs have the ability to practice in multiple specialties without a formalized graduate medical education program and engage in highly variable training experiences with very few “specialty” certifications; and

Whereas, the terminology “practicing at the top of license” in regards to non-physician providers does not appropriately reflect the significant variability in training and experiences of non-physician providers; and

Whereas, there is variability in regulatory and accrediting bodies for the different types of NPPs; therefore be it

RESOLVED, that our American Medical Association encourage oversight and regulation of non-physician providers by regulatory bodies comprised of individuals with equivalent and higher levels of training, including state composite medical boards. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 9/26/23

REFERENCES

1. Auerbach DI, Buerhaus PI, Staiger DO. Implications Of The Rapid Growth Of The Nurse Practitioner Workforce In The US. Health Aff (Millwood). 2020;39(2):273-279. doi:10.1377/hlthaff.2019.00686
2. Chekijian SA, Elia TR, Horton JL, Baccari BM, Temin ES. A Review of Interprofessional Variation in Education: Challenges and Considerations in the Growth of Advanced Practice Providers in Emergency Medicine. AEM Educ Train. 2020 Jul 10;5(2):e10469. doi: 10.1002/aet2.10469. PMID: 33796808; PMCID: PMC7995928.
3. State Practice Environment. Available at https://www.aanp.org/advocacy/state/state-practice-environment.
4. Scope of practice: Education matters. Available at https://www.ama-assn.org/practice-management/scope-practice/scope-practice-education-matters.

Physician and Nonphysician Licensure and Scope of Practice D-160.995
1. Our AMA will: (a) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (b) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; and (c) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.
2. Our AMA will: (a) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience; (b) advocate for the inclusion of non-physician scope of practice characteristics in various analyses of practice location attributes and desirability; (c) advocate for the inclusion of scope of practice expansion into measurements of physician well-being; and (d) study the impact of scope of practice expansion on medical student choice of specialty.
3. Our AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation.
[CME Rep. 1, I-00; Reaffirmed: CME Rep. 2, A-10; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 251, A-18; Appended: Res. 222, I-19]

AMA Support for States in Their Development of Legislation to Support Physician-Led, Team Based Care D-35.982
1. Our AMA will continue to assist states in opposing legislation that would allow for the independent practice of certified registered nurse practitioners.
2. Our AMA will assist state medical societies and specialty organizations that seek to enact legislation that would define the valued role of mid-level and other health care professionals within a physician-led team based model structured to efficiently deliver optimal quality patient care and to assure patient safety.
3. Our AMA will actively oppose health care teams that are not physician-led.
[Res. 240, A-13; Reaffirmation A-15]

Support for Physician Led, Team Based Care D-35.985
Our AMA:
1. Reaffirms, will proactively advance at the federal and state level, and will encourage state and national medical specialty societies to promote policies H-35.970, H-35.973, H-35.974, H-35.988, H-35.989, H-35.992, H-35.993, H-160.919, H-160.929, H-160.947, H-160.949, H-160.950, H-360.987, H 405.969 and D-35.988.
2. Will identify and review available data to analyze the effects on patients? access to care in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services) to determine whether there has been any increased access to care in those states.
3. Will identify and review available data to analyze the type and complexity of care provided by all non-physician providers, including CRNAs in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services), compared to the type and complexity of care provided by physicians and/or the anesthesia care team.
4. Will advocate to policymakers, insurers and other groups, as appropriate, that they should consider the available data to best determine how non-physicians can serve as a complement to address the nation's primary care workforce needs.
5. Will continue to recognize non-physician providers as valuable components of the physician-led health care team.
6. Will continue to advocate that physicians are best qualified by their education and training to lead the health care team.
7. Will call upon the Robert Wood Johnson Foundation to publicly announce that the report entitled, "Common Ground: An Agreement between Nurse and Physician Leaders on Interprofessional

Collaboration for the Future of Patient Care" was premature; was not released officially; was not signed; and was not adopted by the participants.
[BOT Rep. 9, I-11; Reaffirmed: CMS Rep. 1, A-12; Reaffirmed: CMS Rep. 07, A-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 6, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(I-23)

Introduced by: Medical Student Section

Subject: Immigration Status in Medicaid and CHIP

Referred to: Reference Committee B

Whereas, our American Medical Association has numerous policies calling for adequate federal reimbursement for care for undocumented immigrants; and

Whereas, our AMA specifically supports Medicaid coverage for undocumented immigrants for scheduled, outpatient, non-emergency maintenance dialysis and for healthcare during pregnancy and up to 12 months postpartum; and

Whereas, our AMA "supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients" and "recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status"; and

Whereas, in June 2023, our AMA wrote a letter to the Centers for Medicare and Medicaid Services (CMS) supporting proposed regulations to extend Medicaid, Children's Health Insurance Program (CHIP), and ACA plans to Deferred Action for Childhood Arrivals (DACA) participants and also expressing to CMS our stance on ACA coverage for undocumented immigrants[1]; and

Whereas, in the US, only documented adults and children (permanent residents, current visa holders, and those with active refugee, asylum, trafficking, or another qualified or protected status) are eligible for Medicaid and CHIP[2]; and

Whereas, undocumented immigrants are ineligible for Medicaid and CHIP aside from emergency coverage and therefore only receive insurance through their employer, through their educational institution if they are a student, or if purchased out-of-pocket[2]; and

Whereas, 11 million undocumented immigrants (including 650,000 DACA participants) reside in the US, and over 5 million (nearly half) live in California, New York, and Texas[3]; and

Whereas, 5 million undocumented immigrants (nearly half) are completely uninsured, 2 to 3 times the uninsured rate among documented immigrants, 4 times the uninsured rate among citizens, and 20% of the entire US uninsured population[4]; and

Whereas, about 20% of undocumented adults and over 30% of undocumented children live in poverty, with a median household income of $36,000, or 120% of the Federal Poverty Level (FPL) threshold for a household of four[5-6]; and

Whereas, the median undocumented household income of 120% FPL is below the 138% FPL threshold for Medicaid eligibility in expansion states and well below the national average threshold for CHIP at 255% FPL[5-7]; and

Whereas, in addition to ethical considerations for coverage, fiscal concerns are alleviated by consistent data demonstrating that undocumented immigrants pay billions in federal and state taxes annually while receiving no public benefits in return, and if given some federal status, contributions to federal public funds would only increase[8]; and

Whereas, undocumented immigrants are and will continue to be a long-term part of American society, as the average individual has resided in the US for 15 years[9]; and

Whereas, while undocumented immigrants can sometimes access outpatient primary care at public and charity clinics, access to specialty or hospital care is greatly limited[4]; and

Whereas, while all hospitals are required to screen and stabilize undocumented immigrants in emergency departments, much of this care is costlier than necessary due to lack of earlier treatment and may then go uncompensated, and require being offset by public funds anyway, which could instead fund comprehensive outpatient coverage from the start[10]; and

Whereas, California, one of the states with the largest undocumented population, expanded Medicaid and CHIP to all otherwise eligible undocumented immigrants[11]; and

Whereas, New York, one of the states with the largest undocumented population, expanded Medicaid to DACA participants and CHIP to undocumented children[12]; and

Whereas, expansion of Medicaid and CHIP to undocumented immigrants would significantly reduce the uninsured rate, increase reimbursement for physicians and hospitals providing uncompensated care, and avoid cost and resource burdens to the health system by promoting preventive, chronic, outpatient care over emergency and inpatient care; therefore be it

RESOLVED, that our American Medical Association advocate for the removal of eligibility criteria based on immigration status from Medicaid and CHIP. (Directive to Take Action)

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

Received: 09/27/2023

REFERENCES

1. Re: Clarifying Eligibility for a Qualified Health Plan Through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, a Basic Health Program, and for Some Medicaid and Children's Health Insurance Programs for Deferred Action for Childhood Arrivals Recipients [CMS–9894–P]. American Medical Association. Published June 23, 2023. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfscl.zip%2F2023-6-23-Letter-to-Becerra-and-Brooks-LaSure-re-NPRM-to-Expand-Healthcare-to-DACA-Recipients-v2.pdf
2. Coverage for Lawfully Present Immigrants. Healthcare.Gov. Accessed April 30, 2023. https://www.healthcare.gov/immigrants/lawfully-present-immigrants
3. Capps R, Gelatt J, Ruiz Soto AG, Van Hook J. Unauthorized Immigrants in the United States: Stable Numbers, Changing Origin. Migration Policy Institute Published December 2020. Accessed April 30, 2023. https://www.migrationpolicy.org/sites/default/files/publications/mpi-unauthorized-immigrants-stablenumbers-changingorigins_final.pdf
4. Artiga S, Diaz M. Health Coverage and Care of Undocumented Immigrants. Kaiser Family Foundation. Published July 15, 2019. Accessed April 30, 2023. https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-and-care-of-undocumented-immigrants
5. Passel JS, Cohn D. A Portrait of Unauthorized Immigrants in the United States. Pew Research Center. Published April 14, 2009. Accessed April 30, 2023. https://www.pewresearch.org/hispanic/2009/04/14/a-portrait-of-unauthorized-immigrants-in-the-united-states

6. Federal Poverty Level (FPL). Healthcare.Gov. Accessed April 30, 2023. https://www.healthcare.gov/glossary/federal-poverty-level-fpl
7. Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level. Published January 1, 2023. Accessed April 30, 2023. https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income- eligibility-limits-for-children-as-a-percent-of-the-federal-poverty-level
8. Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level. Published January 1, 2023. Accessed April 30, 2023. https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-as-a-percent-of-the-federal-poverty-level
9. Campoy A. The typical undocumented immigrant has been in the US for over a decade. Quartz. Published June 12, 2019. Accessed September 27, 2023. https://qz.com/1641076/how-long-the-typical-undocumented-immigrant-has-been-in-the-us
10. Undocumented Aliens: Questions Persist about Their Impact on Hospitals' Uncompensated Care Costs. Government Accountability Office. Published May 21, 2004. Accessed April 30, 2023. https://www.gao.gov/products/gao-04-472
11. Beam A, Thompson D. California first to cover health care for all immigrants. Published July 1, 2022. Accessed September 27, 2023. https://apnews.com/article/health-california-immigration-gavin-newsom-medicaid-b09edcb2b89ab041b520f431f8aab4b6
12. Immigrants - Your Health Insurance Options. NYC Health Insurance Link. https://www.nyc.gov/site/ochia/find-what-fits/immigrants.page

RELEVANT AMA POLICY

H-160.956 Federal Funding for Safety Net Care for Undocumented Aliens
Our AMA will lobby Congress to adequately appropriate and dispense funds for the current programs that provide reimbursement for the health care of undocumented aliens. [Sub. Res. 207, A-93; Reaffirmed BOT Rep. 17 - I-94; Reaffirmed by Ref. Cmt. B, A-96; Reaffirmation A-02; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Reaffirmation: A-19; Reaffirmation: I-19]

D-440.985 Health Care Payment for Undocumented Persons
Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level. [Res. 148, A-02; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmation: A-19; Reaffirmation: I-19]

H-130.967 Action Regarding Illegal Aliens
Our AMA supports the legislative and regulatory changes that would require the federal government to provide reasonable payment for federally mandated medical screening examinations and further examination and treatment needed to stabilize a condition in patients presenting to hospital emergency departments, when payment from other public or private sources is not available. [BOT Rep. MM, A-89; Reaffirmed by BOT Rep. 17 - I-94; Reaffirmed by Ref. Cmt. B, A-96; Reaffirmation A-02; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17]

H-290.957 Medicaid Dialysis Policy for Undocumented Patients
Our AMA will work with the Centers for Medicare and Medicaid Services and state Medicaid programs to cover scheduled outpatient maintenance dialysis for undocumented patients with end stage kidney disease under Emergency Medicaid. [Res. 121, A-21]

D-290.974 Extending Medicaid Coverage for One Year Postpartum
Our AMA will work with relevant stakeholders to: (1) support and advocate, at the state and federal levels, for extension of Medicaid and Children's Health Insurance Program (CHIP) coverage to at least 12 months after the end of pregnancy; and (2) expand Medicaid and CHIP eligibility for pregnant and postpartum non-citizen immigrants. [Res. 221, A-19; Modified: Joint CMS/CSAPH Rep. 1, I-21; Modified: Res. 701, I-21]

H-165.823 Options to Maximize Coverage under the AMA Proposal for Reform
1. That our AMA advocate for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians.
2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.

c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
e. The public option is financially self-sustaining and has uniform solvency requirements.
f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
g. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.
3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage.
c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.
4. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status. [CMS Rep. 1, I-20; Appended: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: Res. 122, A-22; Modified: Res. 813, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(I-23)

Introduced by: Medical Student Section

Subject: Health Technology Accessibility for Aging Patients

Referred to: Reference Committee B

Whereas, recent advancements in health technology (wearable devices, smartphone apps, telehealth, patient portals, and EHR access) may not be accessible to older patients[1-2]; and

Whereas, older adults' fears of loss of independence can be exacerbated by increasing reliance on younger caregivers to navigate technology, especially during the COVID pandemic[3-5]; and

Whereas, research shows that many subpopulations of older adults, including those with dementia, want to use and benefit from health technology in increased independence, security, and quality of life, but struggle to learn and find and receive assistance[6-8]; and

Whereas, while no standardized definition of "age-friendliness" in technology exists, successful examples include simpler design components and user interfaces, larger font sizes, improved visual contrast, fewer multitasking features, predictable and non-startling sounds, captions, reassurance of data safety, and reduced reliance on manual dexterity[9-12]; and

Whereas, the National Health and Aging Trends Study reports that more than 1 in 4 Americans over the age of 71 have visual impairment[13]; and

Whereas, patients with visual impairment risk privacy when using third-party software such as screen readers and mobile devices to receive their health information[14-15]; and

Whereas, studies show that telehealth and online chat services during the pandemic were not compatible with third-party screen readers[16]; and

Whereas, in 2019, the National Federation of the Blind sued Epic for inaccessible software, with Epic typically working case-by-case with individual systems to integrate screen readers[17-18]; and

Whereas, accessible electronic health records for patients with visual impairment improves quality of care and increases patient agency in their healthcare decisions[16,19-22]; and

Whereas, regulations require extending accessibility of digital documentation to people with physical, sensory, and cognitive disabilities[23]; and

Whereas, AMA Policy D-115.990 "Prescription Container Labeling" seeks to "improve prescription labeling for visually or otherwise impaired patients"; and

Whereas, advance care plans are often stored in physical format, with patients being inconvenienced by needing to maintain multiple printed copies, regularly inform various close contacts of updated decisions, and bring copies to any healthcare encounter[24-25]; and

Whereas, asking patients to keep photos of advance care plans on phones or rely on family to express wishes are unreliable and can lead to outcomes contradicting patient wishes[26–30]; and

Whereas, family and caregivers are not optimal proxies for communicating advance care plans, as over one-third of surrogates do not know patients' DNR statuses and over one-fourth report DNR statuses incongruent with documentation[26]; and

Whereas, a 2018 study showed that over half of advance care plans at one metropolitan VA hospital were stored as free text in progress notes instead of the designated centralized location, including 70% of documents declaring changes from previous orders, and 50% lacked accompanying explanatory information from patient discussions[31]; therefore be it

RESOLVED, that our American Medical Association support the development of a standardized definition of "age-friendliness" in health information technology (HIT) advancements New HOD Policy); and be it further

RESOLVED, that our AMA encourage appropriate parties to identify current best practices to set expectations of HIT developers to ensure that they create devices and technology applicable to and easily accessible by older adults (New HOD Policy); and be it further

RESOLVED, that our AMA work with relevant organizations to encourage the utilization of industry standards of web content accessibility to make electronic health record software accessible for patients with visual impairments without requiring them to use third-party programs (Directive to Take Action); and be it further

RESOLVED, that our AMA require EHR providers to provide standardized, easily accessible digital storage space for advance care paperwork. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 09/27/2023

REFERENCES

1. Dunne N. How healthcare is changing in the digital age. World Economic Forum. Published September 6, 2017. Accessed August 24, 2021. https://www.weforum.org/agenda/2017/09/health-digital-age
2. Lam K, Lu AD, Shi Y, Covinsky KE. Assessing Telemedicine Unreadiness Among Older Adults in the United States During the COVID-19 Pandemic. *JAMA Intern Med*. 2020;180(10):1389-1391.
3. Lindquist LA, Ramirez-Zohfeld V, Forcucci C, Sunkara P, Cameron KA. Overcoming Reluctance to Accept Home-Based Support from an Older Adult Perspective. *J Am Geriatr Soc*. 2018;66(9). doi:10.1111/jgs.15526
4. Vaportzis E, Clausen MG, Gow AJ. Older Adults Perceptions of Technology and Barriers to Interacting with Tablet Computers: A Focus Group Study. *Front Psychol*. 2017;8:1687.
5. Cosco TD, Fortuna K, Wister A, Riadi I, Wagner K, Sixsmith A. COVID-19, Social Isolation, and Mental Health Among Older Adults: A Digital Catch-22. *J Med Internet Res*. 2021;23(5):e21864.
6. Lorenz K, Freddolino PP, Comas-Herrera A, Knapp M, Damant J. Technology-based tools and services for people with dementia and carers: Mapping technology onto the dementia care pathway. *Dementia*. 2019;18(2):725-741.
7. Scheibe M, Lang C, Druschke D, et al. Independent Use of a Home-Based Telemonitoring App by Older Patients With Multimorbidity and Mild Cognitive Impairment: Qualitative Study. *JMIR Hum Factors*. 2021;8(3):e27156.
8. Diaz-Orueta U, Hopper L, Konstantinidis E. Shaping technologies for older adults with and without dementia: Reflections on ethics and preferences. *Health Informatics J*. 2020;26(4):3215-3230.
9. Bryant M. How technologies can help the elderly age at home. Published February 16, 2017. Accessed September 16, 2021. https://www.healthcaredive.com/news/how-technologies-can-help-the-elderly-age-at-home/436386
10. Usability for Seniors: Challenges and Changes. Accessed September 16, 2021. https://www.nngroup.com/articles/usability-for-senior-citizens/
11. Rouzaud Laborde C, Cenko E, Mardini MT, et al. Satisfaction, Usability, and Compliance With the Use of Smartwatches for Ecological Momentary Assessment of Knee Osteoarthritis Symptoms in Older Adults: Usability Study. *JMIR Aging*. 2021;4(3):e24553.
12. Pak R, McLaughlin AC. *Aging, Technology and Health*. London: Elsevier; 2018.
13. Killeen OJ, De Lott LBJ, Zhou Y, et al. Population Prevalence of Vision Impairment in US Adults 71 Years and Older: The National Health and Aging Trends Study. *JAMA Ophthalmol.* 2023;141(2):197-204. doi:10.1001/jamaophthalmol.2022.5840

14. Keskin OF, Caramancion KM, Tatar I, Raza O, Tatar U. Cyber Third-Party Risk Management: A Comparison of Non-Intrusive Risk Scoring Reports. Electronics. 2021;10(10):1168. doi:10.3390/electronics10101168.
15. Ahmed T, Hoyle R, Connelly K, Crandall D, Kapadia A. Privacy Concerns and Behaviors of People with Visual Impairments. In: Proceedings of the 33rd Annual ACM Conference on Human Factors in Computing Systems. ACM; 2015:3523-3532. doi:10.1145/2702123.2702334.
16. Flatten Inaccessibility: How COVID-19 Impacted Adults Who Are Blind, Have Low Vision, or Are Deafblind Early in the Pandemic. The American Foundation for the Blind. Accessed March 12, 2022. https://www.afb.org/research-and-initiatives/flatten-inaccessibility-survey.
17. Clockwork.net. National Federation of the Blind Sues Epic Systems: New Chapter in Accessibility Litigation for Employers and Technology Vendors - Fredrikson & Byron · Fredrikson & Byron, P.A. Fredrikson & Byron. Accessed March 12, 2022. https://www.fredlaw.com/internet_technology_trademark__advertising_alerts/2019/01/09/2054/national_federation_of_the_blind_sues_epic_systems_new_chapter_in_accessibility_litigation_for_employers_and_technology_vendors
18. Supporting Accessible Scheduling Software for Blind and Low-Vision Users. EpicShare. Accessed March 9, 2022. https://www.epicshare.org/share-and-learn/supporting-accessible-scheduling-software-for-blind-and-low-vision-users.
19. Healthcare Accessibility - Going Beyond Ramps and Elevators. Equidox. Published May 15, 2019. Accessed April 15, 2022. https://equidox.co/blog/healthcare-accessibility-going-beyond-ramps-and-elevators
20. Yi YJ. Web accessibility of healthcare Web sites of Korean government and public agencies: a user test for persons with visual impairment. Univ Access Inf Soc. 2020;19(1):41-56. doi:10.1007/s10209-018-0625-5.
21. Rosner Y, Perlman A. The Effect of the Usage of Computer-Based Assistive Devices on the Functioning and Quality of Life of Individuals who are Blind or have low Vision. Journal of Visual Impairment & Blindness. 2018;112(1):87-99. doi:10.1177/0145482X1811200108.
22. How Can an Accessible EHR Experience Benefit Patients With Disabilities? Accessed April 15, 2022. https://www.ironbridgecorp.com/blog/how-can-an-accessible-ehr-experience-benefit-patients-with-disabilities
23. U.S. Access Board - Information and Communication Technology. Accessed March 12, 2022. https://www.access-board.gov/ict.html
24. Huber MT, Highland JD, Krishnamoorthi VR, Tang JW. Utilizing the Electronic Health Record to Improve Advance Care Planning: A Systematic Review. *Am J Hosp Palliat Care*. 2018;35(3). doi:10.1177/1049909117715217
25. Advance Care Planning: Health Care Directives. Accessed September 15, 2021. http://www.nia.nih.gov/health/advance-care-planning-health-care-directives
26. Cunico G, Aivazidou E, Mollona E. Beyond financial proxies in Cohesion Policy inputs' monitoring: A system dynamics approach. *Eval Program Plann*. 2021;89:101964.
27. Tsiaperas T. Doctors ignored dying mom's DNR order, family says in suit against Methodist Health. *The Dallas Morning News*. https://www.dallasnews.com/news/courts/2017/05/12/doctors-ignored-dying-mom-s-dnr-order-family-says-in-suit-against-methodist-health/. Published May 12, 2017. Accessed September 15, 2021.
28. Span P. The Patients Were Saved. That's Why the Families Are Suing. *The New York Times*. https://www.nytimes.com/2017/04/10/health/wrongful-life-lawsuit-dnr.html. Published April 10, 2017. Accessed September 15, 2021.
29. Pope TM. Legal Briefing: New Penalties for Ignoring Advance Directives and Do-Not-Resuscitate Orders. *J Clin Ethics*. 2017;28(1). Accessed September 15, 2021. https://pubmed.ncbi.nlm.nih.gov/28436933H-480.937
30. Dillon E, Chuang J, Gupta A, et al. Provider Perspectives on Advance Care Planning Documentation in the Electronic Health Record: The Experience of Primary Care Providers and Specialists Using Advance Health-Care Directives and Physician Orders for Life-Sustaining Treatment. *Am J Hosp Palliat Care*. 2017;34(10). doi:10.1177/1049909117693578
31. Walker E, McMahan R, Barnes D, Katen M, Lamas D, Sudore R. Advance Care Planning Documentation Practices and Accessibility in the Electronic Health Record: Implications for Patient Safety. *J Pain Symptom Manage*. 2018;55(2):256. doi: 10.1016/j.jpainsymman.2017.09.018

RELEVANT AMA POLICY

H-480.937 Addressing Equity in Telehealth

Our AMA:
(1) recognizes access to broadband internet as a social determinant of health;
(2) encourages initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations;
(3) encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations;
(4) supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities;
(5) encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth;

(6) supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations;
(7) supports efforts to ensure payers allow all contracted physicians to provide care via telehealth;
(8) opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians; and
(9) will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person. [CMS Rep. 7, A-21; Reaffirmation: A-22; Reaffirmed: Res. 213, A-23; Reaffirmation: A-23]

D-140.953 Timely Promotion and Assistance in Advance Care Planning and Advance Directives
Our AMA will: (1) begin a low cost in-house educational effort aimed at physicians, to include relevant billing and reimbursement information, encouraging physicians to lead by example and complete their own advance directives; (2) encourage practicing physicians to voluntarily publicize the fact of having executed our own advance directives, and to share readily available educational materials regarding the importance and components of advance directives in offices and on practice websites, as a way of starting the conversation with patients and families; (3) strongly encourage all physicians of relevant specialties providing primary or/and advanced illness care to include advance care planning as a routine part of their patient care protocols when indicated, including advance directive documentation in patients' medical records (including electronic medical records), as a suggested standard health maintenance practice; (4) collaborate (prioritized and made more urgent by the ongoing COVID-19 pandemic) with stakeholder groups, such as legal, medical, hospital, medical education, and faith-based communities as well as interested citizens, to promote completion of advance directives by all individuals who are of legal age and competent to make healthcare decisions, and to promote the adoption and use of electronic systems to make patients' advance directives readily available to treatment teams regardless of location; and (5) actively promote the officially recognized designation of April 16 as National Healthcare Decisions Day. [Res. 602, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(I-23)

Introduced by: Medical Student Section

Subject: A Public Health-Centered Criminal Justice System

Referred to: Reference Committee B

Whereas, our AMA supports ending cash bail, jail diversion programs, drug and veteran courts, compassionate release, and research into alternatives to incarceration; and

Whereas, the US has the highest incarceration rates in the world with over 2.1 million people in prison in 2018, causing significant harm to individual and community health[1-5]; and

Whereas, despite homicide rates staying consistent, the number of people imprisoned for violent crimes increased by 300% from 1980 to 2009[2,3]; and

Whereas, people incarcerated in the US experience higher rates of nearly all infections, including HIV, STIs, TB, HCV, COVID, and quadruple the rate of mental illness, due in part to crowding, squalor, solitary confinement, assault, and reduced healthcare access[6-18]; and

Whereas, individuals face a 250% greater mortality risk in the first 2 years after release, including extremely disproportionate risk of drug overdose[15]; and

Whereas, racial injustice in police, jury selection, and courts impose the brunt of the carceral system's abuses on individuals from Black and other minoritized communities[25-30]; and

Whereas, up to 45% of people are imprisoned due to technical parole violations, rather than offenses that truly cause harm to communities and exacerbating crowding[31]; and

Whereas, mandatory minimums require judges to sentence offenders to a pre-specified minimum sentence for a particular crime, but are not effective for decreasing crime, with for example cocaine use rates remaining unchanged despite mandatory minimums[32-34]; and

Whereas, despite the attempt at standardization under mandatory minimums, minimums are higher for offenses disproportionately used to charge Black individuals and are more often enforced against Black defendants by prosecutors compared to white defendants, even for the same charge, as prosecutors gain greater influence in deciding when to prosecute[35-38]; and

Whereas, "three-strikes" policies significantly increase the sentence for subsequent felonies after two previous felonies on record, which means that in some states, an individual charged with more than two felonies at one time can receive all three strikes at once[39-41]; and

Whereas, three-strikes policies consistently fail to reduce recidivism, generate massive economic burden, and further detract from effective reentry into society[39,42]; and

Whereas, three-strikes policies and mandatory minimum sentencing deprive judges of the ability to tailor sentencing based on mitigating factors[43-46]; and

Whereas, individuals age 65 and older are the fastest growing demographic among those incarcerated, due in part to longer sentences, resulting in a population that requires greater care for chronic illness and disabilities and support for activities of daily living[47]; and

Whereas, the bipartisan 2018 First Step Act was signed by President Trump, lowering mandatory minimums, easing the three-strike rule, and increasing good time credits and earned time credits, but only affects the 7% of individuals incarcerated in federal prisons[44-49]; and

Whereas, survivors of violence themselves report preferences for undergo violence prevention training for perpetrators instead of incarceration, short sentences and rehabilitation, and funds and resources for social programs for youth over increased investment in prisons[54]; and

Whereas, multiple analyses of real-world federal, state, and international efforts conclude that both crime and recidivism do not increase with reduced prison sentences[55-58]; therefore be it

RESOLVED, that our American Medical Association support legislation that reduces the negative health impacts of incarceration by:

a. advocating for decreasing the magnitude of penalties, including the length of prison sentences, to create a criminal justice model focused on citizen safety and improved public health outcomes and rehabilitative practices rather than retribution,
b. advocating for legislation and regulations that reduce the number of people placed in prison conditions, such as preventing people who were formerly incarcerated from being sent back to prison without justifiable cause, and
c. supporting the continual review of sentences for people at various time points of their sentence to enable early release of people who are incarcerated but unlikely to pose a risk to society (Directive to Take Action); and be it further

RESOLVED, that our AMA (1) recognize the inefficacy of mandatory minimums and three-strike rules and the negative consequences of resultant longer prison sentences to the health of incarcerated individuals, and (2) support legislation that reduces or eliminates mandatory minimums and three-strike rules. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 09/27/2023

REFERENCES

1. Walmsley, R. 2018. World Prison Population List. Institute for Criminal Policy Research, 12, pp.1-19. Retrieved from: <https://www.prisonstudies.org/sites/default/files/resources/downloads/wppl_12.pdf>.
2. Cooper, A and Smith, E. 2011. Homicide Trends in the United States, 1980-2008. Bureau of Justice Statistics. Retrieved from: <https://bjs.ojp.gov/content/pub/pdf/htus8008.pdf>.
3. The Next Step: Ending Excessive Punishment for Violent Crimes. 2020. The Sentencing Project. Retrieved from <https://www.sentencingproject.org/wp-content/uploads/2019/03/The-Next-Step.pdf>.
4. Thomas, J and Torrone, E. 2008. Incarceration as Forced Migration: Effects on Selected Community Health Outcomes. American Journal of Public Health, 98(Supplement_1), pp.S181-S184.
5. Olson, S and Anderson, K. 2020. The effects of incarceration and reentry on community health and well-being. National Academies of Sciences, Engineering, and Medicine.
6. Saloner, B, Parish, K, Ward, J, DiLaura, G. and Dolovich, S. 2020. COVID-19 Cases and Deaths in Federal and State Prisons. JAMA, 324(6), pp.602.
7. Morris, M, Brown, B and Allen, S. 2017. Universal opt-out screening for hepatitis C virus (HCV) within correctional facilities is an effective intervention to improve public health. International Journal of Prisoner Health, 13(3/4), pp.192-199.
8. Davis DM, Bello JK, Rottnek F. 2018. Care of Incarcerated Patients. Am Fam Physician, 98(10), pp. 577-583.
9. Kessler RC, Avenevoli S, Costello EJ, et al. 2009. Design and field procedures in the US National Comorbidity Survey Replication Adolescent Supplement (NCS-A). Int J Methods Psychiatr Res;18(2), pp. 69-83. doi:10.1002/mpr.279.

10. Substance Abuse and Mental Health Services Administration, 2020. Key substance use and mental health indicators in the United States. Results from the 2019 National Survey on Drug Use and Health. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Available at: <https://www.samhsa.gov/data/>.
11. Cloud DH, Drucker E, Browne A, Parsons J. 2015. Public Health and Solitary Confinement in the United States. Am J Public Health, 105(1), pp. 18-26. doi:10.2105/AJPH.2014.302205.
12. Brinkley-Rubinstein L, Sivaraman J, Rosen DL, et al. 2019. Association of Restrictive Housing During Incarceration With Mortality After Release. JAMA Netw Open, 2(10):e1912516. doi:10.1001/jamanetworkopen.2019.12516.
13. Beck A. 2015. Use of Restrictive Housing in U.S. Prisons and Jails, 2011–12. U.S. Department of Justice. Retrieved from: <https://www.bjs.gov/content/pub/pdf/urhuspj1112.pdf>.
14. Paynter MJ, Drake EK, Cassidy C, Snelgrove-Clarke E. 2019. Maternal health outcomes for incarcerated women: A scoping review. J Clin Nurs, 28(11-12), pp. 2046-2060. doi:10.1111/jocn.14837.
15. Binswanger IA, Stern MF, Deyo RA, et al. 2007. Release from prison- a high risk of death for former inmates. N Engl J Med, 356(2), pp.157-165. doi:10.1056/NEJMsa064115.
16. Heard-Garris N, Winkelman TNA, Choi H, et al. 2019. Health Care Use and Health Behaviors Among Young Adults With History of Parental Incarceration. Pediatrics, 142(3):e20174314. doi:10.1542/peds.2017-4314.
17. Heard-Garris N, Sacotte KA, Winkelman TNA, et al. 2019. Association of Childhood History of Parental Incarceration and Juvenile Justice Involvement With Mental Health in Early Adulthood. JAMA Netw Open, 2(9):e1910465. doi:10.1001/jamanetworkopen.2019.10465.
18. Barnert ES, Perry R, Morris RE. 2016. How Does Incarcerating Young People Affect Their Adult Health Outcomes? Academic Pediatrics,16:99–109.
19. Couloute, L. and Kopf, D., 2021. Out of Prison & Out of Work: Unemployment among formerly incarcerated people. Northampton, MA: Prison Policy Initiative. Retrieved from: <https://www.prisonpolicy.org/reports/outofwork.html>.
20. Berghuis M. 2018. Reentry programs for adult male offender recidivism and reintegration: A systematic review and meta-analysis. International journal of offender therapy and comparative criminology, 62(14), pp. 4655-76.
21. Visher CA, Lattimore PK, Barrick K, Tueller S. 2017. Evaluating the long-term effects of prisoner reentry services on recidivism: What types of services matter? Justice Quarterly, 34(1), pp. 136-65.
22. Baquero M, Zweig K, Angell SY, Meropol SB. 2020. Health Behaviors and Outcomes Associated With Personal and Family History of Criminal Justice System Involvement, New York City, 2017. Am J Public Health, 110(3), pp. 378-384. doi:10.2105/AJPH.2019.305415.
23. Testa A, Jackson DB, Vaughn MG, Bello JK. 2020. Incarceration as a unique social stressor during pregnancy: Implications for maternal and newborn health. Soc Sci Med, 246:112777. doi:10.1016/j.socscimed.2019.112777.
24. Wildeman C, Wang EA. 2017. Mass incarceration, public health, and widening inequality in the USA. Lancet, 389(10077), pp.1464-1474. doi:10.1016/S0140-6736(17)30259-3.
25. Equal Justice Initiative, 2010. Illegal Racial Discrimination in Jury Selection: A Continuing Legacy. Montgomery, AL: Library of Congress. Retrieved from: <https://lccn.loc.gov/2016417619>.
26. Taylor, C., 2013. Introduction: African Americans, Police Brutality, and the U.S. Criminal Justice System. The Journal of African American History, 98(2), pp.200-204.
27. American Civil Liberties Union, 2020. A Tale of Two Countries Racially Targeted Arrests in the Era of Marijuana Reform. Retrieved from: <https://www.aclu.org/sites/default/files/field_document/tale_of_two_countries_racially_targeted_arrests_in_the_era_of_marijuana_reform_revised_7.1.20_0.pdf>.
28. Duarte CDP, Salas-Hernández L, Griffin JS. 2020. Policy Determinants of Inequitable Exposure to the Criminal Legal System and Their Health Consequences Among Young People. Am J Public Health, 110(S1), pp. S43-S49. doi:10.2105/AJPH.2019.305440.
29. Camplain R, Camplain C. 2020. Racial/Ethnic Differences in Drug- and Alcohol-Related Arrest Outcomes in a Southwest County From 2009 to 2018. Am J Public Health, 110(Suppl 1): S85–S92.
30. Bop.gov. 2021. BOP Statistics: Inmate Offenses. Retrieved from: <https://www.bop.gov/about/statistics/statistics_inmate_offenses.jsp> [Accessed 5 November 2021].
31. The Council of State Governments Justice Center, 2019. Confined and Costly: How Supervision Violations Are Filling Prisons and Burdening Budgets. Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice. Retrieved from: <https://csgjusticecenter.org/publications/confined-costly/>.
32. Neely CR. 2021. Mandatory minimums: equal but unequal. SSRN Electronic Journal. doi:10.2139/ssrn.3771980.
33. Walker LS, Mezuk B. 2018. Mandatory minimum sentencing policies and cocaine use in the U.S., 1985-2013. BMC Int Health Hum Rights, 18(1), pp. 43. doi:10.1186/s12914-018-0182-2.
34. Wodak D. 2018. Mandatory Minimums and the War on Drugs. The Palgrave Handbook of Philosophy and Public Policy. Cham, Switzerland. pp. 51-62. doi.org/10.1007/978-3-319-93907-0_5.
35. Lynch, M, Barno, M, Omori, M. 2021. Prosecutors, court communities, and policy change: The impact of internal DOJ reforms on federal prosecutorial practices. Criminology, 59, pp. 480– 519. doi: 10.1111/1745-9125.12275.
36. Gillette, C. 2020. Do Mandatory Minimums Increase Racial Disparities in Federal Criminal Sentencing? Undergraduate Economic Review, 17(1)9. Retrieved from: <https://digitalcommons.iwu.edu/uer/vol17/iss1/9>.
37. Fischman, JB and Schanzenbach, MM. 2012. Racial Disparities Under the Federal Sentencing Guidelines. Journal of Empirical Legal Studies, 9, pp. 729-764. doi:10.1111/j.1740-1461.2012.01266.x.
38. Nir E, Liu S. 2021. The Challenge of Imposing Just Sentences Under Mandatory Minimum Statutes: A Qualitative Study of Judicial Perceptions. Criminal Justice Policy Review. doi:10.1177/08874034211030555.
39. 39. Tomislav V. Kovandzic, John J. Sloan III & Lynne M. Vieraitis. 2004. “Striking out” as crime reduction policy: The impact of “three strikes” laws on crime rates in U.S. cities. Justice Quarterly, 21:2, pp. 207-239, doi: 10.1080/07418820400095791.
40. Reasons to Oppose Three Strikes. American Civil Liberties Union. Retrieved from: <https://www.aclu.org/other/10-reasons-oppose-3-strikes-youre-out>.
41. An Overview of the First Step Act. Federal Bureau of Prisons. 2018. Retrieved from: <https://www.bop.gov/inmates/fsa/overview.jsp>.

42. McMillon D, Simon CP, Morenoff J. 2014. Modeling the underlying dynamics of the spread of crime. PLoS One, 9(4):e88923. doi:10.1371/journal.pone.0088923.
43. Reasons to Oppose Three Strikes. American Civil Liberties Union. Retrieved from: <https://www.aclu.org/other/10-reasons-oppose-3-strikes-youre-out>.
44. Caulkins, JP. 2001. How large should the strike zone be in "three strikes and you're out" sentencing laws. Journal of Quantitative Criminology, 17, pp. 227-246.
45. Austin, J, Clark, J, Hardyman, P, & Henry, A. 2000. Three strikes and you're out: The Implementation and impact of strikes laws. National Institute of Justice. Washington, DC:
46. An Overview of the First Step Act. Federal Bureau of Prisons. 2018. Retrieved from: <https://www.bop.gov/inmates/fsa/overview.jsp>.
47. Aging Prison Population. National Commission on Correctional Health Care. https://www.ncchc.org/aging-prison-population
48. Gramlich, J. 2021. America's incarceration rate falls to lowest level since 1995. Pew Research Center. Retrieved from: <https://www.pewresearch.org/fact-tank/2021/08/16/americas-incarceration-rate-lowest-since-1995/>.
49. Correctional Populations in the United States, 2019 – Statistical Tables. US Department of Justice. Retrieved from: <https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/cpus19st.pdf.>
50. Hollinger, A, 2020. Funding Indigent Defense: A Judicial Solution to a Legislative Failure. The George Washington Law Review, 88(195), pp.1-30. Retrieved from: <https://www.gwlr.org/wp-content/uploads/2020/11/88-Geo.-Wash.-L.-Rev.-Arguendo-195.pdf
51. Green, B, 2003. Criminal Neglect: Indigent Defense from a Legal Ethics Perspective Ethics Symposium What Do Clients Want: Practice Contexts. Emory Law Journal, 52(1169), pp.1-32. Retrieved from: <https://ir.lawnet.fordham.edu/faculty_scholarship/272>.
52. Pruitt, L and Colgan, B, 2010. Justice Deserts: Spatial Inequality and Local Funding of Indigent Defense. Arizona Law Review, 52(219), pp.1-98. Retrieved from: <https://arizonalawreview.org/pdf/52-2/52arizlrev219.pdf>.
53. Fairfax, R. 2013. Searching for Solutions to the Indigent Defense Crisis in the Broader Criminal Justice Reform Agenda. Yale Law Journal, 122(2316), pp.1-20. Retrieved from: <https://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=5584&context=ylj>.
54. Alliance for Safety and Justice. 2016. Crime Survivors Speak: The First-Ever National Survey of Victims' Views on Safety and Justice. Oakland, CA: National Institute of Corrections, pp.1-32. Retrieved from: <https://nicic.gov/crime-survivors-speak-first-ever-national-survey-victims-views-safety-and-justice>.
55. Bird, M, Lofstrom, M, Martin, B, Raphael, S and Nguyen, V., 2018. The Impact of Proposition 47 on Crime and Recidivism. San Francisco, CA: Public Policy Institute of California, pp.1-32. Retrieved from: <https://www.ppic.org/wp-content/uploads/r_0618mbr.pdf>.
56. Hunt, K and Peterson, A. 2014. Recidivism Among Offenders Receiving Retroactive Sentence Reductions: The 2007 Crack Cocaine Amendment. Washington, D.C.: United States Sentencing Commission, pp.1-19. Retrieved from: <https://www.ussc.gov/sites/default/files/pdf/research-and-publications/research-projects-and-surveys/miscellaneous/20140527_Recidivism_2007_Crack_Cocaine_Amendment.pdf>.
57. Mauer, M. 2018. Long-Term Sentences: Time to Reconsider the Scale of Punishment. The Sentencing Project. Retrieved from: <https://www.sentencingproject.org/publications/long-term-sentences-time-reconsider-scale-punishment/>.
58. Sterbenz C. 2014. Why Norways Prison System is so Successful. Retrieved from <https://www.businessinsider.com/why-norways-prison-system-is-so-successful-2014-12>.

RELEVANT AMA POLICY

H-95.931 AMA Support for Justice Reinvestment Initiatives
Our AMA supports justice reinvestment initiatives aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs. [Res. 205, A-16]

H-80.993 Ending Money Bail to Decrease Burden on Lower Income Communities
Our AMA: (1) recognizes the adverse health effects of pretrial detention; and (2) will support legislation that promotes the use of non-financial release options for individuals charged with nonviolent crimes. [Res. 408, A-18; Reaffirmed: Res. 234, A-22]

H-430.980 Compassionate Release for Incarcerated Patients
Our AMA supports policies that facilitate compassionate release for incarcerated patients on the basis of serious medical conditions and advanced age; will collaborate with appropriate stakeholders to develop clear, evidence-based eligibility criteria for timely compassionate release; and promote transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions. [BOT Rep. 10, I-20]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(I-23)

Introduced by: Senior Physicians Section

Subject: Saving Traditional Medicare

Referred to: Reference Committee B

Whereas, Traditional Medicare signed into law on July 30, 1965, by President Lyndon B. Johnson, has provided healthcare coverage to millions of elderly and disabled Americans for decades, and is a vital lifeline for those who rely on it for access to affordable, high-quality healthcare services; and

Whereas, Traditional Medicare faces challenges such as funding shortfalls, rising healthcare costs, and the progressive take over by alternative private health plans [A.k.a. Medicare "Advantage"] now covering over 50% of the Medicare eligible individuals[1]; and

Whereas, Medicare Advantage plans have strayed from the core mission of Traditional Medicare plans with numerous allegations of potential fraud and waste; and

Whereas, Medicare Advantage spending [$7 Trillion over the next decade] is largely driven by star quality rating "bonus" payments currently at $12.8B [up 30% over 2022][2]; and

Whereas, Whereas, Coding "intensity" by Medicare Advantage plans has resulted in $23B in overpayments for 2023 with risk scores 10.8% higher than Traditional Medicare[3,4]; therefore be it

RESOLVED, That our American Medical Association continue its efforts to fix the flawed Medicare payment system for physicians recognizing that Traditional Medicare is a critical healthcare program while educating the public on the benefits and threats of Medicare Part C expansion (Directive to Take Action); and be it further

RESOLVED, That our AMA continue to address the funding challenges facing Traditional Medicare through legislative reform and policy changes that increase revenue streams, reduce waste and inefficiency, while at the same time advocating for sustainable, inflation-adjusted reimbursement to clinicians (Directive to Take Action); and be it further

RESOLVED, That our AMA address Medicare plans overpayments by urging the Department of Justice to prosecute those found complicit in fraudulent activity (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for change in CMS risk adjustment methods to guarantee a level playing field by using a competitive bidding process to replace the current benchmark system for determining Medicare Advantage bonus payments (Directive to Take Action); and be it further

RESOLVED, That our AMA support the "Save Medicare ACT" which proposes renaming Medicare "Advantage" plans as "Alternative Private Health Plans". (New HOD Policy)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 09/27/23

REFERENCES

1. Biniek, J.F. (2023, February 17). Is the Biden administration proposing cuts to Medicare Advantage? The Kaiser Family Foundation. Retrieved from: https://www.kff.org/policy-watch/is-the-biden-administration-proposing-cuts-to-medicare-advantage/
2. Biniek, J.F., Damico, A; Neuman, T. (2023, August 9). Spending on Medicare Advantage Quality Bonus Payments Will Reach at Least $12.8 Billion in 2023. The Kaiser Family Foundation. Retrieved from: Spending on Medicare Advantage Quality Bonus Payments Will Reach at Least $12.8 Billion in 2023 | KFF
3. *Ibid.*
4. Ryan, M. R., Chopra, Z., Meyers, D.J., Brown, E.C.F., Murray, R.C., Williams. T.C. (2023, Sept.). Favorable Selection In Medicare Advantage Is Linked To Inflated Benchmarks And Billions In Overpayments To Plans. *Health Affairs, 42*(9), 2630-2640.

RELEVANT AMA POLICY

Strengthening Medicare Through Competitive Bidding H-330.886
Our AMA supports the following principles to guide the use of competitive bidding among health insurers in the Medicare program:
a. Eligible bidders should be subject to specific quality and financial requirements to ensure sufficient skill and capacity to provide services to beneficiaries.
b. Bidding entities must be able to demonstrate the adequacy of their physician and provider networks.
c. Bids must be based on a clearly defined set of standardized benefits that should include, at a minimum, all services provided under the traditional Medicare program and a cap on out-of-pocket expenses.
d. Bids should be developed based on the cost of providing the minimum set of benefits to a standardized Medicare beneficiary within a given geographic region.
e. Geographic regions should be defined to ensure adequate coverage and maximize competition for beneficiaries in a service area.
f. All contracting entities should be required to offer beneficiaries a plan that includes only the standardized benefit package. Expanded benefit options could also be offered for beneficiaries willing to pay higher premiums.
g. Processes and resources must be in place to provide beneficiary education and support for choosing among alternative plans.
2. Our AMA supports using a competitive bidding process to determine federal payments to Medicare Advantage plans.
Citation: CMS Rep. 7, I-13; Reaffirmed: CMS Rep. 01, A-23

Strategies to Strengthen the Medicare Program H-330.896
Our AMA supports the following reforms to strengthen the Medicare program, to be implemented together or separately, and phased-in as appropriate:
1. Restructuring beneficiary cost-sharing so that patients have a single premium and deductible for all Medicare services, with means-tested subsidies and out-of-pocket spending limits that protect against catastrophic expenses. The cost-sharing structure should be developed to provide incentives for appropriate utilization while discouraging unnecessary or inappropriate patterns of care. The use of preventive services should also be encouraged. Simultaneously, policymakers will need to consider modifications to Medicare supplemental insurance (i.e., Medigap) benefit design standards to ensure that policies complement, rather than duplicate or undermine, Medicare's new cost-sharing structure.
2. Offering beneficiaries a choice of plans for which the federal government would contribute a standard amount toward the purchase of traditional fee-for-service Medicare or another health insurance plan approved by Medicare. All plans would be subject to the same fixed contribution amounts and regulatory requirements. Policies would need to be developed, and sufficient resources allocated, to ensure appropriate government standard-setting and regulatory oversight of plans.
3. Restructuring age-eligibility requirements and incentives to match the Social Security schedule of benefits.
Citation: CMS Rep.10, A-07; Reaffirmed: CMS Rep.5, I-12; Modified: Res. 508, A-14; Reaffirmed: CMS Rep.3, I-21

Medicare Advantage Plans D-330.923
Our AMA encourages the Centers for Medicare & Medicaid Services to award Medicare Advantage Programs only to those health plans that meet all of the following criteria: (1) an 85% or higher medical loss ratio; (2) physician payment rates are no less than Medicare Fee for Service rates; and (3) use enforceable contracts that prohibit unilateral changes in physician payment rates.
Citation: Res. 837, I-08; Reaffirmed: Res.116, A-17; Reaffirmation: I-18

Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans D-330.930
Our AMA will continue its efforts to educate physicians and the general public on the implications of participating in programs offered under Medicare Advantage and educate physicians and the public about the lack of secondary coverage (Medigap policies) with Medicare Advantage plans and how this may affect enrollees.
Citation: BOT Action in response to referred for decision Res. 711 I-06; Reaffirmation A-08; Modified: CMS Rep.01, A-19

Elimination of Subsidies to Medicare Advantage Plans D-390.967
1. Our AMA will seek to have all subsidies to private plans offering alternative coverage to Medicare beneficiaries eliminated, that these private Medicare plans compete with traditional Medicare fee-for-service plans on a financially neutral basis and have accountability to the Centers for Medicare and Medicaid Services.
2. Our AMA will seek to prohibit all private plans offering coverage to Medicare beneficiaries from deeming any physician to be a participating physician without a signed contract specific to that product, and that our AMA work with CMS to prohibit all-products clauses from applying to Medicare Advantage plans and private fee-for-service plans.
Citation: Res. 229, A-07; Modified: CMS Rep.01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(I-23)

Introduced by: International Medical Graduates Section

Subject: Addressing Work Requirements for J-1 Visa Waiver Physicians

Referred to: Reference Committee B

Whereas, The J-1 visa serves as a non-immigrant exchange visitor visa, frequently utilized by International Medical Graduates (IMGs) seeking medical residency or fellowship training in the United States; and

Whereas, The J-1 visa permits individuals to remain in the U.S., typically for up to seven years, during the completion of their Graduate Medical Education (GME); and

Whereas, Upon fulfilling their GME, these individuals are mandated by U.S. immigration law to return to their home country for a minimum of two years before becoming eligible for an H-1B visa to re-enter and work in the United States, or for permanent residency; and

Whereas, J-1 physicians upon completing GME are confronted with two primary options: firstly, they can adhere to the two-year home residency requirement, or secondly, they can pursue a waiver of this obligation; and

Whereas, A J-1 visa waiver nullifies the two-year home residency prerequisite, granting physicians the ability to transition to H-1B visa status. In exchange, physicians commit to serving in federally designated Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs), or among Medically Underserved Populations (MUPs). These physicians should dedicate three years to delivering safety-net services to indigent or underserved individuals, all while functioning under H-1B status. Common pathways for obtaining waivers include the Conrad 30 Waiver Program, the Appalachian Regional Commission (ARC), the Delta Regional Authority (DRA), and the Department of Health and Human Services (HHS) program; and

Whereas, For a waiver application, physicians must possess a full-time employment contract, involving at least 40 hours of work per week as a direct care physician; and

Whereas, The stringent requirement of 40 hours of direct patient care for physicians within the The J-1 waiver program places a significant burden. Balancing patient care, essential administrative tasks, and professional growth becomes challenging within this demanding schedule. Physicians find themselves navigating the complexities of continuous patient care while also aiming to dedicate time to administrative responsibilities and pursue non-clinical leadership roles. This rigid structure hampers their ability to effectively deliver high-quality medical services while fostering their own professional progress; therefore be it

RESOLVED, That our American Medical Association acknowledge that the requirement of 40 hours of direct patient care could impose a burden on IMG physicians and may hinder opportunities for professional growth (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for a revision in the J-1 waiver physician's requirement, proposing a transition to a comprehensive 40-hour work requirement that encompasses both direct clinical responsibilities and other professional activities. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 9/27/23

REFERENCES

1. U.S. Department of State - Waiver of the Exchange Visitor Two-Year Home-Country Physical Presence Requirement: https://travel.state.gov/content/travel/en/us-visas/study/exchange/waiver-of-the-exchange-visitor.html
2. J-1 Visa Waiver – U. S. Department of State: https://j1visawaiverrecommendation.state.gov/
3. Conrad 30 Waiver Program – U. S. Citizen and Immigration Service (USCIS): https://www.uscis.gov/working-in-the-united-states/students-and-exchange-visitors/conrad-30-waiver-program
4. State Department's J-1 Visa Exchange Visitor Program – U. S. Department of State: https://travel.state.gov/content/travel/en/us-visas/study/exchange.html

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(I-23)

Introduced by: American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Psychiatric Association

Subject: Youth Residential Treatment Program Regulation

Referred to: Reference Committee B

Whereas, residential treatment including substance use treatment facilities play a crucial role in the behavioral health system of states, providing support for mental health and substance use disorder (M/SUD) recovery through 24/7 structured living environments for individuals who do not require inpatient care; and

Whereas, the regulatory processes for these facilities are predominantly governed by state statutes and regulations, leading to inconsistencies in oversight and licensing standards across states and types of facilities; and

Whereas, many states lack laws regulating these programs, and questions remain on the effectiveness of existing laws; and

Whereas, caregivers are often unable to find child and adolescent residential treatment programs in their communities and need to send the child across state lines to access residential treatment programs; and

Whereas, despite licensing requirements, incidents of maltreatment and death occur in residential facilities, according to data collected by the U.S. Department of Health and Human Services. In 2005, 1,503 incidents of maltreatment by staff were reported in 34 states, including physical abuse, neglect, deprivation of necessities, and sexual abuse. Furthermore, in 2006, at least one death occurred in residential facilities in 28 states, with accidents and suicides being the most common causes; and

Whereas, state agencies may not adequately monitor facilities due to fluctuating staffing levels and inconsistent oversight standards, particularly in facilities that are exempt from licensing requirements, including some juvenile justice facilities and private programs and academies. These gaps in oversight may put vulnerable youth at increased risk of harm; and

Whereas, The 2018 Family First Prevention Services Act mandates that qualified residential treatment programs (QRTPs) receiving Federal funds must use a trauma-informed practice model; are staffed by registered or licensed staff who can provide care consistent with the treatment model; and are licensed and nationally accredited by the Commission on Accreditation of Rehabilitation Facilities, the Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation, or others approved organizations; and

Whereas, many programs do not receive government funding and are not subject to federal regulations, individual states are responsible for regulating them. However, many states exempt

these facilities from licensing requirements, and those with religious affiliations may not be subject to regulation by education and child welfare agencies; and

Whereas, The New York Times has reported on the “troubled teen” industry and the harm it inflicts on children with mental health and behavioral issues due to a reliance on archaic tactics, a lack of oversight and regulation, lack of use of evidence-based and effective treatments, and a focus on maximizing profit, and that despite years of scrutiny, not enough has changed; and

Whereas, Stop Institutional Child Abuse Act was a bill that was introduced in the House of Representatives in 2020 by Representative Adam Schiff of California. The bill aimed to improve oversight and accountability for residential programs for troubled youth, which have been known to subject children to physical, emotional, and sexual abuse. The bill would have required such programs to be licensed and would have created a national database of complaints and violations. Unfortunately, the bill did not make it out of committee, and therefore was not passed into law. This is just one example of the federal government's failure to adequately address the issue of institutional child abuse[7]; therefore be it

RESOLVED, that our American Medical Association advocate for the federal government to work with relevant parties to develop federal licensing standards for youth residential treatment programs (Directive to Take Action); and be it further

RESOLVED, that our AMA recognize the need for federal licensing standards for all youth residential treatment facilities (including private and juvenile facilities) to ensure basic safety and well-being standards for youth. (New HOD Policy)

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

Received: 9/27/23

REFERENCES

1. Allroggen, M., Rau, T., Ohlert, J., & Fegert, J. M. (2017). Lifetime prevalence and incidence of sexual victimization of adolescents in institutional care. Child abuse & neglect, 66, 23-30.
2. Behar, L., Friedman, R., Katz-Leavy, J., Pinto, A., & Boyles, W. Addressing Abuse and Mistreatment of Youth Placed in Residential "Treatment" Facilities. Systems of Care, 289.
3. Friedman, R. M., Pinto, A., Behar, L., Bush, N., Chirolla, A., Epstein, M., ... & Young, C. K. (2006). Unlicensed residential programs: The next challenge in protecting youth. American Journal of Orthopsychiatry, 76(3), 295-303.
4. Hobbs, G. F., Hobbs, C. J., & Wynne, J. M. (1999). Abuse of children in foster and residential care. Child abuse & neglect, 23(12), 1239-1252.
5. Intensive/qualified residential treatment. Intensive/Qualified Residential Treatment - Child Welfare Information Gateway. (n.d.). Retrieved April 14, 2023, from https://www.childwelfare.gov/topics/outofhome/group-residential-care/intensive/
6. Milnamow, C. (2022, December 4). The Trouble Team Industry: Should the federal government intervene? Retrieved April 14, 2023, from https://lawreview.law.miami.edu/the-trouble-team-industry-should-the-federal-government-intervene/
7. Schiff, A. (2020). H.R. 9116, Stop Institutional Child Abuse Act. 116th Congress.
8. Stockton, A. (2022, October 11). Can you punish a child's mental health problems away? The New York Times. Retrieved April 13, 2023, from https://www.nytimes.com/interactive/2022/10/11/opinion/teen-mental-health-care.html?smid=nytcore-ios-share&referringSource=articleShare
9. U.S. Government Accountability Office (2007). Residential treatment programs: Concerns regarding abuse and death in certain programs for troubled youth. Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth | U.S. GAO. Retrieved April 13, 2023, from https://www.gao.gov/products/gao-08-146t
10. U.S. Government Accountability Office (2008). Residential facilities: State and Federal Oversight Gaps May Increase Risk to Youth Well-being. U.S. GAO Retrieved September 26, 2023, https://www.gao.gov/assets/gao-08-696t.pdf

RELEVANT AMA POLICY

H-95.965 Residential Treatment for Women with Substance Use Disorder
Our AMA encourages state medical societies to support an exemption in public aid rules that would allow for the coverage of residential drug treatment programs for women with child-bearing potential. [Res. 405, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Modified: CSAPH Rep. 1, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(I-23)

Introduced by: Washington, American Association of Public Health Physicians

Subject: Improving Access to Post-Acute Medical Care for Patients with Substance Use Disorder (SUD)

Referred to: Reference Committee B

Whereas, patients with substance use disorder (SUD) including opioid use disorder (OUD) who are discharging from the hospital frequently require continued post-acute medical care in settings such as skilled nursing facilities (SNFs); and

Whereas, such patients face barriers to successfully reaching post-acute medical care, including discriminatory policies that seek to reject admission of patients with OUD[1] and regulatory prohibitions against continuing opioid agonist therapy such as methadone at SNFs[2]; and

Whereas, policies against admission of patients with OUD may violate the Americans with Disabilities Act[3]; and

Whereas, methadone treatment for OUD with methadone must be dispensed at a methadone clinic regardless of stay in a SNF; and

Whereas, rural SNFs are situated long distances away from methadone treatment centers, making transportation a barrier to continuation of methadone or rehabilitation stay at an SNF; and

Whereas, the use of methadone for the treatment of OUD is not covered by Medicare Part D and retail pharmacies are prohibited from dispensing it for this purpose; and

Whereas, optimizing SNF care for patients with OUD/SUDs may ultimately require changes in regulations regarding treating SUD/OUDs during SNF admission; and

Whereas, impediments to discharging patients to post-acute medical care exacerbate the crisis in hospital discharge, leading to increased lengths of stay and worsening hospital overcrowding; therefore be it

RESOLVED, that our American Medical Association advocate to ensure that patients who require a post-acute medical care setting are not discriminated against because of their history of substance use disorder (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that our federal, state, and local governments remove barriers to opioid agonist therapy (including methadone, buprenorphine or other appropriate treatments) at skilled nursing facilities (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that Medicare and Medicaid provide coverage for substance use and opioid use disorder treatments in skilled nursing facilities. (Directive to Take Action)

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

Received: 9/27/23

REFERENCES

1. Kimmel SD, Rosenmoss S, Bearnot B, Larochelle M, Walley AY. Rejection of Patients With Opioid Use Disorder Referred for Post-acute Medical Care Before and After an Anti-discrimination Settlement in Massachusetts. J Addict Med. 2021 Jan-Feb 01;15(1):20-26. doi: 10.1097/ADM.0000000000000693. PMID: 32675798; PMCID: PMC7859880.
2. Cohen SM, Joab R, Bolles KM, Friedman S, Kimmel SD. Ending Medical Complicity With Skilled-Nursing Facility Discrimination Against People With Opioid Use Disorder. Ann Intern Med. 2023 Mar;176(3):410-412. doi: 10.7326/M22-3049. Epub 2023 Feb 7. PMID: 36745883.
3. Administering or dispensing of narcotic drugs. 21 C.F.R. Vol Title 21, Volume 9; Chapter II2005.
4. Wakeman, S. E., and Rich, J. D. 2017. "Barriers to Post-Acute Care for Patients on Opioid Agonist Therapy; An Example of Systematic Stigmatization of Addiction." Journal of General Internal Medicine 32(1): 17-19.
5. Baird, J. and Griese, B. 2018. "Unfortunately, Turning Away Opioid Addicts Might be Necessary." McKnight's Long-Term Care News, May 7.
6. Medicare Payment Advisory Commission (MedPAC). 2020. “Chapter 8: Skilled Nursing Facility Services.” Report to the Congress: Medicare Payment Policy.
7. Wood, E., Samet, J. H., and Volkow, N. D. 2013. “Physician Education in Addiction Medicine.” *JAMA* 310(16): 1673–4. World Health Organization. 2019.
8. Ronan MV and Herzig SJ. Hospitalizations related to opioid abuse/dependence and associated serious infections increased sharply, 2002-12. *Health Aff (Millwood)*. 2016;35(5):832–837.
9. *Comprehensive Drug Abuse Prevention and Control Act of 1970 (The Controlled Substances Act). 21*. Vol 841970:1236 – 1296.

RELEVANT AMA POLICY

Treating Opioid Use Disorder in Hospitals D-95.967
1. Our AMA’s Opioid Task Force will work together with the American Hospital Association and other relevant organizations to identify best practices that are being used by hospitals and others to treat opioid use disorder as a chronic disease, including identifying patients with this condition; initiating or providing opioid agonist or partial agonist therapy in inpatient, obstetric and emergency department settings; providing cognitive and behavioral therapy as well as other counseling as appropriate; establishing appropriate discharge plans, including education about opioid use disorder; and participating in community-wide systems of care for patients and families affected by this chronic medical disease.

2. Our AMA will advocate for states to evaluate programs that currently exist or have received federal or state funding to assist physicians, hospitals and their communities to coordinate care for patients with the chronic disease of opioid use disorder.

3. Our AMA will take all necessary steps to seek clarification of interpretations of 21 CFR 1306.07 by the DEA and otherwise seek administrative, statutory and regulatory solutions that will allow for (a) prescribers with the waiver permitting the prescribing of buprenorphine for opioid use disorder to be able to do so, when indicated, for hospitalized inpatients, using a physician order rather than an outpatient prescription, and (b) hospital inpatient pharmacies to be able to fill such authorizations by prescribers without this constituting a violation of federal regulations.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(I-23)

Introduced by: American College of Legal Medicine, Richard Wilbur, MD, JD, FCLM,

Subject: Merit-Based Process for the Selection of all Federal Administrative Law Judges

Referred to: Reference Committee B

Whereas, Medicare and Medicaid beneficiaries must appeal their coverage and payment disputes to Health and Human Services Administrative Law Judges (ALJs); and

Whereas, Medicare and Medicaid beneficiaries deserve competent and neutral Health and Human Services ALJs presiding over their disputes with Medicare and Medicaid; and

Whereas, Medicare and Medicaid providers and suppliers must appeal their payment disputes to Health and Human Services ALJs; and

Whereas, Medicare and Medicaid providers and suppliers deserve competent and neutral Health and Human Services ALJs presiding over their payment disputes with Medicare; and

Whereas, Social Security beneficiaries must appeal their coverage and payment disputes to Social Security ALJs; and

Whereas, Social Security beneficiaries deserve competent and neutral Social Security ALJs presiding over their coverage and payment disputes with Social Security; and

Whereas, the Administrative Procedure Act of 1946 controls the federal agencies, including the Department of Health and Human Services (Medicare and Medicaid) and Social Security[1]; and

Whereas, from 1946 until 2018, attorney candidates who wanted to become federal administrative law judges (ALJs) were required:

a. to pass an examination on administrative law given by the U.S. Department of Personnel Management, and only the top three scoring candidates were offered positions as federal administrative law judges (ALJs),
b. to have at least seven years of experience in an area of law relevant to administrative proceedings, and
c. to prove they had the ability to write clear and understandable decisions following an administrative proceeding; and

Whereas, following the Supreme Court decision in Lucia v. SEC[2], Executive Order (E.O.) 13,843 was signed[3]; and

Whereas, E.O. 13,843 removed all federal administrative law judges (ALJs) from the competitive civil service; and

Whereas, the only current requirements for a new federal ALJ are a license to practice law somewhere in the United States and an appointment to be an ALJ for a federal agency, with the appointment made by the temporary, politically appointed agency head; and

Whereas, E.O 13,843 politicizes the federal ALJ service and will result in the appointment of questionably competent ALJs[4]; therefore be it

RESOLVED, that our American Medical Association support the pre-2018, merit-based process for the selection of all federal administrative law judges (ALJs), including the requirements that:

1. All federal ALJ candidates must be licensed and authorized to practice law under the laws of a State, the District of Columbia, the Commonwealth of Puerto Rico, or any territorial court established under the United States Constitution throughout the ALJ selection process,

2. All federal ALJ candidates must have a full seven (7) years of experience as a licensed attorney preparing for, participating in, and/or reviewing formal hearings or trials involving litigation and/or administrative law at the Federal, State, or local level, and

3. All federal ALJ candidates must pass an examination, the purpose of which is to evaluate the competencies/knowledge, skills, and abilities essential to performing the work of an Administrative Law Judge. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 9/26/23

REFERENCES

1. https://sourcebook.acus.gov/wiki/Administrative_Procedure_Act/view
2. 138 S. Ct. 2044 (2018)
3. https://www.federalregister.gov/documents/2018/07/13/2018-15202/excepting-administrative-law-judges-from-the-competitive-service
4. https://www.govexec.com/oversight/2018/07/judges-union-supreme-court-decision-excuse-politicize-aljs/149773/
5. https://www.opm.gov/policy-data-oversight/classification-qualifications/general-schedule-qualification-standards/specialty-areas/administrative-law-judge-positions/

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(I-23)

Introduced by: Association for Clinical Oncology, College of American Pathologists

Subject: Expansion of Remote Digital Laboratory Access Under CLIA

Referred to: Reference Committee B

Whereas, the Centers for Medicare and Medicaid Services (CMS) used certain enforcement discretion and flexibility to expand laboratory capacity during the Public Health Emergency (PHE) posed by COVID-19, including certain Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations[1]; and

Whereas, one important enforcement discretion was allowing pathologists and other laboratory personnel to remotely review digital clinical laboratory data, digital results, and digital images without obtaining a separate CLIA certificate for the remote testing site, provided that the primary site or home base had such a certificate[2]; and

Whereas, CMS plans to continue this enforcement discretion after the PHE ends[3], and

Whereas, the discretion specifies relevance to “pathologists and laboratory personnel”; and

Whereas, other physician specialties in addition to pathologists, such as hematologists and oncologists, may have qualifications to evaluate blood smears for the evaluation of acute hematologic disorders[4]; and

Whereas, current interpretation of CMS guidance does not appear to allow hematologists or oncologists to use digital hematology microscopy platforms for the remote evaluation of blood smears without obtaining individual CLIA licenses for each remote physician; and

Whereas, current interpretation creates an unnecessary burden in the inability to review blood smears and other digital pathology remotely, which can result in delays in care and increased cost of care; therefore be it

RESOLVED, that our American Medical Association advocate to the Centers for Medicare and Medicaid Services that post-Public Health Emergency enforcement discretion of Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations 42 C.F.R. §§ 493.35(a), 493.43(a), and 493.55(a)(2) that requires laboratories to file a separate application for each laboratory location unless it meets a regulatory exception, be clarified to include all qualified physicians under CLIA, to review digital data, digital results, and digital images at a remote location under the primary location CLIA certificate. (Directive to Take Action)

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

Received: 10/11/23

REFERENCES

1. https://www.cms.gov/files/document/qso-23-15-clia.pdf
2. https://www.cms.gov/files/document/qso-23-15-clia.pdf
3. https://www.cms.gov/files/document/qso-23-15-clia.pdf
4. https://www.rcpath.org/discover-pathology/news/fact-sheets/haematology.html

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(I-23)

Introduced by: Association for Clinical Oncology

Subject: Initial Consultation for Clinical Trials Under Medicare Advantage

Referred to: Reference Committee B

Whereas, more than half of the Medicare-eligible population is enrolled in a Medicare Advantage plan[1]; and

Whereas, existing AMA policy H-460.930(3) affirms the inherent obligation of capitation programs and managed care organizations to invest in broad-based clinical research, including significant financial contribution to support such research[2]; and

Whereas, at A-23, our AMA adopted policy H-460.882 advocating that the Centers for Medicare and Medicaid Services (CMS) require that Medicare Advantage Organizations (MAO) pay physicians and non-physician providers directly for the routine costs of clinical trials, as opposed to the current practice of switching the patient to original Medicare when enrolled on a clinical trial and requiring that patients pay out-of-pocket copays and coinsurance before later being reimbursed by the MAO[3]; and

Whereas, no institution or managed care network, however large, can offer all relevant clinical trials; and

Whereas, coverage of the initial consultation of an out-of-network physician for the purpose of enrollment in a clinical trial remains a financial barrier to clinical trial enrollment for Medicare Advantage patients, as those patients have not yet enrolled in a clinical trial; and

Whereas, current Medicare policy under National Coverage Determination (NCD) 310.1 states that Managed Care Organizations "may have reporting requirements when enrollees participate in clinical trials, in order to track and coordinate their members' care, but *cannot require prior authorization or approval*" (emphasis added)[4]; and

Whereas, NCD 310.1 has the effect that Medicare Advantage patients must currently self-refer for consultation for an out-of-network clinical trial; therefore be it

RESOLVED, that our American Medical Association amend policy H-460.882, "Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations," by addition to read as follows:

4. Our AMA advocate that the Centers for Medicare and Medicaid Services allow out-of-network referral of patients with Medicare Advantage for the purpose of consultation for enrollment in a clinical trial, and that these consultations be considered administratively as participation in a clinical trial. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/11/23

REFERENCES

1. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/
2. https://policysearch.ama-assn.org/policyfinder/detail/%22Importance%20of%20Clinical%20Research%20H-460.930%22?uri=%2FAMADoc%2FHOD.xml-0-4178.xml
3. https://policysearch.ama-assn.org/policyfinder/detail/H-460.882%20?uri=%2FAMADoc%2FHOD.xml-H-460.882.xml
4. https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=1&ncdver=2r=2

RELEVANT AMA POLICY

H-460.882 Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations
(1) Our American Medical Association will advocate that the Centers for Medicare and Medicaid Services require that Medicare Advantage Organizations (MAOs) pay for routine costs for services that are provided as part of clinical trials covered under the Clinical Trials National Coverage Determination 310.1, just as the MAO would have been required to do so had the patient not enrolled in the qualified clinical trial.
(2) Our AMA will advocate for the Centers for Medicare and Medicaid Services (CMS) and Medicare Advantage Organizations (MAOs) to communicate and coordinate the payment for services associated with participation in clinical trials, covered under the Clinical Trials National Coverage Determination 310.1, and to ensure that physicians and non-physician providers are paid directly in order to eliminate the requirement that patients seek reimbursement for billed services.
(3) Our AMA will take the position that Medicare Advantage Organizations (MAOs) and their participating physicians shall actively encourage patients to enroll in clinical trials.

Importance of Clinical Research H-460.930
(1) Given the profound importance of clinical research as the transition between basic science discoveries and standard medical practice of the future, the AMA will a) be an advocate for clinical research; and b) promote the importance of this science and of well-trained researchers to conduct it.
(2) Our AMA continues to advocate vigorously for a stable, continuing base of funding and support for all aspects of clinical research within the research programs of all relevant federal agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the Department of Veterans Affairs and the Department of Defense.
(3) The AMA believes it is an inherent obligation of capitation programs and managed care organizations to invest in broad-based clinical research (as well as in health care delivery and outcomes research) to assure continued transition of new developments from the research bench to medical practice. The AMA strongly encourages these groups to make significant financial contributions to support such research.
(4) Our AMA continues to encourage medical schools a) to support clinical research; b) to train and develop clinical researchers; c) to recognize the contribution of clinical researchers to academic medicine; d) to assure the highest quality of clinical research; and e) to explore innovative ways in which clinical researchers in academic health centers can actively involve practicing physicians in clinical research.
(5) Our AMA encourages and supports development of community and practice-based clinical research networks.

D-285.959 Prevent Medicare Advantage Plans from Limiting Care
Our AMA will: (1) ask the Centers for Medicare and Medicaid Services to further regulate Medicare Advantage Plans so that the same treatment and authorization guidelines are followed for both fee-for-service Medicare and Medicare Advantage patients, including admission to inpatient rehabilitation facilities; and (2) advocate that proprietary criteria shall not supersede the professional judgment of the patient's physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions. Citation: Res. 706, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(I-23)

Introduced by: Association for Clinical Oncology

Subject: ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers

Referred to: Reference Committee B

Whereas, pharmacy benefit managers (PBMs) are third party companies that function as intermediaries between insurance providers and pharmaceutical manufacturers to create formularies, negotiate rebates with manufacturers, process claims, create pharmacy networks, review drug utilization, and manage mail-order specialty pharmacies[1]; and

Whereas, the four largest PBMs collectively have a 68 percent share of the national commercial market[2]; and

Whereas, the largest PBMs are integrated with the largest health insurance companies and wholly owned mail-order specialty pharmacies, which allows them to influence which drugs are prescribed to patients, which pharmacies patients can use, and how much patients pay[3]; and

Whereas, PBMs have substantial influence over independent pharmacies, which have collectively voiced concerns that PBMs negotiate and leverage contractual terms with these pharmacies that are confusing, unfair, arbitrary, and harmful to their business[4]; and

Whereas, PBMs engage in potentially harmful and anti-competitive practices such as charging fees and clawbacks to unaffiliated pharmacies; steering patients toward PBM-owned pharmacies; potentially unfair auditing of unaffiliated pharmacies; the use of complicated and opaque pharmacy reimbursement methods; and negotiating rebates and fees with drug manufacturers that may skew the formulary incentives and impact the cost of prescription drugs to patients[5]; and

Whereas, since 2017, states have enacted more than 100 laws to address the ways PBMs contribute to high costs[6]; and

Whereas, the Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry[7]; and

Whereas, ERISA plans cover about 141 million workers and beneficiaries, or about 44 percent of the population[8]; and

Whereas, ERISA threatens enforcement of state laws that impact employer-sponsored health insurance, especially the self-funded plans that comprise 64 percent of employer-sponsored coverage[9]; and

Whereas, ERISA preemption dilutes states' ability to collect data, control prices, and protect consumers[10]; and

Whereas, the U.S. Supreme Court's 2020 opinion *Rutledge v. PCMA* clarified that state laws that affect or regulate health care costs are not necessarily preempted even though they may alter the incentives and decisions facing employer-sponsored plans;[11] and

Whereas, despite the *Rutledge* ruling, ERISA jurisprudence has been unpredictable, leaving states to regulate and legislate under uncertainty; therefore be it

RESOLVED, that our American Medical Association study enacted state pharmacy benefit management (PBM) legislation and create a model bill that would avoid the Employment Retirement Income Security Act of 1974 (ERISA) preemption. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 10/10/23

REFERENCES

1. https://content.naic.org/cipr-topics/pharmacy-benefit-managers
2. https://www.ama-assn.org/system/files/prp-pbm-shares-hhi.pdf
3. https://www.ftc.gov/news-events/news/press-releases/2023/05/ftc-deepens-inquiry-prescription-drug-middlemen
4. https://www.ftc.gov/news-events/news/press-releases/2023/05/ftc-deepens-inquiry-prescription-drug-middlemen
5. https://www.ftc.gov/news-events/news/press-releases/2023/05/ftc-deepens-inquiry-prescription-drug-middlemen
6. https://nashp.org/legislative-approaches-to-curbing-drug-costs-targeted-at-pbms-2017-2021/
7. https://www.dol.gov/general/topic/health-plans/erisa#:~:text=The%20Employee%20Retirement%20Income%20Security,for%20individuals%20in%20these%20plans
8. https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/what-is-erisa#:~:text=These%20plans%20cover%20about%20141,59%20percent%20earn%20health%20benefits
9. https://www.commonwealthfund.org/publications/issue-briefs/2022/may/state-cost-control-reforms-erisa-preemption
10. https://www.commonwealthfund.org/publications/issue-briefs/2022/may/state-cost-control-reforms-erisa-preemption
11. https://www.healthaffairs.org/content/forefront/implications-i-rutledge-v-pcma-i-state-health-care-cost-regulation

RELEVANT AMA POLICY

AMA Policy on ERISA H-285.915

1. Our AMA will seek, through amendment of the ERISA statute, through enactment of separate federal patient protection legislation, through enactment of similar state patient protection legislation that is uniform across states, and through targeted elimination of the ERISA preemption of self-insured health benefits plans from state regulation, to require that such self-insured plans: (a) Ensure that plan enrollees have access to all needed health care services; (b) Clearly disclose to present and prospective enrollees any provisions restricting patient access to or choice of physicians, or imposing financial incentives concerning the provision of services on such physicians; (c) Be regulated in regard to plan policies and practices regarding utilization management, claims submission and review, and appeals and grievance procedures; (d) Conduct scientifically based and physician-directed quality assurance programs; (e) Be legally accountable for harm to patients resulting from negligent utilization management policies or patient treatment decisions through all available means, including proportionate or comparative liability, depending on state liability rules; (f) Participate proportionately in state high-risk insurance pools that are financed through participation by carriers in that jurisdiction; (g) Be prohibited from indemnifying beneficiaries against actions brought by physicians or other providers to recover charges in excess of the amounts allowed by the plan, in the absence of any provider contractual agreement to accept those amounts as full payment; (h) Inform beneficiaries of any discounted payment arrangements secured by the plan, and base beneficiary coinsurance and deductibles on these discounted amounts when providers have agreed to accept these discounted amounts as full payment; (i) Be subject to breach of contract actions by providers against their administrators; and (j) Adopt coordination of benefits provisions applying to enrollees covered under two or more plans.
2. Our AMA will continue to advocate for the elimination of ERISA preemption of self-insured health plans from state insurance laws consistent with current AMA policy.

Reference Committee C

Report(s) of the Council on Medical Education

01 Leave Policies for Medical Students, Residents, Fellows, and Physicians
03 Ensuring Equity in Interview Processes for Entry to Undergraduate and Graduate Medical Education
04 Recognizing Specialty Certifications for Physicians
05 Organizations to Represent the Interests of Resident and Fellow Physicians

Resolutions

301 Clarification of AMA Policy D-310-948 "Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure"
302 Medical Student Reports of Disability-Related Mistreatment
304 Health Insurance Options for Medical Students
305 Addressing Burnout and Physician Shortages for Public Health
306* Increasing Practice Viability for Female Physicians through Increased Employer and Employee Awareness of Protected Leave Policies

***Not yet reviewed for consideration by the Resolution Committee**

REPORT 1 OF THE COUNCIL ON MEDICAL EDUCATION (I-23)
Leave Policies for Medical Students, Residents, Fellows, and Physicians (Reference Committee C)

EXECUTIVE SUMMARY

This report is written in response to policies adopted at the 2022 Interim Meeting that call for study. Clause four of American Medical Association (AMA) Policy H-405.960, "Policies for Parental, Family and Medical Necessity Leave," asks that the AMA:

> 4. study the impact on and feasibility of medical schools, residency programs, specialty boards, and medical group practices incorporating into their parental leave policies a 12-week minimum leave allowance, with the understanding that no parent be required to take a minimum leave.

Clauses two and five of AMA Policy H-405.947, "Compassionate Leave for Medical Students and Physicians," ask that the AMA:

> 2. study components of compassionate leave policies for medical students and physicians, to include: (a) whether cases requiring extensive travel qualify for additional days of leave and, if so, how many days; (b) policy and duration of leave for an event impacting pregnancy or fertility including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, a failed surrogacy arrangement, or an event that impacts pregnancy or fertility; (c) whether leave is paid or unpaid; (d) whether obligations and time must be made up; and (e) whether make-up time will be paid.
>
> 5. study the concept of equal compassionate leave for pregnancy loss and other such events impacting fertility in a physician or their partner as a benefit for medical students and physicians regardless of gender or gender identity.

This report provides background information and history on parental and bereavement/ compassionate leave policies for medical students, residents, fellows, and physicians. It also discusses the feasibility and impact of such policies, an overview of AMA contributions in this space, and recommendations in order to clarify and strengthen the AMA's position on these topics and improve the well-being of medical students, residents, fellows, and physicians in practice.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-23

Subject: Leave Policies for Medical Students, Residents, Fellows, and Physicians

Presented by: Cynthia Jumper, MD, MPH, Chair

Referred to: Reference Committee C

At the 2022 Interim Meeting of the American Medical Association (AMA) House of Delegates, testimony was received on three resolutions related to leave policies:

- 302-I-22, "Expanding employee leave to include miscarriage and stillbirth"
- 303-I-22, "Medical student leave policy"
- 308-I-22, "Paid family/medical leave in medicine"

As a result, two policies were adopted as amended in lieu of these resolutions, one of which requested study. Amended Policy H-405.960 (4), "Policies for Parental, Family and Medical Necessity Leave," asks that the AMA:

> 4. study the impact on and feasibility of medical schools, residency programs, specialty boards, and medical group practices incorporating into their parental leave policies a 12-week minimum leave allowance, with the understanding that no parent be required to take a minimum leave.

Also, Resolution 309-I-22, "Bereavement Leave for Medical Students and Physicians," was adopted as amended with a change in title (from "Bereavement" to "Compassionate"). It has become new policy H-405.947 (2) and (5) and asks that the AMA:

> 2. study components of compassionate leave policies for medical students and physicians, to include: (a) whether cases requiring extensive travel qualify for additional days of leave and, if so, how many days; (b) policy and duration of leave for an event impacting pregnancy or fertility including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, a failed surrogacy arrangement, or an event that impacts pregnancy or fertility; (c) whether leave is paid or unpaid; (d) whether obligations and time must be made up; and (e) whether make-up time will be paid.
>
> 5. study the concept of equal compassionate leave for pregnancy loss and other such events impacting fertility in a physician or their partner as a benefit for medical students and physicians regardless of gender or gender identity.

This report is written in direct response to these calls for study regarding parental and compassionate leave policies.

BACKGROUND

Considerations of competency in medical education

Before addressing the particulars of parental and compassionate leave, the tantamount issue of educational and professional competency must be acknowledged. Upon completion of medical school, medical students ("students") must achieve established requirements and competencies to be awarded a MD/DO degree; hence, taking leave may prolong training and related costs. Likewise, resident and fellow ("trainee") physicians must achieve competencies for independent practice in the specialty of their program. Different from medical school, residency is a service-learning experience where trainees provide patient care services. Thus, it is important to distinguish which educational activities and/or clinical services are essential to demonstrate competency and could be missed when a trainee is on leave. Nonetheless, all medical students and trainees should have access to leave; but there can be consequences for taking leave due to the demands of professionalism and duty to patients and the public. Physicians in practice are equally deserving of such leave but may also face consequences.

For the purposes of this report and its recommendations, the use of the word "trainees" includes those individuals in non-standard training (NST) programs.

Parental leave

History of FMLA and unpaid leave

The federal Family and Medical Leave Act (FMLA) was introduced in Congress every year from 1984 to 1993, when it finally was signed into law by President Bill Clinton. It entitles "eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave. Eligible employees are entitled to:

- Twelve workweeks of leave in a 12-month period for:
  - the birth of a child and to care for the newborn child within one year of birth;
  - the placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;
  - to care for the employee's spouse, child, or parent who has a serious health condition;
  - a serious health condition that makes the employee unable to perform the essential functions of his or her job;
  - any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty;" or
- Twenty-six work weeks of leave during a single 12-month period to care for a covered servicemember with a serious injury or illness if the eligible employee is the servicemember's spouse, son, daughter, parent, or next of kin (military caregiver leave)."[1]

If an employee has worked for their employer at least 12 months, at least 1,250 hours over the past 12 months, and worked at a location where the company employs 50 or more employees within 75 miles, then they are eligible for FMLA leave.[1] The minimum 1,250 hours of service is set by the Fair Labor Standards Act (FLSA) principles for determining compensable hours or work. Also, special rules may apply if both parents are employed by the same company.

The FMLA is administered by the U.S. Department of Labor for most employees and by the Office of Personnel Management for most federal employees. Answers to frequently asked questions are provided on the FMLA website. States are allowed to determine standards that go beyond the federal law. In response to the COVID-19 pandemic, many states have enacted or expanded family

leave permanently. As of June 2022, seven states (WA, CA, NY, CT, RI, MA, NJ) had enacted and implemented state FMLA laws; four states (OR, CO, MD, DE) had enacted but not yet implemented such laws.[2] For members of the armed forces, FMLA leave may also be applied to the foreign deployment of the employee's spouse, son, daughter, or parent and is called "qualifying exigency."[3]

Medical students

Given that FMLA applies to employed persons, it does not apply to medical students. Thus, such policies are at the discretion of educational institutions. Kraus et al., studied the current state of parental leave policies for medical students by reviewing 199 MD-granting and DO-granting medical schools in the U.S. and its territories. They concluded that many schools do not have easily accessible parental leave policies; many such policies are not separate from formal leaves of absence and do not allow for the minimum 12 weeks allowed per FMLA. Further, schools do not ensure on-time completion of medical education by tailoring policies to the student academic year.[4] Likewise, medical students outside of the U.S. are facing similar issues.[5] Without explicit, equitable leave time, students are forced to make difficult decisions about family planning and/or delays in medical education.[6]

A recent article by the Association of American Medical Colleges discusses two studies which reviewed parental leave policies at U.S. MD and DO schools. The article references research that found only about 1/3 of medical schools had a parental leave policy. Further, it noted a difference in MD vs DO schools; while 25% of the MD-granting schools had a public policy, 60% of the 44 DO-granting schools did.[4] The second study found that "only 14% had "substantive, stand-alone parental leave policies." While most schools offered general leave of absence policies that were not specific to parenting, the researchers also found that policies crafted specifically for pregnant and parenting people were substantially different from general leave policies."[7]

An example of a medical school's own parental leave policy is the University of North Carolina School of Medicine's New Child Adjustment Policy, which offers up to six months parental leave while retaining health insurance and financial aid and avails remote classes options during the transition back to school.[8] By comparison, the University of Chicago Pritzker School of Medicine uses the same policy as the undergraduate school, allowing a one-quarter/ten-week leave with benefits.[8]

Trainees

Given that many residency programs fall short of the 50 employees required to qualify for FMLA's 12-week minimum leave, many programs or institutions have been implementing their own policies. In July 2021, the American Board of Medical Specialties released a new policy to their member boards regarding parental, caregiver, and medical leave during training for achieving board eligibility. The policy states that such boards "must allow for a minimum of 6 weeks of time away from training for purposes of parental, caregiver, and medical leave at least once during training, without exhausting all other allowed time away from training and without extending training."[9] One year later, the Accreditation Council for Graduate Medical Education (ACGME) issued a requirement that all ACGME-accredited programs offer six weeks of paid leave to all residents/fellows for medical, parental, and caregiver leave, effective on the trainees' first day in their program.[10] To further address resident leave policies, in 2022, the ACGME published an article in their "ACGME Answers" series.[11]

Many boards have their own leave policies for trainees to achieve board eligibility. For example, the American Board of Surgery (ABS), starting with the 2021-2022 academic year, states that "48 weeks of full-time clinical activity in each of the five years of residency, regardless of the amount of operative experience obtained" are required.[12] The remaining four weeks of the year are considered non-clinical time that may be used for any purpose, such as vacation, conferences, interviews, etc. All time away from clinical activity (i.e., non-clinical time), including vacation and time taken for interviews, visa issues, etc., must be accounted for on the application for certification."[12] Details are available on the ABS website. Many specialty societies have policies regarding parental leave; some even support paid leave.

Research published in the last few years indicates that several specialties have been analyzing their leave policies and are developing guidance for program directors to help make the transition back to work after parental leave smoother and less overwhelming. As an example of such research, a national survey of 422 program directors in internal medicine showed that while many programs do have program-level policies, others default to institutional policies which tend to be less flexible. It concluded that more than half of respondents favored a national standard to guide the development of program-level parental leave policies so long as programs with limited resources are provided flexibility.[13]

Physicians

Parental leave policies for physicians may vary depending on the employer, given physicians work in a variety of settings—private practice, group practice, academia, hospitals, health systems, insurers, associations, etc. As stated earlier, a physician qualifies for FMLA (or their state policy that may go beyond FMLA) if their employer has 50 or more employees. Otherwise, the physician is likely bound by non-federal employer policies that may or may not include paid or unpaid leave.

The American College of Obstetricians and Gynecologists (ACOG) supports paid parental leave as essential for the well-being of parent and child, endorsing a minimum of six weeks with full benefits and 100% of pay. ACOG also offers guidance for medical schools, training programs, ACGME, specialty boards, and medical practices regarding the incorporation of paid parental leave policies as part of the physician's standard benefit package.[14]

What about paid leave?

The established federal norm, per FMLA, is twelve weeks of unpaid leave despite ample evidence of the benefits (for both parent and child) of paid leave, including improved health and job satisfaction.[15] In the U.S., employer-provided paid leave is more prevalent among high-paying, professional occupations and within large companies.[16] Many other countries endorse paid leave. Among the 38 countries that are members of the Organization for Economic Co-operation and Development, the U.S. is the only one without a national paid maternity or family leave policy.[17] Recent attempts to change U.S. law to paid leave have failed. In 2021, the Robert Wood Johnson Foundation published a brief entitled "Improving Access to Paid Family Leave to Achieve Health Equity," which not only provides principles for a paid family leave program for all but explains how paid leave policies can support economic growth and address racial and socioeconomic disparities in order to promote health equity.[16]

Bereavement/compassionate leave

Definition and terminology

According to the Fair Labor Standards Act (FLSA), the U.S. Department of Labor does not require payment for time not worked, even if it is to attend a funeral.[18] Rather, this type of benefit is determined by an employer. An employer has the authority to decide if it will offer bereavement leave to its employees and set its own definition of such leave, as well as to determine the number of paid and/or unpaid days of absence from work and if documentation is required to explain the absence. For example, AMA Human Resources Policy 615.01 states that bereavement leave "allows employees to take time off without loss of pay for bereavement due to a death of an immediate family member, i.e., spouse, child, stepchild, grandchild, mother, father, stepmother, stepfather, grandmother, grandfather, mother-in-law, father-in-law, brother, sister, significant other, or domestic partner, or any other individual related by blood or whose close association with the employees is the equivalent of a family relationship."[19] Employers must abide by state laws. As of 2019, California was the only state to legally require paid bereavement leave for certain public-sector workers, such as state employees. Relatedly, Oregon requires bereavement leave for qualifying employees, but the employer can decide if paid or unpaid.[20] Globally, the U.S. falls behind such countries as Canada, France, and the United Kingdom that support more generous leave.[20]

In the past, such leave may have been referred to as "funeral leave." While "bereavement" has been a more commonly used term, an even more inclusive adjective is "compassionate" which acknowledges that there may be other reasons, besides death, in which a person is bereaved and in need of time off work. While new AMA human resources policy uses the term "compassionate," it was noted in doing the research for this report that most schools and programs still use the term "bereavement"; thus, the latter term will be used in this report.

Compassionate leave in medical education and practice

There is little published research on this topic. A PubMed® search of the terms "funeral leave," "bereavement leave," and "compassionate leave" yielded zero results in regard to policies in medical schools, training programs, and physician practices.

Bereavement policies vary across medical schools. Given students are not employees of their school, they are not offered paid leave. However, they may be allowed time off. Some medical schools may establish their own policy, while many others follow the same bereavement policy as their university. For example, the University of Illinois Urbana-Champaign provides publicly available student bereavement guidelines.[21] Without standardized leave time and grief resources across medical schools, some students took matters into their own hands and started BereaveMed, an "online resource that is designed to help medical students address their experiences with death and grief through connection and collaboration." It also provides a directory of mental health and wellness resources that are available at many medical schools.[22]

Graduate Medical Education (GME) programs, as employers, are more likely to have established bereavement policies, which may be established by the program itself or may follow the policy of the institution. As such, the number of days and requirements may vary. For example, the policy of the GME program at Emory School of Medicine notes that a program director may approve up to five days of paid bereavement leave per occurrence.[23]

Physicians in medical group practices will likely have bereavement leave available, but the details will vary depending on the size and ownership of the practice.

DISCUSSION

Parental leave: Feasibility and possible impact of increasing minimum to 12 weeks

If a medical student is absent from school for 12 weeks, that equates to approximately three months of schooling (i.e., nearly a semester). While this absence poses challenges, medical schools may consider investigating institutions with established best practices in parental policies, such as those that include a provision of an academic adjustment option guaranteeing approval to return from such leave.[7] Establishment and implementation of such policies may also contribute to the furtherance of equity among medical students. In doing so, institutions should consider the merits of a broad versus prescriptive policy given the challenges that may be unique to students and institutions. The rise in interest and implementation of competency-based medical education (CBME) may one day foster paths for students to take such leave and still demonstrate competency in order to graduate. On the other hand, there may be unintended consequences that impact not only the student on leave, but also their peers, the faculty who are overseeing their competency, and the institution which carries the fiscal responsibilities. Consideration should be given to whether a student's financial aid covers prolonged schooling due to leave, if schools will incur additional expense for providing make-up education, and if there should be additional tuition costs for students who need significant make-up time.

Like students, a 12-week absence from training can have an impact on the resident/fellow competency given the missed educational and clinical experiences. It can also impact their peers who may need to assume added responsibilities for the absent resident/fellow, the program staff who must figure out how to supplement the missed training in order to ensure successful completion of a residency/fellowship as well as monitor any impact on other residents and patients, and the program/institution which has the fiscal responsibility. As pointed out earlier, paid leave versus unpaid leave is an additional consideration. For GME, consideration must be given to the sources of GME funding and if/how trainees are funded on leave versus those who are active in their training.

To teach an effective educational program, students, residents, and fellows play an important role. Large or sudden changes in the participation of learners can impact the quality of education. Such education requires both teachers and learners to take responsibility for the educational program. If possible, advanced notification of the need for leave, with privacy protections, may be important to maintain quality education.

Similar to residents/fellows, the feasibility and impact on the group practice of a physician taking 12-week parental leave time can be tenuous and difficult. While there are clear benefits to the physician-parent and child, the other practice members would need to provide coverage which impacts their time—both professional and personal—and possibly their wellness. In smaller practices, there may not be enough personnel to provide such coverage.

Compassionate leave: Feasibility and possible impact

The calls for study in Policy H-405.947 seeks information on the components of such policy and/or exceptions to said policy. These factors may include extensive travel calling for additional days of leave or events affecting pregnancy, fertility, surrogacy, and adoption. Further, it seeks to clarify whether notification should be required in advance of taking said leave, if such leave is paid or unpaid, if obligations and time must be made up, and if said make-up time will be paid.

Despite the variance and lack of standardization of such policies across medical schools, resident and fellowship programs, and physician practices, generalized notions of the feasibility and impact of such policies can be postulated but may not apply to every environment.

For example, extensive travel for bereavement leave is a very real possibility in the case of a death, where an individual may need to journey a long way to attend to such matters. Travel alone takes up some of those leave days, let alone the intended actions and time to grieve. Negative events related to fertility, pregnancy, and childbirth (e.g., co-morbidities, pregnancy loss, an unsuccessful round of an assisted reproductive technology procedure) as well as failed adoption or surrogacy arrangements also result in emotional grief and may require time and rest. These circumstances may apply to an individual as well as their partner, regardless of gender and gender identity. As discussed earlier, determining if education/work time must be made up is largely at the level of the individual circumstance. For residents, fellows, and physicians, determining whether such leave is paid or unpaid and if that make-up time (should it be required) will be paid is a financial decision for the employer; there may be opportunity to provide standardization to such decisions so that all parties are informed in advance. Another consideration is that by establishing policies, the opportunities for flexibility may be diminished or removed. Such considerations do seem feasible but require time and attention from leadership to be successfully implemented. There are pros and cons when it comes to impact that need to be considered for each environment, balancing competency, well-being, and equity for all individuals.

RELEVANT AMA POLICY AND ENGAGEMENT

The AMA has ample policy in support of leave for students, residents, fellows, and physicians, including a new policy on compassionate leave (I-22). While this list provides links to each item, the full policies are enumerated in the Appendix:

- Policies for Parental, Family and Medical Necessity Leave H-405.960
- AMA Statement on Family and Medical Leave H-420.979
- Compassionate Leave for Medical Students and Physicians H-405.947
- Parental Leave H-405.954
- Paid Sick Leave H-440.823
- Parental Leave and Planning Resources for Medical Students D-295.308
- Support for Residents and Fellows During Family and Medical Leave Time H-310.908
- Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Allopathic and Osteopathic Medical Undergraduate and Graduate Education Programs H-295.856
- FMLA Equivalence H-270.951
- To Amend The Family Leave Act D-420.999
- Gender-Based Questioning in Residency Interviews H-310.976
- Residents and Fellows' Bill of Rights H-310.912
- Principles for Graduate Medical Education H-310.929
- CMS to Pay for Residents? Vacation and Sick Leave D-305.968
- Eliminating Religious and Cultural Discrimination from Residency and Fellowship Programs and Medical Schools H-310.923
- Cultural Leave for American Indian Trainees H-350.957

In particular, "Policies for Parental, Family and Medical Necessity Leave" (H-405.960) recommends that medical practices, departments, and training programs strive to provide 12 weeks of paid parental, family, and medical necessity leave in a 12-month period for their attending and trainee physicians as needed. "Parental Leave" (H-405.954) encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the FMLA: a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.

Also, the "Residents and Fellows' Bill of Rights" (H-310.912) supports paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year.

On a related note, the Council's report on "Support for Institutional Policies for Personal Days for Undergraduate Medical Students was adopted at the 2022 Annual Meeting. As a result, new policy states that the AMA "support a requirement that each medical school have policy defining 1) the number of days a medical student may be excused from each curricular component; 2) the processes for using excused absences, providing alternative, timely means of achieving curricular goals when absent from a curricular component; and 3) effective mechanisms to communicate these policies at appropriate times throughout the curriculum; and that schools be encouraged to create a mechanism by which at least some portion of such days can be used without requiring explanation." This policy further demonstrates AMA's encouragement of institutional policies and its commitment to address the well-being of students.

SUMMARY AND RECOMMENDATIONS

The AMA recognizes the importance of leave policies for medical students, residents, fellows, and physicians. Such policies may positively impact one's physical, mental, and emotional health, thereby reducing stress and burnout, improving satisfaction, and ultimately uplifting patient care. The lack of standardization of parental and bereavement leave policies may contribute to inequities. Given that each institution, program, or practice develops its own related policies, informed by state laws as well as human resources and legal counsel, it is difficult to create universal standards.

Medical schools, graduate medical education programs, and physician practices should be encouraged to offer parental and bereavement leaves that, at minimum, are consistent with federal and state laws and institutional policies. Medical schools should acknowledge that delay of childrearing for the sake of education has significant personal implications. Programs or practices with fewer than 50 employees should address how they can best accommodate their employees. All authorities discussed in this report must evaluate the benefits and challenges of implementing such policies and do what is best for the learner/physician's well-being.

The Council on Medical Education therefore recommends that the following recommendations be adopted and the remainder of the report be filed:

1. That the fifth and fifteenth clauses of AMA Policy H-405.960, "Policies for Parental, Family and Medical Necessity Leave," be amended by addition and deletion, to read as follows:

   5. Our AMA recommends that medical practices, departments, and training programs strive to provide 12 weeks of paid parental, family, and medical necessity leave in a 12-month period for their attending and trainee physicians as needed~~.~~, with the understanding that no parent be required to take a minimum leave.

   15. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties (ABMS) to allow graduating residents to extend training ~~up to 12 weeks~~ after the traditional residency completion date while still maintaining board eligibility, ~~in that year~~ in the event of leave beyond six weeks. Our AMA encourages specialty boards to develop flexible policies for board certification for those physicians who take leave beyond the

minimum of six weeks of family or medical leave (per ABMS policy) and whose residency programs are able to certify that residents meet appropriate competencies for program completion.

2. That AMA Policy H-405.960, "Policies for Parental, Family and Medical Necessity Leave," be amended by addition to read as follows:

19. Medical schools are encouraged to develop clear, equitable parental leave policies and determine how a 12-week parental, family, or medical leave may be incorporated with alternative, timely means of completing missed curriculum while still meeting competency requirements necessary to complete a medical degree.

3. That the first and fifth clauses of AMA Policy H-405.947, "Compassionate Leave for Medical Students and Physicians," be amended by addition and deletion with a change in title to read as follows:

Compassionate Leave for Physicians, Medical Students, Medical Trainees, and Physician Residents and Fellows ~~and Physicians~~

1. Our AMA urges:
(a) medical schools, and the ~~residency and fellowship training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices~~ Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation to incorporate and/or encourage development of compassionate leave policies ~~as part of the physician's standard benefit agreement~~. Such compassionate leave policies should consider inclusion of extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should determine how compassionate leave may be incorporated with alternative, timely means of achieving curricular goals when absent from curricular components and to meet competency requirements necessary to complete a medical degree;
(b) residency and fellowship training programs, their sponsoring institutions, and Accreditation Council for Graduate Medical Education to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit agreement. Such compassionate leave policies should consider appropriateness of coverage during extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should also include whether the leave is paid or unpaid, outline what obligations and absences must be made up, and determine how compassionate leave may be incorporated with alternative, timely means of achieving curricular goals when absent from curricular components and to meet competency requirements necessary to achieve independent practice and board eligibility for their specialty;
(c) medical group practices to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit agreement. Such compassionate leave policies should consider appropriateness of coverage during extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These

policies should also include whether the leave is paid or unpaid and what obligations and absences must be made up.

5. Our AMA ~~will study~~ supports the concept of equal compassionate leave for bereavement due to death or loss (e.g., pregnancy loss and other such events impacting fertility in a physician or their partner) as a benefit for physicians, medical students ~~and physicians,~~ medical trainees, and physician residents and fellows, regardless of gender or gender identity.

4. That the fourth clause of AMA Policy H-405.960, "Policies for Parental, Family and Medical Necessity Leave," be rescinded, as having been fulfilled by this report.

~~4. Our AMA will study the impact on and feasibility of medical schools, residency programs, specialty boards, and medical group practices incorporating into their parental leave policies a 12-week minimum leave allowance, with the understanding that no parent be required to take a minimum leave.~~

5. That the second clause of AMA Policy H-405.947, "Compassionate Leave for Medical Students and Physicians," be rescinded, as having been fulfilled by this report.

~~2. Our AMA will study components of compassionate leave policies for medical students and physicians to include: a. whether cases requiring extensive travel qualify for additional days of leave and, if so, how many days; b. policy and duration of leave for an event impacting pregnancy or fertility including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, a failed surrogacy arrangement, or an event that impacts pregnancy or fertility;~~
~~c. whether leave is paid or unpaid; d. whether obligations and time must be made up; and e. whether make-up time will be paid.~~

Fiscal note: $500

APPENDIX: RELEVANT AMA POLICIES

H-405.960, Policies for Parental, Family and Medical Necessity Leave
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA will study the impact on and feasibility of medical schools, residency programs, specialty boards, and medical group practices incorporating into their parental leave policies a 12-week minimum leave allowance, with the understanding that no parent be required to take a minimum leave.
5. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed.
6. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
7. Medical students and physicians who are unable to work because of pregnancy, childbirth, abortion or stillbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
8. Residency programs should develop written policies on leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) duration of leave allowed after abortion or stillbirth; (d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (e) whether leave is paid or unpaid; (f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance; (h) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (i) how time can be made up in order for a resident physician to be considered board eligible; (j) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (k) whether time spent in making up a leave will be paid; and (l) whether schedule

accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
9. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical students to be eligible for graduation with minimal or no delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.
10. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
11. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
12. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
13. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
14. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.
15. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
16. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.
17. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.
18. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship.

H-420.979, AMA Statement on Family and Medical Leave
Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:
(1) medical leave for the employee, including pregnancy, abortion, and stillbirth;
(2) maternity leave for the employee-mother;

(3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and
(4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.

H-405.954, Parental Leave
1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.
2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.
3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early childcare and unpaid childcare by extended family members.
4. Our AMA: (a) encourages key stakeholders to implement policies and programs that help protect against parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare; and (b) urges key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of health and childcare.

H-440. 823, Paid Sick Leave
Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; and (3) supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome.

D-295.308, Parental Leave and Planning Resources for Medical Students
1. Our AMA will work with key stakeholders to advocate that parties involved in medical training (including but not limited to residency programs, administration, fellowships, away rotations, physician evaluators, and research opportunities) do not discriminate against students who take family/parental leave.
2. Our AMA encourages medical schools to create comprehensive informative resources that promote a culture that is supportive of their students who are parents, including information and policies on parental leave and relevant make up work, options to preserve fertility, breastfeeding, accommodations during pregnancy, and resources for childcare that span the institution and the surrounding area.

H-310.908, Support for Residents and Fellows During Family and Medical Leave Time
Our AMA encourages specialty boards, the Accreditation Council for Graduate Medical Education and residency review committees to study alternative mechanisms and pathways based on competency evaluation to ensure that individuals who have taken family and medical leave graduate as close to their original completion date as possible.

H-295.856, Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Allopathic and Osteopathic Medical Undergraduate and Graduate Education Programs
Our AMA: (1) supports the study of factors surrounding leaves of absence and withdrawal from allopathic and osteopathic medical undergraduate and graduate education programs, including the timing of and reasons for these actions, as well as the sociodemographic information of the students involved; and (2) encourages the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to support the study of factors surrounding leaves of absence and withdrawal from allopathic and osteopathic medical undergraduate and graduate education programs, including the timing of and reasons for these actions, as well as the sociodemographic information of the students involved.

H-405.947, Compassionate Leave for Medical Students and Physicians
1. Our AMA urges medical schools, residency and fellowship training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit agreement.
2. Our AMA will study components of compassionate leave policies for medical students and physicians to include: a. whether cases requiring extensive travel qualify for additional days of leave and, if so, how many days; b. policy and duration of leave for an event impacting pregnancy or fertility including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, a failed surrogacy arrangement, or an event that impacts pregnancy or fertility; c. whether leave is paid or unpaid; d. whether obligations and time must be made up; and e. whether make-up time will be paid.
3. Our AMA encourages medical schools, residency and fellowship programs, specialty boards, specialty societies and medical group practices to incorporate into their compassionate leave policies a three-day minimum leave, with the understanding that no medical student or physician should be required to take a minimum leave.
4. Medical students and physicians who are unable to work beyond the defined compassionate leave period because of physical or psychological stress, medical complications of pregnancy loss, or another related reason should refer to their institution’s sick leave policy, family and medical leave policy, and other benefits on the same basis as other physicians who are temporarily unable to work for other reasons.
5. Our AMA will study the concept of equal compassionate leave for pregnancy loss and other such events impacting fertility in a physician or their partner as a benefit for medical students and physicians regardless of gender or gender identity.
6. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
7. These guidelines as above should be freely available online and in writing to all applicants to medical school, residency, or fellowship.

H-270.951, FMLA Equivalence
Our AMA will advocate that Family and Medical Leave Act policies include any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship.

D-420.999, To Amend The Family Leave Act
Our AMA will work to simplify the Family Medical Leave Act form, reducing the physician work required for completion.

H-310.976, Gender-Based Questioning in Residency Interviews
The AMA (1) opposes gender-based questioning during residency interviews in both public and private institutions for the purpose of sexual discrimination; (2) supports inclusion in the AMA Fellowship and Residency Interactive Database Access (FREIDA) system information on residency Family and Medical Leave policies; and (3) supports monitoring the Accreditation Council for Graduate Medical Education as it proposes changes to the "Common Requirements" and the "Institutional Requirements" of the "Essentials of Accredited Residencies," to ensure that there is no gender-based bias.

H-310.912, Residents and Fellows' Bill of Rights
1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require

salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.
8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:
RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS
Residents and fellows have a right to:
A. An education that fosters professional development, takes priority over service, and leads to independent practice.
With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.
B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.
With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.
C. Regular and timely feedback and evaluation based on valid assessments of resident performance.
With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.
D. A safe and supportive workplace with appropriate facilities.
With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.
E. Adequate compensation and benefits that provide for resident well-being and health.
(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific

responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.
(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience.
Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.
(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.
F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, “Resident/Fellow Clinical and Educational Work Hours,” for more information.
G. Due process in cases of allegations of misconduct or poor performance.
With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.
H. Access to and protection by institutional and accreditation authorities when reporting violations.
With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.
9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.
10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual’s training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).
11.The Residents and Fellows’ Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.

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

H-310.929, Principles for Graduate Medical Education
Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.
(1) PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty. Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.
(2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.
(3) EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.
(4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.
(5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.
(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff

organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.
(7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.
(8) LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.
(9) PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.
(10) INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.
(11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.
(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.

(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.
(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.
(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.

D-305.968, CMS to Pay for Residents? Vacation and Sick Leave
Our AMA will lobby the Centers for Medicare and Medicaid Services to continue to reimburse the direct and indirect costs of graduate medical education for the time resident physicians are on vacation or sick leave.

H-310.923, Eliminating Religious and Cultural Discrimination from Residency and Fellowship Programs and Medical Schools
Our AMA encourages residency programs, fellowship programs, and medical schools to: (1) allow trainees to take leave and attend religious and cultural holidays and observances, provided that patient care and the rights of other trainees are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious and cultural holidays and observances.

H-350.957, Cultural Leave for American Indian Trainees
Our AMA recognizes the importance of cultural identity in fostering trainee success and encourages residency programs, fellowship programs, and medical schools to accommodate cultural observances for trainees from American Indian, Alaska Native, and Native Hawaiian communities.

REFERENCES

1. Family and Medical Leave Act [Internet]. U.S. Department of Labor. [cited 2023 Jun 20]. Available from: https://www.dol.gov/agencies/whd/fmla

2. Paid Family and Medical Leave as of June 2022 [Internet]. National Conference of State Legislatures. [cited 2023 Jun 20]. Available from: https://www.ncsl.org/labor-and-employment/state-family-and-medical-leave-laws#:~:text=11%20states%E2%80%94California%2C%20Colorado%2C,paid%20family%20and%20medical%20leave

3. Fact Sheet #28M(c): Qualifying Exigency Leave under the Family and Medical Leave Act [Internet]. U.S. Department of Labor. [cited 2023 Jun 20]. Available from: https://www.dol.gov/agencies/whd/fact-sheets/28mc-fmla-exigency-leave

4. Kraus MB, Jennifer M.V. Talbott, Melikian R, Merrill SA, Stonnington CM, Hayes SN, et al. Current Parental Leave Policies for Medical Students at U.S. Medical Schools: A Comparative Study. 2021 Mar 23;96(9):1315–8.

5. McGrath C, Szabo RA, Bilszta J. Pregnancy and parental leave policies at Australian and New Zealand medical schools. Women's Health. 2022 Jan 1;18:174550572211426-174550572211426.

6. Ortega SR, Barnes JM, Waller JD. Parental leave in medical school: supporting students as parents. Journal of Osteopathic Medicine. 2022 Feb 18;122(5):229–33.

7. Roselin D, Lee J, Jagsi R, Blair-Loy M, Ira K, Dahiya P, et al. Medical Student Parental Leave Policies at U.S. Medical Schools. Journal of Women's Health. 2022 Jun 14.

8. Medical students advocate for parental leave policies [Internet]. Association of American Medical Colleges. [cited 2023 Jun 21]. Available from: https://www.aamc.org/news/medical-students-advocate-parental-leave-policies

9. ABMS Announces Progressive Leave Policy for Residents and Fellows. American Board of Medical Specialties. 2020.

10. ACGME is Instituting New Mandatory Medical, Parental and Caregiver Leave Requirements for Residency and Fellowship Programs: Are You Ready? [Internet]. The National Law Review. 2022. Available from: https://www.natlawreview.com/article/acgme-instituting-new-mandatory-medical-parental-and-caregiver-leave-requirements

11. ACGME Answers: Resident Leave Policies [Internet]. Accreditation Council for Graduate Medical Education. 2022. Available from: https://www.acgme.org/newsroom/blog/2022/acgme-answers-resident-leave-policies/

12. Training & Certification: Leave Policy - General Surgery [Internet]. The American Board of Surgery. [cited 2023 Jun 21]. Available from: https://www.absurgery.org/default.jsp?policygsleave

13. Stack SW, Finn KM, Kisielewski M, Law KL, Milne CK, Best JA. Parental Leave Policies in Residency: A National Survey of Internal Medicine Program Directors. Academic Medicine. 2022 Jun 23;97(7):1021–8.

14. Paid Parents Leave, Statement of Policy [Internet]. American College of Obstetricians and Gynecologists. [cited 2023 Jun 23]. Available from: https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/paid-parental-leave

15. Miller KA, Lee LK. Advocating for Physician Paid Parental Leave. Pediatrics. 2022 Jun 1.

16. Improving Access to Paid Family Leave to Achieve Health Equity [Internet]. Robert Wood Johnson Foundation. 2022. Available from: https://www.rwjf.org/en/insights/our-research/2021/05/improving-access-to-paid-family-leave-to-achieve-health-equity.html

17. Family Database [Internet]. Organisation for Economic Co-operation and Development. 2022. Available from: https://www.oecd.org/els/soc/PF2_1_Parental_leave_systems.pdf

18. Funeral Leave [Internet]. U.S. Department of Labor. [cited 2023 Jun 22]. Available from: https://www.dol.gov/general/topic/benefits-leave/funeral-leave

19. Human Resources Policy Manual. Policy 615.01 Bereavement. [cited 2023 Jun 21]. American Medical Association.

20. Trevor J. When it comes to bereavement leave, the U.S. is unspeakably cruel [Internet]. Salon. 2019. Available from: https://www.salon.com/2019/09/30/when-it-comes-to-bereavement-leave-the-u-s-is-unspeakably-cruel_partner/

21. Student Bereavement Guidelines [Internet]. University of Illinois Urbana-Champaign. Office of the Dean of Students; [cited 2023 Jun 22]. Available from: https://odos.illinois.edu/community-of-care/resources/students/bereavement/

22. BereaveMed: A Medical Student's Guide to Grief [Internet]. BereaveMed. [cited 2023 Jun 22]. Available from: https://www.bereavemed.com/

23. Housestaff Policies, Section 4: Leave Time [Internet]. Emory University School of Medicine. [cited 2023 Jun 22]. Available from: https://med.emory.edu/education/gme/housestaff/housestaff_policies/section4.html

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-I-23

Subject: Ensuring Equity in Interview Processes for Entry to Undergraduate and Graduate Medical Education

Presented by: Cynthia Jumper, MD, Chair

Referred to: Reference Committee C

American Medical Association (AMA) Policy D-295.303, "Support Hybrid Interview Techniques for Entry to Graduate Medical Education," states that our AMA will:

> "1. work with relevant stakeholders to study the advantages and disadvantages of an online medical school interview option for future medical school applicants, including but not limited to financial implications and potential solutions, long term success, and well-being of students and residents.
>
> "2. encourage appropriate stakeholders, such as the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, Intealth, and Accreditation Council for Graduate Medical Education, to study the feasibility and utility of videoconferencing for graduate medical education (GME) interviews and examine interviewee and program perspectives on incorporating videoconferencing as an adjunct to GME interviews, in order to guide the development of equitable protocols for expansion of hybrid GME interviews."

Defining "hybrid"

During the COVID-19 pandemic, medical schools and residency programs shifted from in-person to virtual interviews due to the public health emergency. With both virtual and in-person modalities now available, medical educators are debating the most equitable and appropriate means of conducting interviews in the application processes. To inform AMA policy on this topic, it is critical to clearly define the different methods of conducting interviews of applicants.

Specifically, the term "hybrid" should be defined with clarity, as it is referenced in the title and body of the policy serving as impetus for this report. This term has been used to describe the use of virtual (also called online) and in-person interviews. In this report, we refer to interview techniques as either virtual or in-person, rather than using the term "hybrid."

For clarity, this report will define "hybrid" interviews as the use of a mix of virtual and in-person interviews of applicants for the same class, as determined either by the school or program and/or individual applicant, resulting in some applicants having virtual interviews and others having in-person interviews. This definition of "hybrid" is consistent with definitions used by the Association of American Medical Colleges (AAMC) and Coalition for Physician Accountability (CPA).

Some schools or programs use both virtual and in-person interviews, through which all applicants are interviewed using one modality, with a subset of applicants then interviewed again via another modality (i.e., a virtual interview followed by an in-person interview) before the medical school

offers an admission or the residency program submits a match list. This method of interviewing will be referred to as a "two-step interview" in this report.

In the application process, applicants may wish to visit a school or program outside of the formal interview after the medical school offers an admission or the residency program submits a match list to obtain the additional information they need to select the medical school or residency that best fits their needs. We will refer to this process as the "second look in-person visit."

BACKGROUND

As a result of the COVID-19 pandemic, many businesses and individuals shifted from face-to-face communications and meetings to virtual technologies. The move was motivated by public health considerations, but even now, with the pandemic much less a health concern than it had been, virtual forms of communication continue and are now considerably more entrenched in both the business world and everyday life for many people. This large-scale, societal communications shift has occurred in medical education as well. The application, interview, and entry process into undergraduate medical education (UME, or medical school) and graduate medical education (GME, or residency/fellowship programs) has seen increased usage of video conferencing since spring 2020, when the pandemic began.

Indeed, current guidance from the AAMC recommends that both medical schools[1] and residency/fellowship programs[2] use virtual applicant interviews but does acknowledge that schools and programs may choose a specific format (i.e., either virtual or in-person interviews) based on their specific mission, goals, and context. The AAMC cites the following considerations when recommending virtual interview formats for both UME and GME:

1. The financial costs associated with interviewing for medical school and residency or fellowship programs are high.
2. Most applicants prefer virtual interviews.
3. Time spent away from school, work, or other commitments due to travel associated with in-person interviews is an undue burden for applicants to bear.
4. Separating assessment and recruitment efforts is an important step to mitigate risk of bias in interview ratings.
5. Medical schools, teaching hospitals and health systems, and the AAMC have made commitments to reduce their carbon footprints.

Similarly, the CPA, which comprises national organizations (including the AMA) responsible for the oversight, education, and assessment of medical students and physicians throughout their medical careers, has called for virtual interviews for applicants to residency/fellowship positions. A 2021 report of 34 recommendations for improving the UME to GME transition[3] from the CPA's Undergraduate Medical Education-Graduate Medical Education Review Committee (UGRC) noted, "To ensure equity and fairness, there should be ongoing study of the impact of virtual interviewing as a permanent means of interviewing for residency." In addition, the CPA stated, "Hybrid interviewing (virtual combined with onsite interviewing) should be prohibited." (Note: These recommendations were not updated beyond the 2021-2022 interview season.) This recommendation to avoid offering both types of interviews at the same time mirrors guidance from the AAMC in its document referenced above, "Interviews in UME: Where Do We Go From Here?"

Potential benefits and disadvantages of virtual versus in-person interviews

Use of virtual interviewing in the selection of medical students and resident/fellow physicians may be an efficient option for institutions and could lead to decreased costs for both applicants and institutions/programs. AMA policy is supportive of efforts to mitigate barriers associated with entry to and progress in medical education.

This format offers increased efficiency and lower (or nonexistent) travel costs for applicants, alongside significant cost savings for schools/programs (e.g., catering and food costs), and potential savings in reduced time commitment and the costs of hosting applicants. That said, schools and programs face significant scheduling and administrative overhead, even in a virtual environment, so time savings for schools and programs may be minor. The virtual interview format also offers admissions personnel and program directors the opportunity to gauge applicants' "virtual etiquette" (or lack thereof)—an important skill for future physicians to develop as telehealth becomes more widespread.

On the negative side, virtual-only interviews eliminate "face time" for both applicants and programs to fully evaluate each other through standard social interactions (e.g., with support and administrative staff). The ways in which an applicant interacts with other individuals in a live setting can be revealing as to emotional intelligence and "bedside manner." This may be indirectly captured by scheduling breaks in the virtual interview process and other strategies to provide opportunities for evaluation of informal interactions.

Another potential pitfall to virtual interviews is the security of the interview. Can the institution/program assure that the applicant is alone and not receiving help from another individual or an off-camera electronic device? Does the applicant have notes available? What if the applicant is recording the interview in some way? Interruptions in the internet connection, electrical failures, or technological glitches in software can also derail virtual interviews. Finally, the personal safety of applicants may be an issue (as the institution does not know where they are located). This can be important should an applicant have a medical or psychological emergency during the interview.

Another potential downside of virtual interviews relates to the possibility of "interview hoarding" by a candidate who may be able to schedule multiple interviews within a shortened time frame and inadvertently limit the opportunities for other applicants to obtain interviews.

Finally, more research is needed on the impact of virtual interviews on the diversity of the medical workforce, which hinges largely on the diversity of medical school entrants. As noted in Council on Medical Education Report 2-I-22, "Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process:"

> "When considering equity, virtual interviews have both pros and cons. On the plus side, students with less means, who were not as able as their more affluent peers to travel to multiple interviews, had greater access via virtual interviews. On the other hand, candidates and programs may not attain a true sense of each other, making ranking difficult and likely defaulting to familiarity and certainty, as opposed to choosing the best "fit." This may perpetuate existing bias. A secondary concern is the potential for a digital divide, with some candidates lacking the technology and/or expertise with visual rhetoric to ensure a professionally enhancing video image; this may also exacerbate existing inequities."[4]

Pros and cons of a "hybrid" interview format

The AAMC document referenced in this report includes a table describing virtual only, in-person only, or hybrid interview formats with proposed steps for successfully using each modality. A key concern with the hybrid interview format is that applicants interviewed through one modality may be unfairly advantaged over applicants interviewed by the other modality, affecting equity and fairness in the application process. For example, an applicant who can interview in-person may have opportunities to directly interact with their interviewers and other faculty, is less likely to encounter technical issues that may affect the quality of the interview, and may be perceived by the program faculty as more interested in the program than an applicant who interviews virtually.

In certain circumstances, however, allowing hybrid interviews may not have as significant of an impact on equity and fairness. For example, students who are doing away rotations at institutions where they are applying for residency are likely already interacting in-person with residency faculty and would be available for an in-person interview during their rotation. Requiring an additional virtual interview in this instance may be superfluous and impose additional cost and time burdens on both applicant and program. This reasoning would extend as well to students applying to a medical school or residency at the same university or teaching hospital in which they performed a clerkship in that specialty, as they are already familiar to the faculty. More challenging are those instances where students, to help solidify their own decision-making, choose to visit the school or program in-person to evaluate the institution and the local environs (e.g., cost of living, affordability, career and educational opportunities for partners or children, etc.) where they may be spending many years in training. Should these applicants be given an opportunity for an in-person interview?

In short, the "hybrid" interview format likely presents significant difficulties for schools and programs regarding fairness, equity, and avoidance of bias. In its discussion of this format in "Interviews in GME: Where Do We Go From Here?" the AAMC suggests the following "steps for success" for this modality:

1. Implement policies, procedures, and interviewer training to ensure standardization across formats and to mitigate risk of bias.
2. Ensure admissions/selection committees are blinded to interview format.
3. Inform applicants about steps taken to make the hybrid approach equitable.
4. Offer virtual recruiting activities to all applicants.

Inherently, these recommendations lack specificity and may be difficult to implement. For example, no guidance is provided for the first recommendation as to what policies and procedures would mitigate the risk of bias in hybrid interviews. The second recommendation would mean that any residency faculty involved in developing the program's match list, including the program director, could not interact with applicants during the interview process to ensure they were blinded as to interview format. They do, however, provide a starting point for further consideration and exploration.

Helping applicants make informed decisions: The "second look in-person visit"

While it is important that the interview/application process is equitable in determining medical school admissions or residency program match lists, it is also important that applicants obtain the information they need to select the medical school or residency that best fits their needs.

Medical schools and residencies conduct interviews to inform their selection of applicants; however, applicants need opportunities to select a school or residency as well, given that they will be spending years not only in training but also residing in that locality. In addition to the formal school/program interview process, reviewing the school/program website, talking to colleagues and classmates, and interviewing graduates are other means by which an applicant can make an informed and educated decision. Applicants who interview virtually may also wish to undertake a campus visit or "second look in-person visit" at a program or institution to gain a more complete picture of their potential landing place prior to accepting an admission or submitting their match rank list.

To help promote and sustain efforts at equity, it is critical for programs and institutions to ensure that any format allowing for a second look in-person visit protects applicants from the perception that a second look is required or confers an advantage for their application. To mitigate these risks, residency programs in fields such as neurological surgery have adopted specialty-wide guidance supporting the idea of campus visits to allow students to visit programs, with the caveat that such programs have their rank lists submitted prior to students' visits so that students do not feel such a visit will impact their standing with any program. Earlier this year, the National Resident Matching Program (NRMP) sought feedback regarding the potential for programs to "voluntarily lock" their rank lists early to achieve this purpose[5] and found that submitting and locking this list early in the process may unintentionally limit the number of applicants to a program or cause programs to not thoroughly evaluate applicants to meet an earlier deadline. To explore this further, an innovations summit to evaluate potential changes to the match process in this new climate of virtual interviews will be convened by NRMP stakeholders.[6]

DISCUSSION

The policy that served as impetus for this report calls for an online interview "option" for medical school applicants in clause one and incorporating videoconferencing for residency program applicants as an "adjunct" to GME interviews in clause two. In the current environment, it may be more appropriate to refer to the in-person interview format as an option or adjunct to virtual interviewing. As stated, the need for fairness and equity in the UME and GME interview and application process remains critical, with the overarching goal being to facilitate meaningful interactions and informed decisions between applicants and programs/institutions. Doing so requires mitigating bias in the process. Unfortunately, both in-person and virtual interviews have the potential for real or perceived bias as described above. Using both methods simultaneously likely exacerbates the potential for bias from both approaches.

As Edje, et al. state, "In its current state, the resident selection process is ambiguous and has grown more so with the recent introduction of virtual components."[7] Undoubtedly, more information and understanding regarding this changing landscape is required, especially as it relates to unique factors including specialty, size, and location of program, duration of training, and proximity to other programs within a defined region.

A good opportunity for this work is the AMA's continued participation in the CPA, which brings together leading medical education, accreditation, and certification bodies responsible for the oversight, education, and assessment of medical students and physicians throughout their medical careers. While the CPA published interview guidelines from its UGRC, these have not been updated past the 2021-2022 application cycle. Current research on the virtual interview format has expanded; such research should continue and should be used to inform future actions and recommendations. Another opportunity is to engage with the NRMP and its innovations summit, as mentioned in this report.

The preeminent concern is to create an equitable, fair experience for all applicants, whether they interview in-person or virtually. This need extends to institutions and programs as well.

SUMMARY AND RECOMMENDATIONS

Even as the COVID-19 pandemic recedes into the background, it is likely that virtual interactions are here to stay in social, business, and professional environments. Interviews for entry to medical school and residency/fellowship programs will continue to reflect this trend. Virtual interviews may lack the immediacy and social cues/clues provided through in-person interactions but offer a host of benefits to both applicants and institutions/programs, some of which may help to mitigate bias and enhance equity. At the same time, however, virtual interviews may also introduce their own unique set of biases and problems related to the selection process, which can affect applicants and institutions/programs alike. To help address these concerns, and ensure a level playing field for all applicants, your Council agrees with the AAMC that all applicants for UME and GME should be evaluated using the same approach, whether in-person or virtual.

Attention to concerns about equity, diversity, and belonging in this new environment is warranted; the AMA should ensure continued attention to and action on such concerns. This would include working with relevant stakeholders (through the CPA, for example) to understand the real and potential biases of these interview formats; encouraging continued research to inform best practices in medical education application processes; disseminating these best practices; and helping facilitate consensus among medical schools, GME programs, and the various specialties with the goal of achieving equity and fairness while also allowing for meaningful interaction and informed decision-making by all parties.

The Council on Medical Education therefore recommends that the following recommendations be adopted and the remainder of this report be filed:

1. That our AMA encourage interested parties to study the impact of different interview formats on applicants, programs, and institutions. (Directive to Take Action)

2. That our AMA continue to monitor the impact of different interview formats for medical school and graduate medical education programs and their effect upon equity, access, monetary cost, and time burden along with the potential downstream effects upon on applicants, programs, and institutions. (New HOD Policy)

3. That our AMA recommend that medical schools use the same interview format for all applicants to the same class to promote equity and fairness. (New HOD Policy)

4. That our AMA recommend that graduate medical education programs use the same interview format for all applicants to the same program to promote equity and fairness. (New HOD Policy)

5. That AMA Policy D-295.303, “Support Hybrid Interview Techniques for Entry to Graduate Medical Education,” be rescinded, as having been addressed through this report. (Rescind HOD Policy)

Fiscal note: $1,000.

APPENDIX: RELEVANT AMA POLICIES

D-310.949, "Medical Student Involvement and Validation of the Standardized Video Interview Implementation"

Our AMA: (1) will work with the Association of American Medical Colleges and its partners to advocate for medical students and residents to be recognized as equal stakeholders in any changes to the residency application process, including any future working groups related to the residency application process; (2) will advocate for delaying expansion of the Standardized Video Interview until data demonstrates the Association of American Medical Colleges' stated goal of predicting resident performance, and make timely recommendations regarding the efficacy and implications of the Standardized Video Interview as a mandatory residency application requirement; and (3) will, in collaboration with the Association of American Medical Colleges, study the potential implications and repercussions of expanding the Standardized Video Interview to all residency applicants. (Res. 960, I-17)

H-310.966, "Residency Interview Costs"

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

2. Our AMA will work with appropriate stakeholders, such as the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, in consideration of the following strategies to address the high cost of interviewing for residency/fellowship: a) establish a method of collecting data on interviewing costs for medical students and resident physicians of all specialties for study, and b) support further study of residency/fellowship interview strategies aimed at mitigating costs associated with such interviews. (Res. 265, A-90; Reaffirmed: Sunset Report, I-00; Modified: CME Rep. 2, A-10; Appended: Res. 308, A-15)

REFERENCES

[1] Interviews in UME: Where Do We Go From Here? Association of American Medical Colleges. https://www.aamc.org/about-us/mission-areas/medical-education/interviews-ume-where-do-we-go-here. Accessed June 21, 2023.

[2] Interviews in GME: Where Do We Go From Here? Association of American Medical Colleges. Available at: https://www.aamc.org/about-us/mission-areas/medical-education/interviews-gme-where-do-we-go-here. Accessed June 21, 2023.

[3] Recommendations for Comprehensive Improvement of the UME-GME Transition. Coalition for Physician Accountability's Undergraduate Medical Education-Graduate Medical Education Review Committee (UGRC). Available at: https://physicianaccountability.org/wp-content/uploads/2021/08/UGRC-Coalition-Report-FINAL.pdf. Accessed June 21, 2023.

[4] Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process. AMA Council on Medical Education. Available at: https://councilreports.ama-assn.org/councilreports/downloadreport?uri=/councilreports/CME_2_I_22_final_annotated.pdf. Accessed June 22, 2023.

[5] NRMP® Call for Public Comment – Consideration of Voluntary Locking Functionality for Program Rank Order Lists. National Resident Matching Program. Available at: https://www.nrmp.org/about/news/2023/03/nrmp-call-for-public-comment-consideration-of-voluntary-locking-functionality-for-program-rank-order-lists/. Accessed August 15, 2023.

[6] NRMP to engage constituents in a Match Innovations Summit in response to public comments on the proposed Voluntary Rank Order List (ROL) Lock functionality. National Resident Matching Program. Available at: https://www.nrmp.org/about/news/2023/06/nrmp-to-engage-constituents-in-a-match-innovations-summit-in-response-to-public-comments-on-the-proposed-voluntary-rank-order-list-rol-lock-functionality/. Accessed July 24, 2023.

[7] Edje L, Casillas C, O'Toole JK. Strategies to Counteract Impact of Harmful Bias in Selection of Medical Residents. Acad Med. April 26, 2023. Available at: https://journals.lww.com/academicmedicine/fulltext/2023/08001/strategies_to_counteract_impact_of_harmful_bias_in.10.aspx. Accessed August 15, 2023.

REPORT 4 OF THE COUNCIL ON MEDICAL EDUCATION (Interim 2023)
Recognizing Specialty Certifications for Physicians (Resolution 316-I-22)
(Reference Committee C)

EXECUTIVE SUMMARY

The history of board certification can be traced back to the late 19th century when the need for standardized medical education and training became apparent. In the early years of medical practice, there were no standardized requirements or guidelines for physicians to demonstrate their specialty qualifications. Medical education and training varied widely, and there was a lack of standardized curricula and evaluation methods. Certification boards were established for specialists to be able to distinguish themselves from other physicians. Society relies on and grants physicians the ability to establish and enforce standards for medical practice—that is, grants the profession collectively the privilege and obligation of self-regulation. This privilege depends on trust, and this privilege can and has been lost when the public no longer trusts professional oversight.

In 1933, the American Medical Association (AMA) established the American Board of Medical Specialties (ABMS) to bring order to the proliferation of specialty boards and address conflicts arising between specialty boards. Other entities later emerged as certification boards and have varying standards for obtaining initial board certification and maintaining continuing certification over time. AMA support of these entities is contingent with the certification program meeting accepted standards that include offering an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty. Continuing demonstration of physician competency sets the qualifications of physicians above other health professionals. Ongoing assessment and demonstration of competency help identify gaps in knowledge or skills as medicine advances, allowing physicians to address those gaps and provide safe, up-to-date, and effective care to patients. Demonstrating ongoing competency helps build and maintain public trust in the medical profession.

The AMA believes that patients deserve to have increased clarity and transparency in health care. Recognizing that there is confusion among the public as to the education, training, and skills of different health care professionals, which can lead to patients seeking and obtaining inappropriate and potentially unsafe medical care, the AMA created the "Truth in Advertising" campaign to help ensure patients know the education, training, and qualifications of their health care professionals.

The Council on Medical Education stands in support of the current AMA policy. The Council recommends encouraging continued advocacy to federal and state legislatures, federal and state regulators, physician credentialing organizations, hospitals, and other interested parties to define physician board certification as the medical profession establishing specialty-specific standards for knowledge and skills, using an independent assessment process to determine the acquisition of knowledge and skills for initial certification and recertification. The Council recommends reaffirmation of Policy H-275.926, "Medical Specialty Board Certification Standards."

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-I-23

Subject: Recognizing Specialty Certifications for Physicians (Resolution 316-I-22)

Presented by: Cynthia Jumper, MD, Chair

Referred to: Reference Committee C

Resolution 316-I-22, Recognizing Specialty Certifications for Physicians was authored by the Congress of Neurological Surgeons and American Association of Neurological Surgeons and submitted to the 2022 Interim Meeting of the House of Delegates (HOD). The second resolve reads as follows:

> RESOLVED, That our American Medical Association advocate for federal and state legislatures, federal and state regulators, physician credentialing organizations, hospitals, and other health care stakeholders and the public to define physician board certification as establishing specialty-specific standards for knowledge and skills, using an independent assessment process to determine the acquisition of knowledge and skills for initial certification and recertification. (Directive to Take Action).

The second resolve was referred by the HOD for a report back; this report is in response to the referral.

Background

The need for standardized certification

The history of board certification can be traced back to the late 19th century when the need for standardized medical education and training became apparent. In the early years of medical practice, there were no standardized requirements or guidelines for physicians to demonstrate their specialty qualifications. The first board was the American Board of Ophthalmology, which was incorporated on May 3, 1917, to allow ophthalmologists to distinguish themselves from other physicians as eye specialists. Other specialties also formed their own boards leading the AMA to establish the American Board of Medical Specialties (ABMS) in 1933 to bring order to the proliferation of specialty boards and address conflicts arising between specialty boards. Additionally, other entities were established to provide board certification including, but not limited to, the American Osteopathic Association Bureau of Osteopathic Specialists, the National Board of Physicians and Surgeons, the American Board of Physician Specialties, the American Board of Cosmetic Surgery, and the American Board of Facial Plastic and Reconstructive Surgery.

Medical education and training varied widely, and there was a lack of standardized curricula and evaluation methods. Society relies on and grants physicians the ability to establish and enforce standards for medical practice; that is, grants the profession collectively the privilege and

obligation of self-regulation. This privilege depends on trust, and this privilege can and has been lost when the public no longer trusts professional oversight.[1] Thus, certification programs were established to help the public select a physician to meet their needs, as an indicator that a physician has been determined by their peers to be competent in a chosen specialty, and as a testament to the mastery that the physician has shown in their respective field of medicine. Board certification serves as an independent evaluation of a physician's or specialist's knowledge and skills to practice safely and effectively in a specialty.

As part of its efforts, the Council on Medical Education (Council) recognized the importance of assessing physicians' competency after completing their formal education and the need for standardized certification in medical specialties. Several factors were influential in the development of standardized certification in medical specialties, including variation in medical education, calls for professional regulation to ensure competency and accountability of physicians, rapid advancement of medical knowledge, desire for expertise and specialization, and standardization and quality assurance.

The establishment of the American Board of Medical Specialties

These developments led to the AMA establishing the ABMS in 1933 to ensure that physicians met certain standards of knowledge and skill in their respective fields. The founding members of ABMS were the American Board of Dermatology, the American Board of Obstetrics and Gynecology, the American Board of Ophthalmology, and the American Board of Otolaryngology – Head and Neck Surgery.[2] Member boards are established by their respective specialties and are physician-led, non-profit, independent evaluation organizations whose accountability is both to the profession and to the public. Members of the governing bodies include representatives from among the national specialty organizations in related fields. Now an independent organization, ABMS is governed by a Board of Directors, which includes representation from each of the ABMS Member Boards and members of the public. These individuals are working and retired physicians and professionals from across the country who have a broad range of experience in patient care, health policy, business, and community service. The Board of Directors is organized so that a significant portion of its activities are conducted by its committees, each of which operates under a written charter. All committees report to the Board of Directors, and all significant findings of a committee are presented to the Board of Directors for review, discussion, and approval. Additionally, the Board of Directors oversees the activities of the ABMS management team. The governance of ABMS is an essential component of the U.S. medical profession's system of collective self-regulation.

Member boards certify physicians in their primary specialty and subspecialty areas and encourage the professional development of those board-certified physicians throughout their career. This is accomplished through a comprehensive process involving educational requirements, professional peer evaluation, examination, and professional development. Member boards can also revoke certifications when an individual breaches them. There are currently 24 certifying boards or Member Boards of ABMS. In 2022, ABMS published descriptions of all the medical specialties where certification is offered by an ABMS Member Board in the ABMS Guide to Medical Specialties. The ABMS certification process provides an independent evaluation of a physician's or specialist's knowledge and skills to practice safely and effectively in a specialty and serves as a trusted credential patients can rely upon when selecting a physician for their needs.

ABMS/ACGME Core Competencies

To evaluate a physician's knowledge and skills, the ABMS and Accreditation Council for Graduate Medical Education (ACGME) co-developed six core competencies integral to the delivery of high-quality patient care. These competencies are the basis of the milestones physicians and specialists must meet during training and are also the basis for continuing certification assessment. The table below outlines the six core competencies.

Table 1. ABMS/ACGME Core Competencies

PRACTICE-BASED LEARNING & IMPROVEMENT	Show ability to investigate and evaluate patient care practices, appraise and assimilate scientific evidence, and improve practice.
PATIENT CARE & PROCEDURAL SKILLS	Provide care that is compassionate, appropriate, and effective for the treatment of health problems and to promote health.
SYSTEMS-BASED PRACTICE	Demonstrate awareness of and responsibility to systems of health care. Be able to call on system resources to provide optimal care.
MEDICAL KNOWLEDGE	Demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and their application in patient care.
INTERPERSONAL & COMMUNICATION SKILLS	Demonstrate skills that result in effective information exchange and teaming with patients, their families, and professional associates.
PROFESSIONALISM	Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to diverse patient populations.

Each ABMS Member Board's continuing certification program is developed by practicing physicians and specialists according to the standards set through ABMS. Activities and requirements must be met in the following four main components: professionalism, lifelong learning, assessment, and improvement.

Governance of ABMS Member Boards

The governance process used by the Member Boards of the ABMS involves a combination of self-regulation and collaboration within the framework established by the ABMS. While each individual specialty board operates independently, they adhere to certain common principles and guidelines set forth by the ABMS. The ABMS establishes general standards and requirements that Member Boards must meet to ensure consistency and quality across specialties. These standards include criteria for education, training, examinations, and ongoing professional development. The Member Boards are responsible for designing and implementing the certification process for their respective specialties. This process typically involves a combination of educational qualifications, completion of an accredited training program, passing written and/or oral examinations, and meeting specific practice experience criteria. The ABMS promotes the concept of lifelong learning and ongoing professional development through continuing board certification (CBC) programs. Member Boards develop and administer their own CBC programs, which often include requirements such as participation in continuing medical education (CME) activities, self-assessment modules, practice improvement activities, and periodic assessments. While each specialty board operates independently, collaboration and standardization are fostered among the Member Boards. The ABMS provides a forum for sharing best practices, collaborating on research and development, and ensuring consistency in certification standards and processes across specialties. The governance process emphasizes continuous improvement and adaptation to changes in medical knowledge, technology, and health care delivery. Member Boards regularly

review and update their certification and CBC processes to align with evolving standards and practices.

ABMS and Board Eligibility

The ABMS defines board eligibility as the period of time between when a physician completes an ACGME-accredited residency program and when initial certification in a specialty or subspecialty is achieved. The ABMS Board Eligibility Policy for Specialty Certification and the ABMS Eligibility Policy for Subspecialty Certification enable Member Boards to set parameters for how candidates can use the term "board eligible" to signal their preparations for certification while at the same time closing off the potential for abuse through using the term indefinitely. The ability to become board certified by an ABMS Member Board is directly related to when the candidate completed an ACGME-accredited residency or fellowship program. A candidate's eligibility for board certification (board eligible period) expires on a date determined by the ABMS Member Board. For initial certification in a specialty and subspecialty, that date must be no more than seven years following the successful completion of accredited training. In addition, individual Member Board requirements must be met, including time in practice required (if any) for admissibility to the qualifying or certifying examination.[3]

AOA-BOS, Certification Process, and Board Eligibility

The Bureau of Osteopathic Specialists (BOS) is the supervisory body for the approved specialty certifying boards of the American Osteopathic Association (AOA) and is dedicated to establishing and maintaining high standards for certification of osteopathic and non-osteopathic physicians. The BOS ensures that all physicians it certifies demonstrate expertise and competence in their respective areas of specialization. The BOS serves as the certifying body for 29 primary medical specialties and 77 medical subspecialties. The BOS monitors the processes for all certifications, including primary certification, continuous certification, and certificates of added qualification; provides a mechanism to evaluate the validity and reliability of all certification examinations conducted by AOA specialty certifying boards; assesses examination scores and pass rates; and ensures notification of appropriate examination information to the ACGME. The BOS also provides pass rates as well as individual physician examination results (pass/fail) to physicians' training programs.

The BOS defines board eligibility status as "the time frame between a physician's completion of a residency or fellowship training program in a specialty or subspecialty and when the physician achieves initial certification in that specialty or subspecialty or when the physician's board eligibility status expires. The BOS certification examination process includes steps for initial entry, re-entry, and final entry. The re-entry process provides a pathway to certification for candidates who did not achieve board certification through the initial process and the final entry process is for candidates who did not achieve board certification through the re-entry process. To qualify for initial primary certification from the AOA through a specialty certifying board, the applicant must first meet one of five eligibility requirements and then meet additional requirements related to licensure, code of ethics, training, examinations, and clinical practice. Board eligibility status commences upon the physician's completion of a residency or fellowship training program in a specialty or subspecialty. Board eligibility status terminates when the physician achieves initial certification in that specialty or subspecialty or on December 31st of the following sixth (6th) year." Board certification issued by the AOA provides assurance to the public that a physician has demonstrated high levels of clinical competence and is an indication of excellence. Certification is issued upon successful completion of an AOA or ACGME accredited training program and by passing the associated examination(s) administered by an AOA specialty certifying board.

Other board certification entities

In addition to ABMS and AOA-BOS, there are several other entities that provide initial and continuing board certification. These entities have varying standards for obtaining initial board certification and maintaining continuing certification over time. These entities include:

- American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM)
- American Board of Cosmetic Surgery (ABCS)
- American Board of Facial Plastic and Reconstructive Surgery (ABFPRS)
- American Board of Oral & Maxillofacial Surgery (ABOMS)
- American Board of Physician Specialties (ABPS)
- National Board of Physicians and Surgeons (NBPAS)
- United Council for Neurologic Subspecialties (UCNS)

American Association of Neuromuscular & Electrodiagnostic Medicine

In 1987, the AANEM established the American Board of Electrodiagnostic Medicine (ABEM), now an independent credentialing organization in electrodiagnostic medicine. The maintenance of certification program for physicians was added in 1994 to assure that the ABEM followed the requirements of the ABMS. Initial certification for ABEM involves a process where candidates are evaluated in the core competencies. Candidates for the ABEM Initial Examination must meet the following requirements:[4]

- Board certified through American Board of Psychiatry and Neurology, American Board of Physical Medicine and Rehabilitation, American Osteopathic Board of Neurology and Psychiatry, or American Osteopathic Board of Physical Medicine and Rehabilitation (or a Canadian equivalent)
- Six or more months of electrodiagnostic (EDX) training during a residency and/or fellowship program
- Completed 200 EDX studies during training
- One or more years of independent experience
- Completed 200 EDX studies during independent experience
- Complete and pass the annual online CoreComp questions to maintain continuous certification

To maintain one's Continuous Certification with ABEM, one must:

- Attest to possess an active, unrestricted license to practice medicine
- Attest to possess an active primary board certification in either neurology or physical medicine and rehabilitation
- Complete 150 CME credits within one's 10-year cycle
- Pay an annual administrative fee to gain access to the online CoreComp questions.
- Complete and pass the annual online CoreComp questions

American Board of Cosmetic Surgery

The ABCS requires all interested surgeons complete an ACGME or AOA residency program in a related specialty:

- General surgery
- Plastic surgery
- Neurological surgery

- Obstetrics and gynecology
- Orthopedic surgery
- Otolaryngology
- Thoracic surgery
- Urology
- American Board of Oral and Maxillofacial Surgery (ABOMS) with MD degree

Candidate surgeons must also complete an American Academy of Cosmetic Surgery certified fellowship in cometic surgery and pass both written and oral examinations. With all specialties except plastic surgery, the candidate surgeon must also be board certified in one or more of the aforementioned specialties by a board recognized by the ABMS, the AOA, the ABOMS, or the Royal College of Physicians and Surgeons of Canada (RCPSC)

To maintain continuous certification, applicants for ABCS must also pass the ABCS Annual Certifying Examination, which consists of both an oral and written component that is prepared and psychometrically evaluated by the National Board of Osteopathic Medical Examiners (NBOME)[5].

American Board of Facial Plastic and Reconstructive Surgery

The ABFPRS was established in 1986 to improve the quality of medical and surgical treatment available to the public through the establishment of a mechanism for the education, qualification, training, review, and certification of surgeons specializing in facial plastic and reconstructive surgery. Candidates for the ABFPRS initial certification must:[6]

- Have completed a residency program approved by the ACGME or the RCPSC in one of the two medical specialties containing identifiable training in facial plastic and reconstructive surgery: otolaryngology/head-and-neck surgery or plastic surgery
- Have earned prior certification by the American Board of Otolaryngology, the American Board of Plastic Surgery or the RCPSC in otolaryngology/head-and-neck surgery or plastic surgery
- Have been in practice a minimum of two years
- Have 100 operative reports accepted by a peer-review committee
- Successfully pass an 8-hour written and oral examination
- Operate in an accredited facility
- Hold the appropriate licensure and adhere to the ABFPRS Code of Ethics
- Complete the FACEforward® online longitudinal assessments annually to maintain certification

American Board of Oral & Maxillofacial Surgery

Board Certification by the ABOMS requires successful completion of the Qualifying and Oral Certifying Applications and Examinations. Once certified by ABOMS, candidates must participate in the Certification Maintenance process. For initial certification, a candidate must successfully complete both the qualifying examination and the oral certifying examination. The ABOMS also allows internationally trained applicants an opportunity to take the qualifying exam by meeting different requirements that hold the same caliber as the application for individuals taking the examination for the first time. Candidates have three consecutive years following successful completion of the qualifying examination to take and pass the oral certifying examination. Candidates who successfully complete these examinations become diplomates that have time-limited certifications. To maintain one's status as an ABOMS diplomate, one must complete the

components of certification maintenance in four areas: professional standing, lifelong learning, cognitive expertise, and performance in practice. Certification Maintenance is a continuous process of learning, self-assessment, and testing that proceeds over a 10-year period.[7]

American Board of Physician Specialties

ABPS is the official multi-specialty board certifying body of the American Association of Physician Specialists, Inc. ABPS assists the certifying bodies by guiding the planning, development, and psychometric evaluation of assessment procedures designed to measure professional competency. Eligibility requirements and examinations of the boards of certification are developed based on a substantial review and analysis of the current state of clinical knowledge in the field of a particular specialty, as reflected in medical literature and the patient-care setting. Candidates can apply for either certification or recertification and ABPS verifies credentials for both certification and recertification applicants using various sources including, but not limited to, the Federation of State Medical Boards Credentials Verification service and the American Medical Association Physicians Profiling services. ABPS offers two exam processes: one for specialties such as anesthesiology, emergency medicine, and orthopedic surgery that require two steps (written/computer-based and oral exams) and one for specialties such as dermatology, family medicine, and internal medicine that are a single-level (written/computer-based exam).[8]

National Board of Physicians and Surgeons

The NBPAS was established in 2015 and is a non-profit, physician-led organization that provides an alternative pathway for continuous certification from ABMS or AOA in all the broadly recognized areas of specialty medical practice. The NBPAS does not provide initial board certification; it is a pathway for continuous certification after completing the initial board certification from an ABMS or AOA member board. NBPAS performs primary source verification of physician education and training as required by the National Committee for Quality Assurance, Utilization Review Accreditation Commission, The Joint Commission, and Det Norske Veritas, Inc. accreditation standards. The NBPAS requires all physicians to meet the following criteria to be eligible for certification:

- Previous certification through an ABMS/AOA Member Board
- An active, valid, unrestricted license to practice medicine in at least one U.S. state or territory
- Submission of continuing medical education credits
- Active privileges to practice that specialty in at least one U.S. hospital or outpatient facility licensed by a nationally recognized credentialing organization with deeming authority from Centers for Medicare & Medicaid Services
- Medical staff appointment/membership

While the NBPAS indicates it reserves the right to deny certification to any individual believed by the board to lack sufficient qualifications, it also expresses on its website that certification by NBPAS is a measure of training, experience, and life-long learning and does not guarantee competence or any specific medical outcomes.[9]

Existing AMA policy conflicts with support for NBPAS because the board does not offer initial certification. Specifically, AMA Policy H-275.926, “Medical Specialty Board Certification Standards” states 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. (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.

United Council for Neurologic Subspecialties

UCNS certification has been the recognized certification for emerging neurologic subspecialties since 2003. Requirements for eligibility for UCNS initial certification include[10]:

- Applicants must be certified by an ABMS certifying board or possess equivalent certification by the RCPSC or the AOA.
- Applicants must hold a current, active, valid, unrestricted, and unqualified license to practice medicine in at least one jurisdiction in the United States, its territories, or Canada, and in each jurisdiction in which they practice.
- Applicants must complete one of four eligibility pathways. The pathways are:
    1. UCNS-accredited fellowship
    2. Practice track
    3. Academic appointment at a UCNS-accredited fellowship
    4. Internationally trained faculty at UCNS-accredited training programs
- Applicants must provide documentation of a 36-month* period of time in which the applicant has spent a minimum of 25% of their time in the practice of their specialty.
- Applicants for continuous certification must complete and pass annual online assessments.

Below is a table that provides a comparative overview of these entities based on current AMA policy.

Table 1. Comparison of Credentialing Organizations

Medical Specialty Board Certification Standards H-275.926 (3)	Credentialing Organizations								
	ABMS	AOA-BOS	AANEM	ABCS[i]	ABFPRS[ii]	ABOMS	ABPS[iii]	NBPAS[iv]	UCNS
Certification programs must include a process for defining specialty-specific standards for knowledge and skills	X	X	X	X	X	X	X	X	X
Certification programs must offer an independent, external assessment of knowledge and skills for initial certification in the medical specialty	X	X	X	X	X	X	X		X
Certification programs must offer an independent, external assessment of knowledge and skills for recertification or continuous certification in the medical specialty	X	X	X	X	X	X	X		X

[i]With all specialties except plastic surgery, must also be board certified in one or more of these specialties, by a board recognized by the ABMS, AOA, ABOMS, or the RCPSC.
[ii]Must have earned prior certification by the American Board of Otolaryngology, the American Board of Plastic Surgery, or the RCPSC in otolaryngology/head-and-neck surgery or plastic surgery.
[iii]Must be currently board certified through the ABMS or AOA to be eligible for recertification.
[iv] Must hold a previous certification through an ABMS or AOA member board in the same specialty.

AMA's Truth in Advertising Campaign

The AMA believes that patients deserve to have increased clarity and transparency in health care. There is no place for confusing or misleading health care advertising that has the potential to put patient safety at risk. Recognizing that there is confusion among the public as to the education, training, and skills of different health care professionals, which can lead to patients seeking and obtaining inappropriate and potentially unsafe medical care, the AMA created the "Truth in Advertising" campaign to help ensure patients know the education, training, and qualifications of their health care professionals. The campaign does not increase or limit anyone's scope of practice. Instead, the campaign increases the transparency of health care professionals' qualifications for patients, so that patients can clearly see and make informed decisions about who provides their care.

The campaign includes a model bill created by the AMA that states can use to advocate for health care professional transparency. The model bill features two main components: (1) prohibition of

deceptive or misleading advertisements and requiring all health care practitioners to indicate their license in any advertisements and (2) requirement that all health care practitioners wear a name badge during all patient encounters that includes, among other information, the health care practitioner's license. Presently the "Truth in Advertising" campaign does not acknowledge that there are non-ACGME and non-AOA fellowships that should not be excluded (e.g., ABPS). The model bill also includes an optional drafting note on board certification. This item is optional because it is not AMA policy. The optional drafting note language outlines parameters physicians must meet to be able to claim they are "board certified" in any advertisements and states as follows:

Drafting Note Re: Board Certification—To provide further guidance on an additional type of requirement related to MD or DO board certification, this drafting note provides the following sample.

> A medical doctor or doctor of osteopathic medicine may not hold oneself out to the public in any manner as being certified by a public or private board including but not limited to a multidisciplinary board or "board certified," unless all of the following criteria are satisfied:
> (a) The advertisement states the full name of the certifying board.
> (b) The board either:
> 1. Is a member board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA); or
>
> 2. Is a non-ABMS or non-AOA board that requires as prerequisites for issuing certification:
> (i) successful completion of a postgraduate training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the AOA that provides complete training in the specialty or subspecialty certified by the non-ABMS or non-AOA board;
> (ii) certification by an ABMS or AOA board covering that training field that provides complete ACGME or AOA-accredited training in the specialty or subspecialty certified by the non-ABMS or non-AOA board; and
> (iii) successful passage of examination in the specialty or subspecialty certified by the non-ABMS or non-AOA board.

Discussion

Continuing demonstration of physician competency sets the qualifications of physicians above other health professionals. Ongoing assessment and demonstration of competency help identify gaps in knowledge or skills as medicine advances, allowing physicians to address those gaps and provide safe, up-to-date, and effective care to patients. Demonstrating ongoing competency helps build and maintain public trust in the medical profession. Patients and the broader community have confidence in physicians who actively engage in professional development and demonstrate their commitment to providing high-quality care. Physicians have a professional responsibility to continuously improve and maintain their competence. By engaging in ongoing assessment and self-reflection, physicians demonstrate accountability for their own practice and commitment to meeting the highest standards of patient care. The field of medicine is constantly evolving, with new research, technologies, and treatment options emerging regularly. Continuing education and assessment help physicians stay up to date with the latest evidence-based practices and guidelines, ensuring that patients receive the most current and effective treatments. While there are different ways to achieve continuing board certification, it is debatable whether they produce the same outcomes for patients.

The ABMS has established principles for determining physician competency. These principles guide the certification and continuation of certification processes for medical specialties. The key principles are evidence-based standards, ongoing assessment, lifelong learning, specialty-specific

criteria, transparency and fairness, quality improvement, and collaboration. Other entities also require ongoing assessment of knowledge and skills and should not be discriminated against 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.

The resolution directly impacts the optional drafting note on board certification in the AMA's Truth in Advertising Campaign. Broadly speaking, the campaign addresses transparency in the level of training, education, and licensing of health care professionals to ensure patients know who is providing their care [and whether they are sufficiently qualified to perform a given procedure or treat a particular disease or condition]. The optional drafting note on board certification specifically addresses whether a physician can advertise as board certified and has been revised multiple times since it was originally added in 2011. More than 25 states have enacted the advertising language and/or name badge language of our Truth in Advertising bill, while three states have enacted language related to board certification and two states have enacted language like the board certification optional drafting note in AMA's model bill. There is not consensus regarding the definition of "board certification" and therefore the future of the optional drafting note in the Truth in Advertising campaign will need to be determined by the House of Delegates.

Summary and Recommendation

The Council on Medical Education therefore recommends that the following resolve be adopted in lieu of Resolution 304-A-22 and the remainder of this report be filed.

That our American Medical Association (AMA):

1. Encourage continued advocacy to federal and state legislatures, federal and state regulators, physician credentialing organizations, hospitals, and other interested parties to define physician board certification as the medical profession establishing specialty-specific standards for knowledge and skills, using an independent assessment process to determine the acquisition of knowledge and skills for initial certification and recertification. (Directive to Take Action)

2. Reaffirm the following policy:

- H-275.926, "Medical Specialty Board Certification Standards"

Fiscal note: $1000

APPENDIX: RELEVANT AMA POLICIES

Medical Specialty Board Certification Standards H-275.926

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.

Continuing Board Certification D-275.954

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.

Continuing Board Certification 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.

Mechanisms to Measure Physician Competency H-275.936

Addressing Public Health Disinformation Disseminated by Health Professionals D-440.914

References

[1] Nora LM, Wynia MK, Granatir T. Of the profession, by the profession, and for patients, families, and communities: ABMS board certification and medicine's professional self-regulation. JAMA. 2015 May 12;313(18):1805-6.
[2] ABMS. Our Story. [Internet]. USA: Illinois; c2023. [cited 2023 June 28]. Available from: https://www.abms.org/about-abms/our-story/.
[3] ABMS. ABMS Board Eligibility. [Internet]. USA: Illinois; c2023 [cited 2023 June 28]. Available from: https://www.abms.org/wp-content/uploads/2020/10/abms-board-eligibility-faq-rev-may-2020-abms-org.pdf.
[4] AANEM. Physician Certification [Internet]. USA: California; c2023. [cited 2023 June 28] Available from: https://www.aanem.org/abem/home/physician-certification.
[5] ABCS. How are ABCS Surgeons Trained? [Internet]. USA: Indiana; c2023. [cited 2023 July 20]. Available from: https://www.americanboardcosmeticsurgery.org/patient-resources/how-cosmetic-surgeons-train/
[6] ABFPRS. Applying for ABFPRS Certification. [Internet]. USA: Virgina; c2023. [cited 2023 July 20]. Available from: https://www.abfprs.org/applying-for-certification/.
[7] ABOMS. Become Certified. [Internet]. USA: Illinois; c2023. [cited 2023 July 20]. Available from: https://www.aboms.org/become-certified.
[8] ABPS. General Policies Medical Board Certification. [Internet]. USA: Florida; c2023. [cited 2023 July 20]. Available from: https://www.abpsus.org/general-policies-medical-board-certification/#2.
[9] NBPAS. Terms and Conditions. [Internet]. USA: California; c2023. [cited 2023 June 28] Available from: https://nbpas.org/pages/terms-conditions.
[10] UCNS. Certification General Eligibility Requirements. [Internet]. USA: Minnesota; c2023. [cited 2023 June 28] Available from: https://www.ucns.org/common/Uploaded%20files/Certification/Certification%20General%20Eligibility%20Requirements.pdf.

REPORT 5 OF THE COUNCIL ON MEDICAL EDUCATION (I-23)
Organizations to Represent the Interests of Resident and Fellow Physicians (Resolution 304-A-22)
(Reference Committee C)

EXECUTIVE SUMMARY

The American Medical Association (AMA) adopted policy H-310.912, "Residents and Fellows' Bill of Rights" to protect the rights and well-being of medical residents and fellows in the United States. This set of guidelines and principles aims to ensure the professional development, well-being, and rights of medical residents and fellows are safeguarded, allowing them to provide quality care and grow in their medical careers. This bill of rights stems from a history of reforms to improve the training experience for residents and fellows.

As the needs of residents and fellows continue to evolve with the changing medical education ecosystem, it is necessary to understand the entities best suited to protect the rights and well-being of these trainees as detailed in the Residents and Fellows' Bill of Rights. These entities include governmental agencies, resident/fellow forums, resident medical staff organizations, accreditors, associations, and unions. Ultimately, there is no single entity suited to being permanently responsible for the interests of residents and fellows that can hold institutions accountable for fulfilling the Residents and Fellows' Bill of Rights, as described in AMA policy. Residents and fellows need to be empowered as the leading advocates for the Resident and Fellows' Bill of Rights to make this policy a reality.

What is fundamental is representation and organization of residents and fellows to advocate within their institutions and nationally to influence medical education and workplace policies. The AMA and Federation of Medicine can advocate for resident and fellow empowerment both within our profession and at the residents and fellows' sponsoring institutions to facilitate implementation of the rights detailed in this bill of rights. In addition, self-advocacy requires protection from retaliation and threats to livelihood for trainees participating in good faith advocacy.

The Council on Medical Education recommends adopting new policy encouraging the formation of peer-led resident/fellow organizations that can advocate for implementation of the AMA's Resident and Fellows' Bill of Rights at institutions that sponsor graduate medical education (GME), as well as the development of a formal process for resident/fellow physicians to transfer to another GME program without penalty when an employment situation is not sustainable for a trainee and/or program. The Council on Medical Education also recommends amplifying awareness of FREIDA™ as a resource for medical students, residents, and fellows; investigating its current capacity to post open, vacant positions by program directors; and adding the ability for residents and fellows to post positions with program transfers. Lastly, the Council recommends amending Policy H-310.912, "Residents and Fellows' Bill of Rights."

REPORT OF THE COUNCIL ON MEDICAL EDUCATION
DRAFT OUTLINE

CME Report 5-I-23

Subject: Organizations to Represent the Interests of Resident and Fellow Physicians (Resolution 304-A-22)

Presented by: Cynthia Jumper, MD, Chair

Referred to: Reference Committee C

Resolution 304-A-22, "Accountable Organizations to Resident and Fellow Trainees," was authored by the American Medical Association (AMA) Resident and Fellow Section and submitted to the 2022 Annual Meeting of the House of Delegates (HOD). The resolution reads as follows:

> RESOLVED, That our American Medical Association work with relevant stakeholders to: (1) determine which organizations or governmental entities are best suited for being permanently responsible for resident and fellow interests without conflicts of interests; (2) determine how organizations can be held accountable for fulfilling their duties to protect the rights and well-being of resident and fellow trainees as detailed in the Residents and Fellows' Bill of Rights; (3) determine methods of advocating for residents and fellows that are timely and effective without jeopardizing trainees' current and future employability; (4) study and report back by the 2023 Annual Meeting on how such an organization may be created, in the event that no organizations or entities are identified that meet the above criteria; and (5) determine transparent methods to communicate available residency positions to displaced residents.

The resolution was subsequently referred by the HOD for a report back the House; this report is in response to the referral. The title of this report has been revised slightly to avoid potential confusion of the term "accountable organization" with "accountable care organization" or ACO.

Background

AMA Residents and Fellows' Bill of Rights

In 2011, the AMA adopted policy H-310.912, "Residents and Fellows' Bill of Rights" with the intent to protect the rights and well-being of medical residents and fellows in the United States. This set of guidelines and principles aims to ensure the professional development, well-being, and rights of medical residents and fellows are safeguarded, allowing them to provide quality care and grow in their medical careers. The key provisions of the bill can be summarized as follows:

1. An education that fosters professional development, takes priority over service, and leads to independent practice.
2. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.

3. Regular and timely feedback and evaluation based on valid assessments of resident performance.
4. A safe and supportive workplace with appropriate facilities.
5. Adequate compensation and benefits that provide for resident well-being and health.
6. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
7. Due process in cases of allegations of misconduct or poor performance.
8. Access to and protection by institutional and accreditation authorities when reporting violations.

The need to establish this bill of rights stems from a history of reforms to improve the training experience for residents and fellows. Prior to 1989, there had been no national standardized duty hour regulations for residents in the United States. Residency programs typically had arbitrary work hour policies, and it was common for residents to work extremely long hours, including shifts that lasted over 24 consecutive hours or more. On-duty hours of first-year residents exceeded a mean of 80 hours per week (e.g., neurosurgery residents reported averaging 110 hours per week).[1] The lack of uniform regulations produced significant variations in work hour practices across different institutions and specialties. Excessive work hours also raised growing concern about the working conditions and treatment of medical residents due to high-profile cases of medical errors or adverse outcomes for patients. Several research studies conducted in the late 1980s and early 2000s shed light on the adverse effects of long work hours and sleep deprivation on resident physicians.[2,3,4,5] These studies highlighted the increased risk of medical errors, decreased quality of patient care, and the negative impact on resident well-being, and they provided empirical evidence that supported the need for reform in residency training.

One high-profile case that was instrumental to policy changes for residents was Libby Zion. Ms. Zion died while under the care of fatigued and overworked residents at New York Hospital (now New York Presbyterian Hospital).[6] Following a civil trial for this case, David Axelrod, the New York State commissioner of public health, appointed a commission led by Bertrand M. Bell, MD, to investigate her death and evaluate the circumstances that led to it. The New York State Ad Hoc Advisory Committee on Emergency Services report, which became known as the Bell Commission Report, examined the broader issues of patient safety, quality of care, and supervision within the medical context and brought attention to the need for appropriate supervision and patient safety measures within medical settings. Following the recommendations of the Bell Commission, New York State enacted the Libby Zion law in 1989, which implemented regulations on resident work hours, supervision, and the qualifications of supervising physicians. The law mandated a limit of 80 hours of work per week for residents, with additional restrictions on the duration of continuous work shifts.

The Libby Zion Law led to increased awareness and discussions about the need for national standards and guidelines regarding resident work hours, which eventually influenced the development of duty hour regulations at the national level by the Accreditation Council for Graduate Medical Education (ACGME).

ACGME Duty Hour Standards

Prior to 2003, the ACGME did not have national standardized duty hour regulations for residents in the United States. Residency programs had flexibility in setting their own work hour policies, resulting in significant variations in duty hour practices across institutions and specialties. The absence of specific ACGME duty hour standards meant that work hour practices were determined by individual residency programs and could vary widely. Some programs implemented more restrictive policies voluntarily, while others adhered to more traditional models with longer work hours and limited time off. In response to mounting concerns about resident well-being, patient safety, and the need for standardized guidelines, the ACGME developed formal duty hour regulations, which were implemented in 2003.[7] These regulations marked a significant shift in the approach to resident work hours and aimed to balance resident well-being, patient safety, educational opportunities, and work hours and mitigate fatigue while maintaining high-quality training experiences. Key reforms that were introduced in 2003 include:

1. **Work Hours Limits:** Residents were not to work more than 80 hours per week, averaged over a four-week period.
2. **Mandatory Time Off:** Residents were required to have at least one day off per week, averaged over four weeks, or at least one day off every seven days.
3. **Maximum Shift Length:** Residents would have a maximum shift length of 24 consecutive hours, with an additional six hours permitted for specific patient care activities and transitions. Following each shift, residents were required to have a minimum of 10 hours off duty for rest.
4. **Supervision and Handovers:** Residents were required to be supervised appropriately and strategies needed to be in place to ensure smooth handovers of patient care during shift changes. These changes aimed to enhance patient safety and ensure effective communication and continuity of care during transitions between resident physicians.
5. **Moonlighting Restrictions:** Moonlighting, referring to engaging in additional paid work outside of the residency program, was regulated to prevent excessive work hours and potential fatigue.
6. **Educational Requirements:** To emphasize the importance of education and learning opportunities, residents should have dedicated time for educational activities, including conferences, didactic sessions, and self-directed learning.
7. **Oversight and Compliance:** This reform established mechanisms to monitor and enforce compliance with the new duty hour standards. This included conducting regular site visits, surveys, and evaluations of residency programs to ensure adherence to the regulations.

In 2011, ACGME implemented additional reforms in duty hour standards to further address concerns about resident well-being, patient safety, and the need for enhanced educational experiences.[8] These reforms aimed to build upon the previous regulations, further enhancing resident well-being, patient safety, and educational experiences. Key reforms that were introduced in 2011 include:

1. **Limiting Shift Length for First-Year Residents:** Established stricter limits on shift duration for first-year residents (interns). Interns' shifts were capped at a maximum of 16 consecutive hours, recognizing the increased vulnerability of inexperienced residents to fatigue-related errors.
2. **Enhanced Supervision:** Emphasized the importance of appropriate supervision and oversight of resident physicians. Faculty and senior physicians were required to provide direct supervision and be physically present during critical patient care activities and procedures.

3. **Handover Principles:** Introduced principles for safe and effective handovers of patient care during shift changes. These principles aimed to ensure seamless transitions between resident physicians, minimizing the potential for errors and miscommunication.
4. **Individualized Learning Plans:** Emphasized the development of individualized learning plans for residents. These plans were intended to align with each resident's educational goals and ensure adequate opportunities for professional development and learning.
5. **Enhanced Monitoring and Compliance:** Implemented more robust mechanisms for monitoring and enforcing compliance with the duty hour standards. This included increased oversight, regular program evaluations, and the use of data-driven metrics to assess and address issues related to resident work hours.
6. **Resident Input and Feedback:** Emphasized the importance of resident input and feedback in shaping duty hour policies and ensuring resident well-being. Encouraged open communication channels for residents to voice concerns and provide input on work hour practices and the learning environment.

ACGME continues to conduct ongoing evaluations of the duty hour standards to optimize both resident training and patient care outcomes.

Additionally, the National Academy of Medicine (formerly known as the Institute of Medicine), published "Resident Duty Hours: Enhancing Sleep, Supervision, and Safety" in 2009. This report specifically examined the impact of resident duty hours on patient safety, resident well-being, and education. It highlighted concerns about the potential negative effects of long work hours and sleep deprivation on patient outcomes and resident performance. The report recommended several changes, including reducing the maximum number of continuous work hours, providing protected sleep periods, enhancing supervision, and promoting a culture of professionalism and shared responsibility.

Negative impacts of private equity in medical education: Hahnemann and Summa Health

The impact of private equity ownership of teaching hospitals and medical groups has raised concerns of new weaknesses and gaps in protecting residents and fellows' education and rights. As detailed in Council on Medical Education Report 1-I-22, "The Impact of Private Equity on Medical Training," the closure of Philadelphia's Hahnemann University Hospital (HUH) in fall 2019 highlighted the growing and damaging influence of private equity on medical education and training. It may be analogous to compare the excesses of managed care organizations in the 1990s, which provided impetus for the AMA to develop the Physicians for Responsible Negotiation, to the corporate overreaching exhibited by the owners of HUH, which has similarly served to catalyze opposition to the interference of private equity in medical education.

HUH's closing left 572 resident and fellow physicians without an ACGME-accredited program in which to continue their medical education.[9] They were also affected by the loss of long-tail medical liability insurance needed to continue practice. While the AMA and other local and national organizations in medical education came together to aid the affected physicians, residents and fellow trainees remain vulnerable to the negative effects of hospital closures that threaten the quality and completion of their graduate medical education (GME), financial well-being, and legal status within the United States.

A similar event occurred in 2016 at Summa Health™, an integrated nonprofit health care delivery system in the Akron, Ohio area that sponsors 15 ACGME-accredited residency and fellowship programs. A contract dispute between Summa Health™ and Summa Emergency Associates (SEA), an independent physician group that is separate from the health system led to the replacement of

about 60 faculty physicians and 30 residents in Summa's emergency medicine program. The 60 physicians were replaced by a group of emergency physicians paid by Canton-based US Acute Care Solutions.[10] This event led to the loss of accreditation for the institution's emergency medicine residency in 2017, causing displacement to the education of the affected residents and disruption to patient care services. The program acquired new leadership and faculty but remained nonaccredited until 2019.[11] As with HUH, the AMA and other organizations offered financial support to the affected trainees seeking relocation.

Organizations with purview over resident/fellow training and work conditions

As the needs of residents and fellows continue to evolve with the changing medical education ecosystem, understanding what entities are best suited to protect the rights and well-being of resident and fellow trainees, as detailed in the Residents and Fellows' Bill of Rights, becomes necessary. These organizations include governmental agencies, accreditors, resident/fellow forums, resident medical staff organizations, associations, and unions.

Governmental agencies

State and federal governments have broad authority to regulate workplace safety and standards through law and regulation. Federal authority to regulate residencies is linked to the federal government's major role as a funder of GME and health care.

In the United States, the abolition of slavery and the rise of the industrial economy after the Civil War led to the legal principle where workers bargained with owners for wages in exchange for their labor, leading to the formation of labor unions. With industrialization, workplace hazards expanded, and the study of workplace hazards became included in the scope of public health referred to as occupational safety and health.

With the New Deal, the National Labor Relations Act of 1935 established the right of employees to form and join unions, obligated employers to bargain collectively, and created the National Labor Relations Board (NLRB) to enforce employee rights. In addition, the first federal legislation to control workplace conditions was enacted. State and the federal departments of labor began to establish and enforce workplace health and safety standards, and unions bargained with employers for improved working conditions. In 1970, the Occupational Safety and Health Act established the National Institute of Occupational Safety and Health (NIOSH) in the National Institutes of Health to research workplace safety and the Occupational Safety and Health Administration (OSHA) to regulate working conditions.

OSHA health care standards focus on workplace exposures to infection, drugs, chemicals, and radiation; musculoskeletal injuries from patient handling; and workplace violence. OSHA standards are not specific to residents. OSHA does not regulate work hours, and there are no laws generally limiting work hours for adult employees. OSHA twice rejected petitions to regulate resident duty hours in 2002 and 2011. Agencies regulating specific industries (e.g., Federal Aviation Administration) may limit duty hours for workers in that specific industry. There are no federal agencies regulating resident work hours; however, the Centers for Medicare and Medicaid Services (CMS) grants deeming authority to ACGME to set standards for residency education as a requirement for receiving Medicare GME funding.

CMS primarily oversees the Medicare and Medicaid programs including Medicare GME funding. CMS does not usually set standards on working conditions, although in November 2022, CMS issued a memo on workplace violence and safety requirements in hospitals. Hospitals' failure to

meet CMS regulatory expectations may lead to citations. The full CMS memo is featured as Appendix B of this report.

States also have labor agencies that regulate workplace health and safety, but state laws specific to residency duty hours and working conditions, such as New York's Libby Zion law, are the exception rather than the rule. States also regulate hospitals and other clinical facilities, licenses physicians including residents, and may set standards for health and safety requirements for employees and patients.

Workplace laws and regulations are enforceable, but enforcement is divided between different agencies and levels of government (federal, state, local). It should also be noted that workplace regulations are rarely specific to residency and usually do not consider educational issues. Additionally, the process of changing laws and regulations is a long, complex legal process involving a broad array of interested parties whose political influence may shape outcomes with unintended consequences. Professional self-governance in establishing and enforcing professional standards has long been advocated by the AMA and the Federation of Medicine.

Accreditors

An accreditor is a non-governmental or private professional organization that develops professional standards and criteria and conducts peer evaluations and expert visits to assess if the criteria are met. An accreditor is entitled to accord formal status to operate an educational institution, program, or facility following successful examination of the application and evaluation of such entities. Accreditors are often deemed authority by governmental agencies because of their expertise and capacity to encourage compliance with standards.

The primary accreditors setting standards affecting residents are the ACGME and the Joint Commission, previously known as the Joint Commission on Accreditation of Healthcare Organizations. The ACGME accredits residency programs and their sponsoring institutions and the Joint Commission accredits health care organizations, including those sponsoring residency education.

The ACGME sets accreditation standards and requirements for all allopathic (MD) and osteopathic (DO) residency programs across various specialties and their sponsoring institutions. As of July 1, 2020, the ACGME became the accrediting body for all residency programs, including those previously accredited by the American Osteopathic Association.[12] The ACGME Board of Directors is comprised of members nominated by the AMA, American Board of Medical Specialties (ABMS), American Hospital Association, Association of American Medical Colleges, Council of Medical Specialty Societies, American Osteopathic Association, and American Association of Colleges of Osteopathic Medicine; public and at-large members; the chair of the Council of Review Committee Chairs, and two resident members. The ACGME also oversees each specialty's review committee, which all include a resident/fellow member, that accredits individual residency programs and proposes specialty-specific accreditation requirements. The ACGME also oversees the Institutional Review Committee, which accredits sponsoring institutions. ACGME accreditation requirements address the resident learning and working environment including work hours, leave, well-being, facilities, and services to support resident rest, safety, and well-being. The ACGME also requires at least two peer-selected residents to serve on each ACGME-accredited Sponsoring Institution's Graduate Medical Education Committee, which is required to oversee the learning and work environment at all residency programs sponsored by the institution.

ACGME's Council of Review Committee Residents (CRCR) also serves as a forum for resident physicians serving on the ACGME's board and review committees to provide input, feedback, and perspective on matters related to GME and accreditation. The CRCR consists of residents from various specialties across the United States appointed by their respective residency programs or specialty organizations to provide a resident physician perspective on accreditation policy.

In recognition of professional self-governance, government agencies usually defer to ACGME to set standards for resident education.

The ACGME promulgates educational standards for residency programs and sponsoring institutions that are enforceable through corrective actions such as probation or loss of accreditation. However, accreditors have few intermediate sanctions short of loss of accreditation, which would also negatively impact the affected residents at that institution/program. Accreditation standards must be related to education and the learning environment, which may limit accreditation standards from addressing workplace and patient care issues that cannot be tied to resident education. Furthermore, accreditation standards apply broadly and may not address specific problems at individual institutions or programs.

The Joint Commission accredits and certifies health care organizations and programs in the United States. The Joint Commission board includes representatives from the AMA, American College of Physicians, American College of Surgeons, American Dental Association, American Hospital Association, and public/at-large members. While the Joint Commission does not have specific accreditation standards or requirements pertaining directly to resident learning environment or work conditions, the Joint Commission indirectly impacts resident physician training and work conditions through its broader standards related to patient safety and quality of care. By emphasizing patient safety, organizations accredited by the Joint Commission are encouraged to create environments that prioritize patient well-being, which can impact working conditions for resident physicians.

Resident/fellow forum or resident medical staff organization

A resident/fellow forum or resident medical staff organization provides an opportunity for residents to give feedback directly to their sponsoring institution leaders including the designated institutional official (DIO). Additionally, the resident medical staff model gives residents a formal role in the medical staff, where they can influence institutional policy through the medical staff.

The ACGME requires sponsoring institutions with multiple ACGME-accredited programs to have a Graduate Medical Education Committee (GMEC) that includes a minimum of two peer-selected residents/fellows from among its ACGME-accredited programs. When a program only has one resident/fellow, the sponsoring institution must include that individual on its program's GMEC among its voting members. The ACGME requirements also mandate that sponsoring institutions with more than one program must ensure availability of an organization, council, town hall, or other platform (resident/fellow forum) that allows all residents/fellows across the sponsoring institution's ACGME-accredited programs to communicate and exchange information relevant to their ACGME-accredited programs and their learning and working environment. This requirement also mandates that any resident/fellow from that sponsoring institution can directly raise a concern to the forum; conduct their forum without the DIO, faculty members, or other administrators present; and have the option to present concerns that arise from discussions at the forum to the DIO and GMEC.[13] However, these requirements do not mandate that a sponsoring institution establish or support an ongoing resident organization at the institution. The resident/fellow forum can facilitate organizing and collective action by residents at the institution and discussion of institution

or program specific issues, but without ongoing institutional support and with frequent resident turnover, the resident/fellow forum's ability to address long-term resident concerns can be limited.

A resident medical staff organization formally incorporates residents into the organized medical staff with their own governance structure. The organized medical staff has responsibility for credentialing, privileging, peer review, and oversight of clinical quality and patient safety, and the organized medical staff is a self-regulating organization of professionals governed by bylaws that are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The resident medical staff organization can advocate for workplace health and safety through the medical staff and engage in peer review of residents. In addition, since most residency physician faculty are also members of the medical staff, the organized medical staff can enable formal discussions between residents and faculty about the learning and work environments at the institution. A limitation of the resident medical staff is that the organized medical staff is associated with a specific health care organization. Residents may have clinical rotations in other health care facilities independent of the sponsoring institution where the organized medical staff, and thus the resident medical staff, does not have authority.

Associations

Professional associations, such as the AMA and other medical societies, organize members of the profession to establish practice, educational, and ethical standards, advance professional knowledge and skills, and advocate for the profession and the people the profession serves. Government bodies usually give considerable deference to professional association standards, providing professional associations authority beyond that gained through advocacy by the association. Professional associations facilitate organizing and collective action by members and enable unified effort in dealings with government bodies, businesses, organizations, and other professions and trades. Professional associations can also enable mobilization of the resources of the profession including collective expertise and professional networks.

Since its founding, the AMA, through the Council on Medical Education, made advancing medical educational standards a high priority, having established accreditation and credentialing bodies including the ACGME and the ABMS. Federation members including state and specialty medical associations collaborate with the AMA on accreditation, certification, and licensure issues. The American Osteopathic Association has a similar role for osteopathic physician education. The Association of American Medical Colleges (AAMC) is the professional association of medical schools and teaching hospitals and takes a leadership role in allopathic medical education accreditation, and the American Association of Colleges of Osteopathic Medicine (AACOM) takes a similar role in osteopathic medicine education.

As association members, residents and fellows can leverage the influence of their professional associations to advocate for the rights and well-being of resident and fellow trainees. The Residents and Fellows' Bill of Rights is a leading example of AMA policy to protect resident and fellow rights and well-being. The AMA provides many opportunities for residents and fellows to influence and formulate AMA policy. The Resident and Fellow Section is composed of peer-selected resident and fellow leaders from state and specialty medical societies who develop section policy that is then proposed for adoption as AMA policy. Residents and fellows also have designated voting seats on AMA governing bodies including the House of Delegates, AMA Councils, and the Board of Trustees. Through the AMA, residents and fellows have influenced ACGME accreditation standards on the learning and working environment, including work hour standards, and have mobilized the medical profession to assist residents harmed by the closure of Hahnemann University Hospital.

In the AOA, the Bureau of Emerging Leaders is the representative body and advocate for all osteopathic medical students, osteopathic physicians in postdoctoral training, and early-career osteopathic physicians.

The AAMC established the Organization of Resident Representatives (ORR) to provide resident input into AAMC policy and to provide leadership opportunities for residents interested in academic medicine. ORR resident members are appointed by Council of Faculty and Academic Societies members representing either department chairs or program directors.

AACOM established the Assembly of Osteopathic Graduate Medical Education Residents and Fellows Council to develop future leaders in the osteopathic profession by creating a community and forum for residents and fellows to connect, collaborate, and learn.

Associations can facilitate organizing and collective action, providing residents with opportunities to network with residents from other institutions/regions/states. Residents may influence association policy that the association can utilize to support resident advocacy and lobby on their behalf. Associations can leverage their influence to help shape professional standards and norms. Associations also appoint members of accreditation organizations that develop standards and requirements. However, association policies are not directly enforceable; enforcement only occurs if adopted by governmental and regulatory bodies. Furthermore, association policies are usually not specific to problems at particular institutions or programs. Resident and fellow influence may also be limited by organization governance rules (e.g., resident leaders are not peer-selected, residents have no or limited participation in policymaking and/or leadership, and/or resources for resident activities are limited).

Unions

Through the National Labor Relations Act, a certified union has the sole legal authority to collectively bargain for employment terms and conditions for the class of employees the union represents. The employer is obligated to engage in collective bargaining with the union.

A union can serve as a collective voice for resident physicians representing their interests and concerns to their employer. Unions are recognized in law with the authority to negotiate binding labor contracts with employers, such as hospitals or healthcare systems. These enforceable contracts outline the terms and conditions of employment, including work hours, schedules, compensation, benefits, and grievance procedures. Through collective bargaining, unions can negotiate for improvements in work conditions, duty hours, supervision, workload, and other aspects that affect resident physicians' work and safety environment and well-being, but education standards are not part of collective bargaining. Unions often establish grievance procedures to address complaints and disputes regarding work conditions, training, or other employment-related matters. They provide support and guidance to resident physicians when filing grievances and assist in resolving conflicts. Unions can act as an intermediary between resident physicians and employers to ensure that concerns are addressed, and rights are protected. Unions can also advocate for changes in laws or regulations to enhance work hours, supervision, and other aspects of resident training. They can also offer educational support by providing educational resources, training programs, workshops, conferences, or seminars on topics such as contract negotiations, labor rights, and professional development. Unions that represent resident physicians include the Committee on Interns and Residents (CIR) of the Service Employees International Union (SEIU), the Union of American Physicians and Dentists and the Alliance of Resident Physicians.

Unions provide three basic functions: collective bargaining, political advocacy, and mutual aid (health insurance and pensions for membership). For physicians, the right to collectively bargain (i.e., negotiating contract terms with an employer on behalf of its employees) is a key driver of physician union development and participation. A study published in the Journal of the American Medical Association in 2022 focused specifically on resident/fellow unions as a tool to address burnout during training and serve as a needed counterweight to deleterious corporate influence in health care.[14] However, unions are not a panacea to the growing trend of corporate influence in medical education and practice. For example, during the mass layoff of all residents at Hahnemann, a collective bargaining agreement would not have prevented the residents from losing their positions. The Worker Adjustment and Retraining Notification (WARN) Act requires advance notice in cases of mass layoffs, but it would not have ensured the residents would have continued their GME during that time. They would still have had to find new positions mid-year. Further, certain states and regions of the country are less hospitable to the development of unions than others. In addition, even with a certified union at their workplace, some residents may opt out of joining the union and paying dues, because of a 2018 Supreme Court ruling banning mandatory union fees for public-sector workers;[15] however, all residents would still fall under the collective bargaining agreement including the wages, benefits, and working and safety conditions the resident union obtained in negotiation. Reaching a collective bargaining agreement can be challenging, and employers may stall for years when employees choose to work without a contract instead of going on strike. While a union can provide some level of protection to its members' employment, a union cannot guarantee that residents' future employability would not be jeopardized by their activism. State labor laws and the composition of the NLRB may also affect the ability of a union to provide its members protection from retribution by employers.

A Comparison of Organizations for Residents

The table below provides a high-level perspective of which organizations can assist in protecting the rights and well-being of resident and fellow trainees as detailed in the Residents and Fellows' Bill of Rights.

Table 1. Organizations that can assist resident and fellow physicians with protecting their rights.

Bill of Rights	Governmental Agencies	Resident /Fellow Forum or Resident Medical Staff Organization	Accreditors	Associations	Unions
1. Education	✓	✓	✓	✓	
2. Supervision	✓	✓	✓	✓	✓
3. Assessment & Evaluation		✓	✓	✓	✓
4. Workplace Safety	✓	✓	✓	✓	✓
5. Compensation & Benefits	✓	✓		✓	✓
6. Patient Safety & Resident Well-being	✓	✓	✓	✓	✓
7. Due Process	✓	✓		✓	✓
8. Access & Protection	✓		✓	✓	

Communicating available residency positions to displaced residents

Residents may be displaced because of closure of their program or sponsoring institution or because of circumstances that make continued employment in their residency program untenable. To meet the NRMP Match agreement, Section 6.1.2 (Duty to Act in an Ethical and Professional Manner) and 10.0.b (Binding Commitment) state a resident must enter and remain at their matched training program for 45 calendar days after the start date of the relevant appointment contract. For residents and program directors, there is not a single, unified mechanism for displaced residents to find appropriate residency position vacancies to facilitate a transfer.

While the Match is designed to place residents starting with first-year positions, it does have subcategories such as Physician-R—meaning, reserved for doctors with previous residency experience—and Advanced, which places residents into PGY-2 positions. These positions may present an avenue to transfer through the Match. Program directors may share information about their residents seeking transfers and vacancies at their program through their program director association or informal networks. The AAMC developed FindAResident that compiles listings of potential residency openings, which is accessible for a subscription fee. ResidentSwap is a website providing anonymous listings of positions currently filled by residents who would like to swap their current location or specialty with another resident.

The AMA has been a leader in providing data and information to residents and fellows to support their careers as physicians. The AMA Residency and Fellowship Database, FREIDA™ offers guidance on finding residency programs by helping members compare and rank programs.

Discussion

There is no single organization or government entity suited to being permanently responsible for resident and fellow interests that can hold organizations accountable for fulfilling the Residents and Fellows' Bill of Rights as described in AMA policy. In addition, any organization or governmental entity with the authority to implement such standards will not be free of political influence, given the stakes involved in GME and physician workforce. Residents and fellows must be empowered to be the leading advocates for the Resident and Fellows' Bill of Rights to make this policy a reality.

Residents and fellows have many opportunities as described in this report to advocate for implementing the Residents and Fellows' Bill of Rights at their programs and institutions. What is fundamental to their success is representation and empowerment of residents and fellows to advocate within their institution and more broadly to influence national medical education and workplace policies. The AMA and Federation of Medicine can advocate for resident empowerment, both within our profession and at the residents and fellows' sponsoring institutions to facilitate implementation of the Resident and Fellows' Bill of Rights. In addition, self-advocacy requires protection from retaliation and threats to the careers and livelihood of residents participating in good faith advocacy. As the AMA seeks to empower our physician members to advocate for patients and their practices, the AMA can similarly support resident and fellow physicians doing the same at their hospitals and clinics during training.

Unfortunately, there are sometimes circumstances in a residency program in which the employment situation for a resident or fellow is not sustainable and efforts for change are ineffective or too prolonged. A formal process needs to be developed for resident or fellow physicians to be able to transfer to another GME program without penalty to their education and career. Beyond the Match, transfer seekers are often on their own to secure a position. At the organizational level, the AMA could explore expanding the capacity for FREIDA™ to support program, resident, and fellow postings of available residency and fellowship positions.

Summary and Recommendations

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 304-A-22 and the remainder of this report be filed:

1. That Our AMA will encourage the formation of peer-led resident/fellow organizations that can advocate for trainees' interests, as outlined by the AMA's Residents and Fellows' Bill of Rights, at sponsoring institutions. (New HOD Policy)

2. That Our AMA will encourage the development of a formal process for resident/fellow physicians to transfer to another graduate medical education program, without penalty, when an employment situation is not sustainable for a trainee and/or program. (New HOD Policy)

3. That Our AMA will investigate promoting the current capacity of FREIDA™ to post open positions and adding the ability for FREIDA™ to facilitate the process of residents and fellows who wish to transfer programs. (Directive to Take Action)

4. That AMA Policy H-310.912, "Residents and Fellows' Bill of Rights," be amended by addition, to read as follows (Modify Current HOD Policy):

"12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles, including resident/fellow empowerment and peer-selected representation in institutional leadership.

"13. Our AMA encourages development of accreditation standards and institutional policies designed to facilitate and protect residents/fellows who seek to exercise their rights."

Fiscal note: $1000

APPENDIX A: RELEVANT AMA POLICIES

Residents and Fellows' Bill of Rights H-310.912

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.

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

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

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

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

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

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

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

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS
Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.
With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.
B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.
With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.
C. Regular and timely feedback and evaluation based on valid assessments of resident performance.
With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.
D. A safe and supportive workplace with appropriate facilities.
With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.
E. Adequate compensation and benefits that provide for resident well-being and health.
(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.
(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience.
Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.
F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.
G. Due process in cases of allegations of misconduct or poor performance.
With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.
H. Access to and protection by institutional and accreditation authorities when reporting violations.
With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

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

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

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

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

Resident Physicians, Unions and Organized Labor H-383.998

Our AMA strongly advocates for the separation of academic issues from terms of employment in determining negotiable items for labor organizations representing resident physicians and that those organizations should adhere to the AMA's Principles of Medical Ethics, which prohibits such organizations or any of its members from engaging in any strike by the withholding of essential medical services from patients.

1.2.10 Political Action by Physicians

Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients. However, they have a responsibility to do so in ways that are not disruptive to patient care.

Physicians who participate in advocacy activities should:

(a) Ensure that the health of patients is not jeopardized and that patient care is not compromised.

(b) Avoid using disruptive means to press for reform. Strikes and other collection actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.

(c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians' primary and overriding commitment to patients.

(d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate.

AMA Principles of Medical Ethics: I,III,VI

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

APPENDIX B: CMS Memo on Workplace Violence in Hospitals

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality

Ref: QSO-23-04-Hospitals

DATE: **November 28, 2022**

TO: State Survey Agency Directors

FROM: Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

SUBJECT: Workplace Violence-Hospitals

Memorandum Summary

- Workers in hospitals, nursing homes, and other healthcare settings face risks of workplace violence. Many factors contribute to this risk, including working directly with people who have a history of aggressive behavior, behavioral issues, or may be under the influence of drugs.
- An April 2020 Bureau of Labor Statistics Fact Sheet found that healthcare workers accounted for 73 percent of all nonfatal workplace injuries and illnesses due to violence in 2018. This number has been steadily growing since tracking of these specific events began in 2011.
- Exposure to workplace violence hazards come at a high cost; however, with appropriate controls in place, it can be addressed.
- CMS will continue to enforce the regulatory expectations that patient and staff have an environment that prioritizes their safety to ensure effective delivery of healthcare.

Background

CMS believes that healthcare workers have a right to provide care in a safe setting. CMS health and safety requirements do not preclude healthcare workers from taking appropriate action to protect themselves from workplace violence. However, it is incumbent on the leadership at these healthcare facilities to ensure they provide adequate training, sufficient staffing levels, and ongoing assessment of patients and residents for aggressive behavior and indicators to adapt their care interventions and environment appropriately.

Medicare certified hospitals have a regulatory obligation to care for patients in a safe setting under the Medicare Hospital Conditions of Participation (CoPs) at §482.13(c)(2). The intention of this requirement is to specify that each patient receives care in an environment that a reasonable person would consider to be safe. For example, hospital staff should follow current

standards of practice for patient environmental safety, infection control, and security. The hospital must protect vulnerable patients, including newborns and children. Additionally, this standard is intended to provide protection for the patient's emotional health and safety as well as his/her physical safety. Respect, dignity and comfort would also be components of an emotionally safe environment.

In order to provide care in a safe setting, hospitals should identify patients at risk for intentional harm to self or others, identify environmental safety risks for such patients, and provide education and training for staff and volunteers. Patients at risk of suicide (or other forms of self-harm) or who exhibit violent behaviors toward others receive healthcare services in both inpatient and outpatient locations of hospitals. Although all risks cannot be eliminated, hospitals are expected to demonstrate how they identify patients at risk of self-harm or harm to others and steps they are taking to minimize those risks in accordance with nationally recognized standards and guidelines. The potential risks include, but are not limited to, those from ligatures, sharps, harmful substances, access to medications, breakable windows, accessible light fixtures, plastic bags (for suffocation), oxygen tubing, bell cords, etc.

All hospitals are expected to implement a patient risk assessment strategy, but it is up to the hospital to implement the appropriate strategies. For example, a patient risk assessment strategy in a post-partum unit would most likely not be the same risk assessment strategy utilized in the emergency department.

Additionally, under the Medicare Hospital Emergency Preparedness CoP at §482.15(a), a hospital's emergency preparedness plan must be based on, and include, a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. It must also include strategies for addressing emergency events identified by the risk assessment as well as address the patient population, including, but not limited to, persons at-risk.

Hospitals should also provide the appropriate level of education and training to staff regarding the identification of patients at risk of harm to self or others, the identification of environmental patient safety risk factors, and mitigation strategies. Staff would include direct employees, volunteers, contractors, per diem staff and any other individuals providing clinical care under arrangement. The Emergency Preparedness CoP at §482.15(d)(1) contains requirements for hospitals to train staff and to have policies and procedures aimed at protecting both their workforce and their patients.

Hospitals have the flexibility to tailor the training to the particular services staff provide and the patient populations they serve. CMS expects hospitals to provide education and training to all new staff initially upon orientation and whenever policies and procedures change. Additionally, CMS recommends ongoing training at least every two years after initial training.

CMS has cited hospitals in the past for failures to meet these obligations. Examples include a nurse in a unit without adequate staffing who was sexually assaulted by a behavioral health patient who was stopped only through intervention by other patients; a patient who died after hospital staff and law enforcement performed a takedown that resulted in a hospital custodian holding the patient down on the floor with his knee against the patient's back, during which the

patient stopped breathing and died; and a patient who was acting out and shot in his hospital room by off-duty police officers following the failure of hospital staff to perform appropriate assessment and de-escalation of the patient. These cases highlight systemic failures in facilities that place both patients and staff at risk.

CMS will continue to enforce the regulatory expectations that patient and staff have an environment that prioritizes their safety to ensure effective delivery of healthcare.

Contact: Questions about this memorandum should be addressed to QSOG_Hospital@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated to all survey and certification staff and managers immediately.

/s/

Karen L. Tritz
Director, Survey & Operations Group

David R. Wright
Director, Quality, Safety & Oversight Group

cc: Survey and Operations Group Management
Office of Program Operations and Local Engagement (OPOLE)
Centers for Clinical Standards and Quality (CCSQ)

References

[1] Baldwin Jr DC, Daugherty SR, Tsai R, Scotti Jr MJ. A national survey of residents' self-reported work hours: thinking beyond specialty. Academic medicine. 2003 Nov 1;78(11):1154-63.
[2] Papp KK, Stoller EP, Sage P, Aikens JE, Owens J, Avidan A, Phillips B, Rosen R, Strohl KP. The effects of sleep loss and fatigue on resident–physicians: A multi-institutional, mixed-method study. Academic Medicine. 2004 May 1;79(5):394-406.
[3] Jagsi R, Kitch BT, Weinstein DF, Campbell EG, Hutter M, Weissman JS. Residents report on adverse events and their causes. Archives of Internal Medicine. 2005 Dec 12;165(22):2607-13.
[4] Fletcher KE, Davis SQ, Underwood W, Mangrulkar RS, McMahon Jr LF, Saint S. Systematic review: effects of resident work hours on patient safety. Annals of internal medicine. 2004 Dec 7;141(11):851-7.
[5] Johns MM, Wolman DM, Ulmer C, editors. Resident duty hours: enhancing sleep, supervision, and safety.
[6] Lerner BH. A life-changing case for doctors in training.
[7] Philibert I, Chang B, Flynn T, Friedmann P, Minter R, Scher E, Williams WT. The 2003 common duty hour limits: process, outcome, and lessons learned. Journal of Graduate Medical Education. 2009 Dec 1;1(2):334-7.
[8] The ACGME 2011 Duty Hour Standards: Enhancing Quality of Care, Supervision, and Resident Professional Development Enhancing Quality of Care, Supervision and Resident Professional Development The members of the ACGME Task Force on Quality Care and Professionalism [Internet]. Available from: https://www.acgme.org/globalassets/pdfs/jgme-monograph1.pdf.
[9] AMA analysis shows most physicians work outside of private practice [Internet]. American Medical Association. 2021. Available from: https://www.ama-assn.org/press-center/press-releases/ama-analysis-shows-most-physicians-work-outside-private-practice.
[10] Brie Zeltner TPD. Summa doctors say leadership needs replacing after ER staffing shakeup [Internet]. cleveland. 2017 [cited 2023 Aug 24]. Available from: https://www.cleveland.com/healthfit/2017/01/summa_doctors_say_leadership_needs_replacing_after_er_staffing_shakeup.html.
[11] Ginger Christ TPD. Summa Health to relaunch emergency medicine residency program [Internet]. cleveland. 2019 [cited 2023 Aug 24]. Available from: https://www.cleveland.com/business/2019/09/summa-health-to-relaunch-emergency-medicine-residency-program.html.
[12] Transition to a Single GME Accreditation System History [Internet]. www.acgme.org. Available from: https://www.acgme.org/about/transition-to-a-single-gme-accreditation-system-history/.
[13] ACGME Institutional Requirements [Internet]. [cited 2023 Aug 24]. Available from: https://www.acgme.org/globalassets/pfassets/programrequirements/800_institutionalrequirements_2022.pdf
[14] Lin GL, Ge TJ, Pal R. Resident and fellow unions: collective activism to promote well-being for physicians in training. JAMA. 2022 Aug 16;328(7):619-20.
[15] SHRM-SCP LNP J. D., SHRM-SCP LNP J. D. Supreme Court Bans Mandatory Union Fees for Public-Sector Workers [Internet]. SHRM. 2018. Available from: https://www.shrm.org/resourcesandtools/legal-and-compliance/employment-law/pages/supreme-court-janus-union-fees.aspx

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(I-23)

Introduced by: Kelly Caverzagie, MD, Cynthia Jumper, MD, Krystal Tomei, MD, Shannon Kilgore, MD

Subject: Clarification of AMA Policy D-310-948 “Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure”

Referred to: Reference Committee C

Whereas, Report 1 of the Council on Medical Education at I-22 was titled, “The Impact of Private Equity on Medical Training” and addressed a multitude of topics focused on how private equity, and by extension, for-profit entities impact medical education; and

Whereas, one recommendation in this report was to amend AMA Policy D-310-948 “Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure” by addition to expand the current policy to broaden the scope and work of medical education organizations to collect data and information about the impact of corporate entities on medical education; and

Whereas, after passage of the policy by the House of Delegates, an unintentional error in the language of the amended policy was identified by the Council on Medical Education that materially changes the intent of the recommendation such that the word “non-profit” was used when the correct term should be “for-profit” as the subject of the actions provided in the policy; and

Whereas, it is important that policies within the AMA policy compendium be accurate with regards to their intent; therefore be it

RESOLVED, that our American Medical Association amend Policy D-310.948 “Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure” by addition and deletion to read as follows:

> Our AMA: (6) will continue to work with ACGME, interested specialty societies, and others to monitor issues, collect data, and share information related to training programs run by corporate and ~~nonprofit~~ for-profit entities and their effect on medical education. (Modify HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 9/19/23

RELEVANT AMA POLICY

Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure D-310.948
Our AMA will:
1. ask the Centers for Medicare & Medicaid Services (CMS) to stipulate in its regulations that residency slots are not assets that belong to the teaching institution;
2. encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to develop a process similar to the Supplemental Offer and Acceptance Program (SOAP) that could be used in the event of a sudden teaching institution or program closure;
3. encourage the Accreditation Council for Graduate Medical Education (ACGME) to specify in its Institutional Requirements that sponsoring institutions are to provide residents and residency applicants information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger;
4. work with AAMC, AACOM, ACGME, and relevant state and specialty societies to coordinate and collaborate on the communication with sponsoring institutions, residency programs, and resident physicians in the event of a sudden institution or program closure to minimize confusion, reduce misinformation, and increase clarity;
5. encourage ACGME to revise its Institutional Requirements, under section IV.E., Professional Liability Insurance, to state that sponsoring institutions must create and maintain a fund that will ensure professional liability coverage for residents in the event of an institution or program closure; and
6. continue to work with ACGME, interested specialty societies, and others to monitor issues, collect data, and share information related to training programs run by corporate and nonprofit entities and their effect on medical education.
Policy Timeline
CME Rep. 3, I-20Modified: CME Rep. 01, I-22.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(I-23)

Introduced by: Medical Student Section

Subject: Medical Student Reports of Disability-Related Mistreatment

Referred to: Reference Committee C

Whereas, Liaison Committee on Medical Education (LCME) standards explicitly include disability as a protected category subject to discrimination and requires medical schools to develop policies on defining, reporting, and responding to mistreatment, but no universal definition or reporting protocol for mistreatment exists[1-10]; and

Whereas, medical students with disabilities comprise 7.6% of allopathic and 4.27% of osteopathic medical school classes, and disability-related mistreatment may include denial of reasonable accommodations, exclusion from training opportunities based on disability, ableist remarks, and lower evaluations or grades due to evaluator judgments of student disability[1-5,11-16]; and

Whereas, LCME collects data on medical student mistreatment using the American Association of Medical Colleges' Medical School Graduation Questionnaire, which explicitly includes mistreatment based on race, ethnicity, gender, and sexual orientation, but not disability[5,9-10]; therefore be it

RESOLVED, that our American Medical Association work with the Association of American Medical Colleges (AAMC) and other relevant bodies to encourage data collection of medical student mistreatment based on disability as a protected category in internal and external mistreatment surveys, including the AAMC Medical School Graduation Questionnaire. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 09/11/2023

REFERENCES

1. Meeks L, Jain N. Accessibility, Inclusion, And Action In Medical Education. Accessed March 2022. Association of American Medical Colleges. 2018.
2. Liaison Committee on Medical Education. Functions and Structure of a Medical School (contains the LCME standards). Published 2021. Accessed March 10, 2022. https://lcme.org/publications.
3. O'Brien, E. Mechaber, A. Ledford, C. et al. Perception of Medical STudent Mistreatment: Does Specialty Matter? Academic medicine. 2020:97(2),247-253. doi: 10.1097/ACM.0000000000004223.
4. Gan, R. Snell, L. When the Learning Environment is Suboptimal: Exploring Medical Students' Perceptions of "Mistreatment". *Academic Medicine*. 2014:89(4),608-61. doi: 10.1097/ACM.0000000000000172.
5. Report of the Council on Medical Education. CME Report 9-A-13. Accessed March 17, 2022. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-education/cme-rpt9-a-13.pdf
6. Mistreatment of Students or Unprofessional Behavior. Wisconsin School of Medicine and Public Health Education Website. Published July 19, 2017. Accessed on March 13, 2022. https://www.med.wisc.edu/education/mistreatment-discrimination-harassment-of-students/
7. Medical Student Mistreatment Policy. UCSF School of Medicine Medical Education. Updated November 06, 2020. Accessed on March 13, 2022. https://meded.ucsf.edu/policies-procedures/medical-student-mistreatment-policy#:~:text=It%20can%20take%20the%20form,a%20sarcastic%20or%20insulting%20manner

8. Student Mistreatment. Emory University School of Medicine Website. Updated July 8 2021. Accessed on March 13, 2022. https://med.emory.edu/education/programs/md/student-handbook/policies/som/mistreatment.html
9. Association of American Medical College. 2022 AAMC Medical School Graduation Questionnaire. AAMC Website. Published 2022. Accessed March 13 2022. https://www.aamc.org/media/51116/download.
10. Liaison Committee on Medical Education. Data Collection Instrument for Full Accreditation Surveys. Published 2021. Accessed March 10, 2022. https://lcme.org/publications.
11. Meeks LM, Case B, Stergiopoulos E, Evans BK, Petersen KH. Structural Barriers to Student Disability Disclosure in US-Allopathic Medical Schools. J Med Educ Curric Dev. May 26 2021;8:23821205211018696. doi:10.1177/23821205211018696
12. Association of American Medical Colleges. Medical School Graduation Questionnaire. Published 2020. Accessed March 5, 2021.https://www.aamc.org/media/46851/download.
13. Meeks, L. M., Case, B., Plegue, M., Moreland, C. J., Jain, S., & Taylor, N. (2020, October 20). National prevalence of disability and clinical accommodations in medical education. Journal of medical education and curricular development. Retrieved April 14, 2022, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7592311/
14. Meeks L., Jain NR. The Guide to Assisting Students with Disabilities: Equal Access in Health Science and Professional Education. Online. Springer Publishing Company; 2015. Accessed March 17, 2022. https://www.perlego.com/book/1447339/the-guide-to-assisting-students-with-disabilities-pdf.
15. Cook AF, Arora VM, Rasinski KA, Curlin FA, Yoon JD. The prevalence of medical student mistreatment and its association with burnout. Acad Med. 2014 May;89(5), 749. doi:10.1097/ACM.0000000000000204.
16. Dyrbye LN, Satele D, West CP. Association of characteristics of the learning environment and US Medical Student Burnout, Empathy, and Career Regret. JAMA Netw Open. 2021 Aug 2;4(8). doi: 10.1001/jamanetworkopen.2021.19110

RELEVANT AMA POLICY

D-615.977 Advocacy for Physicians and Medical Students with Disabilities

Our AMA will: (1) establish an advisory group composed of AMA members who themselves have a disability to ensure additional opportunities for including physicians and medical students with disabilities in all AMA activities; (2) promote and foster educational and training opportunities for AMA members and the medical community at large to better understand the role disabilities can play in the healthcare work environment, including cultivating a rich understanding of so-called invisible disabilities for which accommodations may not be immediately apparent; (3) develop and promote tools for physicians with disabilities to advocate for themselves in their own workplaces, including a deeper understanding of the legal options available to physicians and medical students to manage their own disability-related needs in the workplace; and (4) communicate to employers and medical staff leaders the importance of including within personnel policies and medical staff bylaws protections and reasonable accommodations for physicians and medical students with visible and invisible disabilities. [BOT Rep. 19, I-21]

D-90.990 Evaluate Barriers to Medical Education for Trainees with Disabilities

1. Our AMA urges that all medical schools and graduate medical education (GME) institutions and programs create, review, and revise technical standards, concentrating on replacing “organic” standards with “functional” standards that emphasize abilities rather than limitations, and that those institutions also disseminate these standards and information on how to request accommodations for disabilities in a prominent and easily found location on their websites.
2. Our AMA urges all medical schools and GME institutions to: a) make available to students and trainees a designated, qualified person or committee trained in the application of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and ,available support services; b) encourage students and trainees to avail themselves of any needed support services; and c) foster a supportive and inclusive environment where students and trainees with disabilities feel comfortable accessing support services.
3. Our AMA encourages the National Board of Medical Examiners (NBME), National Board of Osteopathic Medical Examiners (NBOME), and member boards of the American Board of Medical Specialties and the American Osteopathic Association to evaluate and enhance their processes for reviewing requests for accommodations from applicants with disabilities in order to reduce delays in completion of licensing and initial board certification examinations. This should include an assessment of the experience of those applicants and the development of a transparent communication process that keeps applicants informed about the expected timeline to address their requests. These processes should require neither proof of accommodation nor proof of poor academic performance prior to the time at which a need for accommodation was requested.
4. Our AMA encourages research and broad dissemination of results in the area of disabilities accommodation in the medical environment that includes: the efficacy of established accommodations; innovative accommodation models that either reduce barriers or provide educational approaches to facilitate the avoidance of barriers; impact of disabled learners and physicians on the delivery of health

care to patients with disabilities; and research on the safety of established and potential accommodations for use in clinical programs and practice.
5. Our AMA will collaborate with the NBME and the NBOME to facilitate a timely accommodations application.
6. Our AMA recommends adherence to the ADA recommendations in section 36.309 that requires the documentation requested by a testing entity to evaluate a request for testing accommodations be both reasonable and limited to only the information needed to determine the nature of an examinee's disability and their need for the requested testing accommodations, as noted by the Civil Rights Division of the Department of Justice in their 2014 interpretation of this ADA provision.
7. Our AMA will collaborate with key stakeholders to raise awareness regarding the process for applying and preparing for examinations, inclusive of requests for accommodations. [CME Rep. 2, I-21, Appended - BOT Action in response to referred for decision: Res. 314, A-21]

H-295.955 Teacher-Learner Relationship In Medical Education
The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) *procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education*. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

CODE OF BEHAVIOR
The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.
A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.
In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.
Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.
On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.
While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a

private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.

Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients. [BOT Rep. ZZ, I-90, Reaffirmed by CME Rep, 9, A-98; Reaffirmed: CME Rep. 2, I-99, Modified: BOT Rep. 11, A-07; Reaffirmed: CME Rep. A-13, Reaffirmed: BOT Rep. 9 I-20]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(I-23)

Introduced by: Medical Student Section

Subject: Health Insurance Options for Medical Students

Referred to: Reference Committee C

Whereas, one in seven US medical students reports parental household income in the lowest two quintiles, and 6% come from households around or below the Federal Poverty Level threshold for a family of four, with Black, Latine, and Asian students disproportionately represented[1-3]; and

Whereas, the ACA allows individuals to remain on parental health coverage until age 26; and

Whereas, because student loans are not included in Annual Gross Income (AGI), many students may qualify for Medicaid or Affordable Care Act (ACA) subsidies based on income; and

Whereas, universities, including medical schools, frequently mandate health insurance as a condition of enrollment[4]; and

Whereas, medical schools who offer health insurance plans to their students may mandate that students only enroll in their plans, without any option for waivers if a student is eligible for Medicaid, ACA subsidies, parental coverage, or other comprehensive plans[5-10]; and

Whereas, median annual premium costs for medical school insurance plans are estimated at $3,000 to $4,000, ranging up to $6,500 to $7,000 (with annual increases ranging from 5-12%), substantially higher than out-of-pocket expenses with Medicaid or ACA subsidies[10-13]; and

Whereas, medical students deserve freedom to choose from all insurance plans available to them to make fiscally responsible decisions given the immense costs of medical education, as long as those plans meet standard coverage requirements; and

Whereas, the Association of American Medical Colleges (AAMC) Group on Student Affairs recommends that “medical students should be allowed to select a personal policy after providing documentation that the policy provides comparable coverage”[14]; and

Whereas, AAMC defines a leave of absence (LOA) as a period of non-enrollment during which a student is usually not required to pay tuition and fees[15]; and

Whereas, common reasons for medical student LOA include personal medical leave, disability, parental leave, caregiver responsibilities, and research or educational opportunities[16]; and

Whereas, according to a national survey of 3,162 medical students from 110 allopathic medical schools, 17.5% considered taking an LOA, while 3.8% of students ultimately took a LOA during their undergraduate medical education[17,18]; and

Whereas, Black, Asian, Native Hawaiian and Pacific Islander, American Indian and Alaska Native, Hispanic/Chicano/Latino, low-income, and disabled medical students are more likely to take LOAs compared to those from other backgrounds[18,19]; and

Whereas, in 2019, 5% of US allopathic medical students reported disabilities and chronic health conditions in 2019, which indicated an increase from prior years but is also thought to be a significant underestimate of true prevalence[20]; and

Whereas, LOA may result in loss of access to health insurance, conflicting with AAMC Group on Student Affairs Recommendations for Student Healthcare and Insurance and leaving students without coverage, especially harming students on LOA dealing with health issues[21]; and

Whereas, many medical schools that offer health insurance to students taking LOAs may restrict coverage during LOA via fewer benefits, prior authorizations, and financial barriers to disincentivize use, limiting students' ability to adequately address their needs during LOA to most efficiently return to school[22-25]; and

Whereas, AMA Policy H-405.960 "Policies for Parental, Family and Medical Necessity Leave" addresses provision for continuation of insurance benefits for physicians and residents taking leave, but not for medical students; therefore be it

RESOLVED, that our American Medical Association work with relevant parties to urge medical schools to allow students and their families who qualify for and enroll in other health insurance with equal or greater coverage, including Medicaid, the Children's Health Insurance Program (CHIP), or Affordable Care Act (ACA) Marketplace health insurance plans, to be exempt from otherwise mandatory student health insurance plans (Directive to Take Action); and be it further

RESOLVED, that our AMA support the continuation of comprehensive medical insurance benefits for students taking a leave of absence and encourage medical schools to publicize their policies regarding the continuation of insurance benefits during leaves of absence. (New HOD Policy)

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

Received: 09/27/2023

REFERENCES

1. Shahriar AA, Puram VV, Miller JM, et al. Socioeconomic Diversity of the Matriculating US Medical Student Body by Race, Ethnicity, and Sex, 2017-2019. *JAMA Netw Open*. 2022;5(3):e222621. doi:10.1001/jamanetworkopen.2022.2621
2. Household Income Quintiles. Tax Policy Center. Published January 25, 2022. Accessed March 21, 2022. https://www.taxpolicycenter.org/statistics/household-income-quintiles
3. Federal Poverty Level (FPL) - HealthCare.gov Glossary. HealthCare.gov. Accessed March 21, 2022. https://www.healthcare.gov/glossary/federal-poverty-level-fpl
4. Office USGA. Health Insurance: Most College Students Are Covered through Employer-Sponsored Plans, and Some Colleges and States Are Taking Steps to Increase Coverage. Accessed March 21, 2022. https://www.gao.gov/products/gao-08-389
5. Waivers | UCSHIP. Accessed March 21, 2022. https://www.ucop.edu/ucship/waivers/index.html#waiving
6. Mandatory Student Health Insurance (Hard Waiver Process). Campus Health. Accessed March 21, 2022. https://campushealth.unc.edu/charges-insurance/mandatory-student-health-insurance-hard-waiver-process/
7. BYU-Idaho will allow students to use Medicaid, apologizes for causing 'turmoil.' The Salt Lake Tribune. Accessed March 21, 2022. https://www.sltrib.com/news/education/2019/11/26/byu-idaho-reverses-course/
8. Wake Forest School of Medicine Student Health Insurance Plan | University Health Plans, Inc. Accessed March 21, 2022. https://www.universityhealthplans.com/WFSM
9. FAQ. Student & Occupational Health Services. Accessed March 21, 2022. https://wusmhealth.wustl.edu/students/20152016-student-health-insurance-plan/faq/
10. Tuition and Student Fees Reports. AAMC. Accessed March 21, 2022. https://www.aamc.org/data-reports/reporting-tools/report/tuition-and-student-fees-reports

11. Health Insurance for Medical Students | NYU Langone Health. Accessed April 8, 2023. https://med.nyu.edu/education/md-degree/current-md-students/student-health-wellness-services/health-insurance
12. Student health insurance: required reading. healthinsurance.org. Published February 1, 2023. Accessed April 9, 2023. https://www.healthinsurance.org/obamacare/student-health-insurance-required-reading/
13. Lederman D. U.S. Exempts Some Student Health Plans. Inside Higher Ed. Accessed April 9, 2023. https://www.insidehighered.com/news/2013/01/31/us-says-self-funded-student-health-plans-meet-obamacare-threshold
14. Association of American Medical Colleges Group on Student Affairs Recommendations for Student Healthcare and Insurance. Accessed April 10, 2023. https://www.aamc.org/media/24841/download
15. AAMC. Taking a Break from Your Medical Education. AAMC Students & Residents. Published December 12, 2022. Accessed March 8, 2023. https://students-residents.aamc.org/financial-aid-resources/taking-break-your-medical-education
16. Nguyen M, Song SH, Ferritto A, Ata A, Mason HRC. Demographic Factors and Academic Outcomes Associated With Taking a Leave of Absence From Medical School. JAMA Netw Open. 2021;4(1):e2033570. Published 2021 Jan 4. doi:10.1001/jamanetworkopen.2020.33570
17. Mytien Nguyen, M. S. (2021, January 22). Factors and outcomes associated with taking a leave of absence from medical school. JAMA Network Open. Retrieved April 9, 2023, from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2775403
18. Rajapuram N, Langness S, Marshall MR, Sammann A. Medical students in distress: The impact of gender, race, debt, and disability. PLoS One. 2020;15(12):e0243250. Published 2020 Dec 3. doi:10.1371/journal.pone.0243250
19. Meeks LM, Plegue M, Swenor BK, et al. The Performance and Trajectory of Medical Students With Disabilities: Results From a Multisite, Multicohort Study. Acad Med. 2022;97(3):389-397. doi:10.1097/ACM.0000000000004510
20. Meeks LM, Case B, Herzer K, Plegue M, Swenor BK. Change in Prevalence of Disabilities and Accommodation Practices Among US Medical Schools, 2016 vs 2019. *JAMA*. 2019;322(20):2022-2024. doi:10.1001/jama.2019.15372
21. Fallar R, Leikauf J, Dokun O, et al. Medical Students' Experiences of Unplanned Leaves of Absence. Med Sci Educ. 2019;29(4):1003-1011. Published 2019 Aug 7. doi:10.1007/s40670-019-00792-4
22. "Health Insurance for Medical Students." NYU Langone Health, https://med.nyu.edu/education/md-degree/current-md-students/student-health-wellness-services/health-insurance.
23. Brown University. Medical Leave of Absence | Graduate School. (n.d.). Retrieved April 6, 2023, from https://www.brown.edu/academics/gradschool/medical-leave-absence.
24. 2.09 leaves of absence. Student Handbook. (2021, May 4). Retrieved April 6, 2023, from https://medstudenthandbook.hms.harvard.edu/209-leaves-absence
25. Harvard University Student Health Program. Leave of Absence/Withdrawal | Harvard University Student Health Program. (n.d.). Retrieved April 6, 2023, from https://hushp.harvard.edu/leave-absencewithdrawal

RELEVANT AMA POLICY

H-295.942 Insurance Coverage for Medical Students and Resident Physicians

The AMA urges (1) all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. (5) Our AMA: (a) actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians; (b) will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance. [BOT Rep. W, I-91; Reaffirmed: BOT Rep. 14, I-93; Appended: Res. 311, I-98; Modified: Res. 306, A-04; Modified: CME Rep. 2, A-14]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(I-23)

Introduced by: American Association of Public Health Physicians

Subject: Addressing Burnout and Physician Shortages for Public Health

Referred to: Reference Committee C

Whereas, there is a clear inadequacy in the number of physicians trained in preventive medicine within the United States, posing a challenge to meeting the healthcare needs of both the immediate and long-term population[1]; and

Whereas, the Centers for Disease Control and Prevention (CDC) has announced the imminent closure of its Preventive Medicine Residency program, slated to take effect on July 1, 2024[2]; and

Whereas, a noticeable gap in Public Health physician training and funding has surfaced, often requiring a smaller number of remaining physicians to assume the roles vacated by their departing colleagues; and

Whereas, a significant knowledge deficit exists among practicing physicians, especially those in training, regarding the public health implications of climate change, despite the escalating frequency of climate-related events; and

Whereas, a core curriculum of preventive medicine residencies encompasses training in assessing and responding to population-level risks associated with environmental health, as well as the planning and evaluation of the medical components of emergency preparedness programs and training exercises[3]; and

Whereas, the CDC is grappling with substantial funding challenges, directly impacting the functioning of state and local health departments[4]; and

Whereas, according to a Medscape report Public Health and Preventive Medicine burnout has increased from last year's report[5] and given the factors that cause burnout will only continue to get worse along with our other physician specially colleagues; and

Whereas, nationally about 63% of physicians report burnout symptoms at least once per week[6]; and

Whereas, 41% of public health executives, many of whom are physicians, report feeling bullied, threatened, or harassed[7]; and

Whereas, 59% public health executives report "I have felt my public health expertise undermined or challenged"[8]; and

Whereas, nearly a third of the public health workforce plan to leave in the next year for reasons other than retirement[9]; and

Whereas, addressing physician burnout has been unequivocally placed as a top priority for our AMA as an integral part of our AMA Recovery plan for American's Physician; therefore be it

RESOLVED, that our American Medical Association vigorously advocate for expanded training opportunities within residency programs, encompassing both preventive medicine residencies and public health physician training, in addition to advocating for increased funding and heightened federal support to address the repercussions of natural disasters (Directive to Take Action); and be it further

RESOLVED, that our AMA steadfastly supports the allocation of state and national funds aimed at fortifying the roles of public health physicians, including Public Health and General Preventive Medicine Residency programs in multiple federal Public Health agencies (New HOD Policy); and be it further

RESOLVED, that our AMA unequivocally calls for the reinstatement of the CDC Preventive Medicine Residency program or Fellowship, as the CDC is the nation's premier public health agency. (New HOD Policy)

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

Received: 9/27/23

REFERENCES

1. Journal of Public Health Management & Practice, Ricketts, et al., "The Supply and Demand of the Preventive Medicine Physician Workforce" pp. s116-s122, May/June 2021, Volume 27, number 3.
2. Preventive Medicine Residency and Fellowship (PMR/F) | CDC. accessed September 24, 2023
3. Program Requirements and FAQs and Applications (acgme.org)
4. https://www.cnn.com/2023/07/14/health/cdc-funding-cuts-debt-deal/index.html
5. https://www.medscape.com/slideshow/2023-lifestyle-public-health-6016098#4
6. https://www.mayoclinicproceedings.org/article/S0025-6196(22)00515-8/fulltext accessed 9/26/2023
7. https://test-de-beaumont-foundation.pantheonsite.io/phwins/2021-findings/stress-and-burnout/
8. https://test-de-beaumont-foundation.pantheonsite.io/phwins/2021-findings/stress-and-burnout/
9. https://test-de-beaumont-foundation.pantheonsite.io/phwins/2021-findings/stress-and-burnout

RELEVANT AMA POLICY

D-440.922 Full Commitment by our AMA to the Betterment and Strengthen of Public Health System
Our AMA will: (1) champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes; (2) develop an organization-wide strategy on public health including ways in which the AMA can strengthen the health and public health system infrastructure and report back regularly on progress; (3) work with the Federation and other stakeholders to strongly support the legal authority of health officials to enact reasonable, evidence-based public health measures, including mandates, when necessary to protect the public from serious illness, injury, and death and actively oppose efforts to strip such authority from health officials; and (4) advocate for (a) consistent, sustainable funding to support our public health infrastructure, (b) incentives, including loan forgiveness and debt reduction, to help strengthen the governmental public health workforce in recruiting and retaining staff, (c) public health data modernization and data governance efforts as well as efforts to promote interoperability between health care and public health; and (d) efforts to ensure equitable access to public health funding and programs.Res.407,1-20 Modified CSPH Rep.2,I-21 Reaffirmed CMS Rep 5, A-22

H-440.965 The Future of Public Health

The AMA (1) encourages all its members to reevaluate and renew their commitment to working cooperatively with public health officials; and (2) urges its members to utilize this commitment to strengthen the quality of the delivery of public health services and to insure quality health care for all citizens within their communities. Res 82,I-88 ,Reaffirmed: sunset Report, I-98 Reaffirmed : CSCPH Rep2, A=08 Reaffirmed : CSAPH rep. 01,A-18

H-440.982 Center for Disease Control Funding

The AMA supports funding for the Centers for Disease Control that is adequate to support its important and expanding public health activities. BOT Rep.Q,I-83 Reaffirmed CLRPD Rep 1,I-93 Reaffirmed: CSA Rep8, A-o5, Reaffirmation A-15, Reaffirmed CSAPHRep 1,A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(I-23)

Introduced by: Women Physicians Section

Subject: Increasing Practice Viability for Female Physicians through Increased Employer and Employee Awareness of Protected Leave Policies

Referred to: Reference Committee C

Whereas, "Women physicians are significantly less likely to work full time than their male physician counterparts, with 77.4% of female physicians working full time within six years of completing their medical training, compared to 96.4% of male physicians"[6]; and

Whereas, "After various characteristics were controlled for, including professional work hours and spousal employment status, married or partnered female physician-researchers with children reported spending 8.5 hours per week more on parenting or domestic activities than their male counterparts"[5]; and

Whereas, according to the U.S. Department of Labor, the Family Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave[3]; and

Whereas, based on findings of the 2018 FMLA Employee survey, 24% of women reported a need for leave compared to men and took leave more often (18% versus 14%)[4]; and

Whereas, additional findings from the 2018 FMLA Employee survey indicated that "substantially fewer women than men receive full pay (32 percent versus 55 percent) while on leave, and more receive no pay (41% versus 25%)". Survey findings also noted these differences were not exclusively determined by women taking longer leaves[4]; and

Whereas, "Overall, 7% of employees surveyed reported needing but not taking leave ('unmet need') for a qualifying FMLA reason in the previous 12 months"[4]; and

Whereas, beginning July 1, 2022, the ACGME required all Accreditation Council for Graduate Medical Education-accredited Programs to offer six weeks of paid leave to residents and fellows for medical, parental and caregiver leave, "for qualifying reasons that are consistent with applicable laws at least once and at any time during an ACGME-accredited program"[1]; and

Whereas, in July 2021, all American Board of Medical Specialties Member Boards with training programs of two or more years duration allowed for a minimum of six weeks away during training for purposes of parental, caregiver, and medical leave, without exhausting time allowed for vacation or sick leave nor requiring an extension in training[2]; therefore be it

RESOLVED, that our American Medical Association oppose any discrimination related to physicians taking protected leave during training and/or medical practice for medical, religious, and/or family reasons (New HOD Policy); and be it further

RESOLVED, that our AMA encourage relevant stakeholders to survey physicians and medical students who have taken family leave, in an effort to learn about the experiences of various demographic groups and identify potential disparities in career progression trends. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/5/23

REFERENCES

1. ACGME Institutional Requirements. 2021-2022. Copyright 2021 Accreditation Council for Graduate Medical Education (ACGME) ACGME-approved focused revision: September 26, 2021; effective July 1, 2022. Last accessed: 31 August 2023. ACGME Institutional Requirements
2. "ABMS Announces Progressive Leave Policy for Residents and Fellows." 13 July 2020. Last accessed: 31 August 2023. Copyright 2023 American Board of Medical Specialties. ABMS Announces Progressive Leave Policy for Residents and Fellows
3. "Family and Medical Leave Act." Wage and Hour Division. Copyright 2023 U.S. Department of Labor. dol.gov/agencies/whd/fmla.
4. Herr, J., Roy, R., & Klerman, J. A. (2020). Gender Differences in Needing and Taking Leave. Produced for the U.S. Department of Labor, Chief Evaluation Office. Rockville, MD: Abt Associates Inc. Gender Differences in Needing and Taking Leave
5. Jolly S, Griffith KA, DeCastro R, Stewart A, Ubel P, Jagsi R. Gender differences in time spent on parenting and domestic responsibilities by high-achieving young physician-researchers. Ann Intern Med. 2014 Mar 4;160(5):344-53. doi: 10.7326/M13-0974. PMID: 24737273; PMCID: PMC4131769.
6. Paturel, Amy. "Why Women Leave Medicine." AAMC News. Association of American Medical Colleges. Copyright 2019. Last accessed: August 31, 2023. https://www.aamc.org/news/why-women-leave-medicine

RELEVANT AMA POLICY

FMLA Equivalence H-270.951
Our AMA will advocate that Family and Medical Leave Act policies include any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship. [Res. 002, A-18]

Policies for Parental, Family and Medical Necessity Leave H-405.960
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA will study the impact on and feasibility of medical schools, residency programs, specialty boards, and medical group practices incorporating into their parental leave policies a 12-week minimum leave allowance, with the understanding that no parent be required to take a minimum leave.
5. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed.

6. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
7. Medical students and physicians who are unable to work because of pregnancy, childbirth, abortion or stillbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
8. Residency programs should develop written policies on leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) duration of leave allowed after abortion or stillbirth; (d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (e) whether leave is paid or unpaid; (f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance; (h) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (i) how time can be made up in order for a resident physician to be considered board eligible; (j) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (k) whether time spent in making up a leave will be paid; and (l) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
9. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical students to be eligible for graduation with minimal or no delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.
10. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
11. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
12. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
13. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
14. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.
15. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
16. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.
17. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.
18. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship. [CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22; Modified: Res. 302, I-22; Modified: Res. 312, I-22]

Compassionate Leave for Medical Students and Physicians H-405.947

1. Our AMA urges medical schools, residency and fellowship training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit agreement.
2. Our AMA will study components of compassionate leave policies for medical students and physicians to include:
a. whether cases requiring extensive travel qualify for additional days of leave and, if so, how many days;
b. policy and duration of leave for an event impacting pregnancy or fertility including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, a failed surrogacy arrangement, or an event that impacts pregnancy or fertility;
c. whether leave is paid or unpaid;
d. whether obligations and time must be made up; and
e. whether make-up time will be paid.
3. Our AMA encourages medical schools, residency and fellowship programs, specialty boards, specialty societies and medical group practices to incorporate into their compassionate leave policies a three-day minimum leave, with the understanding that no medical student or physician should be required to take a minimum leave.
4. Medical students and physicians who are unable to work beyond the defined compassionate leave period because of physical or psychological stress, medical complications of pregnancy loss, or another related reason should refer to their institution’s sick leave policy, family and medical leave policy, and other benefits on the same basis as other physicians who are temporarily unable to work for other reasons.
5. Our AMA will study the concept of equal compassionate leave for pregnancy loss and other such events impacting fertility in a physician or their partner as a benefit for medical students and physicians regardless of gender or gender identity.
6. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
7. These guidelines as above should be freely available online and in writing to all applicants to medical school, residency, or fellowship. [Res. 309, I-22]

Reference Committee F

Report(s) of the Board of Trustees

12 American Medical Association Meeting Venues and Accessibility
13 House of Delegates (HOD) Modernization

Report(s) of the Council on Long Range Planning and Development

01 Women Physicians Section Five-Year Review

Report(s) of the HOD Committee on Compensation of the Officers

01 Report of the House of Delegates Committee on the Compensation of the Officers

Report(s) of the Speakers

02 Extending Online Forum Trial Through A-24

Resolutions

601 Carbon Pricing to Address Climate Change
606 Prevention of Healthcare-Related Scams
608*Confronting Ageism in Medicine

***Not yet reviewed for consideration by the Resolution Committee**

REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-I-23

Subject: American Medical Association Meeting Venues and Accessibility (Resolution 610-A-22, Resolve 2; and Resolution 602-I-22)

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

Referred to: Reference Committee F

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

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

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

AMA policy on lodging and accommodations includes the following:

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

2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.

3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has regulation or ~~enacted comprehensive~~ legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy.

4. It is the policy of our AMA not ~~to hold meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or~~ pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.

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

6. All future AMA meetings will be structured to provide accommodations for members and invited attendees who are able to physically attend, but who need assistance in order to meaningfully participate.

7. Our AMA will revisit our criteria for selection of hotels and other venues in order to facilitate maximum participation by members and invited attendees with disabilities.

8. Our AMA will report back to the HOD by no later than the 2023 Annual Meeting with a plan on how to maximize meeting participation for members and invited attendees with disabilities.

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

RESOLUTION 602-I-22

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

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

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

While Policy G-630.140 supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors, there are already very few venues that can accommodate the House (and its many associated ancillary meetings of the sections, caucuses, etc.)

meeting without requiring multiple hotels and a convention center. Additionally, the size of the House is increasing. There are now over 700 delegate slots, with a corresponding number of alternate delegates, though not all credential or attend the meetings. This number further limits the venues that are options for our Annual and Interim Meetings.

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

RESOLUTION 610-A-22, RESOLVE 2

As noted above, Board of Trustees Report 18-A-23 responded to the following adopted resolve of Resolution 610-A-22: That our AMA report back to the HOD by no later than the 2023 Annual Meeting with a plan on how to maximize meeting participation for members and invited attendees with disabilities. BOT Report 18-A-23 covered in detail accessibility options already in place for meeting attendees with disabilities. This report thus only will discuss the referred resolve asking that our AMA investigate ways of allowing meaningful participation in all meetings of the AMA by members who are limited in their ability to physically attend meetings.

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

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

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

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

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

DISCUSSION

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

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

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

CONCLUSION

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

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

RECOMMENDATION

The Board of Trustees therefore recommends that Policy G-630.140, "Lodging, Meeting Venues, and Social Functions," be amended by addition and deletion as follows in lieu of Resolution 610-A-22, Resolve 2, and Resolution 602-I-22, and the remainder of this report be filed:

AMA policy on lodging and accommodations includes the following:

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

2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.

3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted regulation or legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy.

4. It is the policy of our AMA not to ~~hold meetings and/or primarily sponsored by our AMA or~~ pay member officer or employee dues in any club, restaurant, or other institution that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.

5. Our AMA will not hold meetings organized by or primarily sponsored by our AMA at venues that have exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.

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

7. All future AMA meetings will be structured to provide accommodations for members and invited attendees who are able to physically attend, but who need assistance in order to meaningfully participate.

8. Our AMA will revisit our criteria for selection of hotels and other venues in order to facilitate maximum participation by members and invited attendees with disabilities.

9. Our AMA will utilize security experts to assess the safety risk for our attendees and guests at all venues. (Modify Current HOD Policy)

Fiscal Note: No significant fiscal impact

REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-I-23

Subject: House of Delegates (HOD) Modernization (Resolution 622-A-22)

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

Referred to: Reference Committee F

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

BACKGROUND

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

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

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

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

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

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

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

CONCLUSION

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

RECOMMENDATION

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

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

Fiscal Note: $150 to update these policies in PolicyFinder.

RELEVANT AMA POLICY

Directives from the Election Task Force D-610.998(10)
Review of Implementation
10. After an interval of 2 years a review of our election process, including the adopted Recommendations from this report, be conducted by the Speaker and, at the Speakers discretion the appointment of another election task force, with a report back to the House.

Speakers Task Force to Review and Modernize the Resolution Process (Res 604-A-23 get policy #)
1. Our American Medical Association form a Speakers Task Force on the Resolution Process to review the entire process of handling resolutions for our AMA House of Delegates, including but not limited to definitions of on time resolutions, emergency resolutions, and late resolutions, deadlines for submission of resolutions by all sections, processing and review of reference committee reports, and use of virtual meetings so that all on time resolutions can be submitted by the same deadline.
2. Our AMA Speakers Task Force on the Resolution Process report back to our AMA House of Delegates by the 2024 Annual Meeting with recommendations regarding the resolution process.

Increasing the Effectiveness of Online Reference Committee Testimony D-600.956
1. Our AMA will conduct a trial of two-years during which all reference committees, prior to the in-person reference committee hearing, produce a preliminary reference committee document based on the written online testimony.
2. The preliminary reference committee document will be used to inform the discussion at the in-person reference committee.
3. There be an evaluation to determine if this procedure should continue.
4. The period for online testimony will be no longer than 14 days.

Surveillance Management System for Organized Medicine Policies and Reports (BOT Report 20-A-23 get policy #)
1. Our AMA maintains the existing resolution management structure within the House of Delegates without imposing a potentially confusing or unsustainable prioritization matrix on delegates and reference committees.
2. That our AMA continues to invest in critical information technology and other appropriate infrastructure that allows for the tracking of past resolutions, existing policy, and supporting materials.

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-I-23

Subject: Women Physicians Section Five-Year Review

Presented by: Gary Thal, MD, Chair

Referred to: Reference Committee F

AMA Bylaw 7.0.9 states, "A delineated section must reconfirm its qualifications for continued delineated section status and associated representation in the House of Delegates by demonstrating at least every 5 years that it continues to meet the criteria adopted by the House of Delegates." AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and Development (CLRPD) is "to evaluate and make recommendations to the House of Delegates, through the Board of Trustees, with respect to the formation and/or change in status of any section. The Council will apply criteria adopted by the House of Delegates."

The Council believes the five-year review cycle offers an excellent opportunity to provide the House of Delegates (HOD) with updates on section activities to ensure that these sections continue to meet HOD goals. The Council assessed information from the letter of application submitted by the Women Physicians Section (WPS) for renewal of delineated section status, which is presented in the discussion section of this report.

APPLICATION OF CRITERIA TO THE WOMEN PHYSICIANS SECTION

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

The WPS identified the following priority areas of concern as focal points of the last five years: issues/concerns of women physicians and women patients, such as gender discrimination; underrepresentation of women physician leaders; health issues that disproportionately impact women patients; and gender bias and discrimination with professional development and advancement of women in medicine.

The Council asked the section what actions have been taken on these issues, as well as the results of those activities. On the issue of gender discrimination and inequities in professional development, the WPS submitted resolutions on topics related to salary transparency, female physician work patterns, maternal discrimination, and caregiver burnout. WPS resolutions resulted in the establishment of two new AMA policies and the amendment of three AMA policies.

On health issues that disproportionally or uniquely impact women patients, WPS resolutions resulted in the establishment of 10 new AMA policies and the amendment of 16 AMA policies. On the issue of under-representation of women physician leaders in organized medicine and academic medicine, the WPS continues work on the WPS Pathway to Leadership education series and provides EdHub content on negotiation skills for women in medicine and other appropriate topics.

Criterion 2: Consistency – Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.

Over the past five years, the WPS collaborated with the Medical Student Section on joint educational sessions and mentoring events, partnered with the Organized Medical Staff Section to host a webinar entitled, "Unique Challenges Facing Women Physicians During COVID-19," and co-hosted several education sessions with other AMA sections. Additionally, WPS partnered with the AMA Alliance for WPS members to periodically serve as guest authors for *Physician Family* magazine (a quarterly publication produced by the AMA Alliance).

Each year, the WPS governing council (GC) coordinates with staff to identify strategic directives for the section. Section activities have focused on support to increase leadership opportunities, social media presence, mentorship, and collaboration. The WPS leads the AMA's Women in Medicine (WIM) event each September. During this time, the WPS implements two major programs: Inspirational Physicians Recognition Program (formerly the Physician Mentor Recognition Program), which provides an opportunity for physicians to express appreciation to the special men and women who have offered time, wisdom, and support throughout their professional journeys, and the Joan F. Giambalvo Fund for the Advancement of Women (formerly the Giambalvo Memorial Scholarship Fund). The AMA Foundation, in association with the WPS, established the Fund with the goal of advancing the progress of women in the medical profession and strengthening the ability of the AMA to identify and address the needs of women physicians and medical students.

Criterion 3: Appropriateness – The structure of the group will be consistent with its objectives and activities.

Membership of the WPS consists of 1) automatic enrollment of all female physician and medical student members of the AMA as identified in the AMA Masterfile, 2) an "opt-out" mechanism for female AMA members who do not wish to be WPS members, and 3) an "opt-in" mechanism for any other active AMA member who wishes to join the WPS. The structure of the section has remained stable over time and continues to support opportunities for members to contribute to the governance, leadership, objectives, and activities of WPS.

The WPS convenes a GC from its members and holds strategic planning meetings to plot its annual and long-term goals and ensure alignment with the goals of the AMA. All section members have opportunities throughout the year to contribute to the deliberations of the WPS either in person or by virtual means such as AMA HOD Meetings, Online Forums, listservs, X (formerly Twitter), and special interest Facebook groups.

HOD Meetings provide specific opportunities for members to participate in the section:

- Submit a resolution to the WPS or join the WPS policy committee to develop resolutions for consideration by the section.
- Participate in the WPS Online Forum to review and ratify resolutions.
- Comment on pending HOD reports and resolutions to determine WPS position.
- Attend educational sessions at the Annual and Interim Meetings.

In addition, WPS members can:

- Serve as a WPS Associate for their state and specialty societies.
- Run for a seat on the GC – the Council meets three times a year; two of the meetings are in connection with the AMA Annual and Interim Meetings.
- Participate in the WIM event every September.
- Apply for a grant through the Joan F. Giambalvo Fund for the Advancement of Women.
- Nominate their mentors through the Inspirational Physician Award.

Additionally, the WPS continues to work with the American Medical Women's Association to cross promote programs and meetings.

Criterion 4: Representation Threshold – Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members.

The WPS membership is defined in the AMA's Bylaws as follows:

- 7.10.1 Membership. All female physicians and medical students who are active members of the AMA shall be eligible to be members of the Women Physicians Section.
- 7.10.11 Other active members of the AMA who express an interest in women's issues shall be eligible to join the section.

According to CLRPD Report 1-JUN-21, Demographic Characteristics of the House of Delegates and AMA Leadership (hereinafter referred to as the "2021 CLRPD report"), there are 103,229 female members in the AMA. In addition, several male members have chosen to join the WPS. When the WPS was established as a section in 2013, there were 67,000 female members.

Criterion 5: Stability – The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians will be represented by this section and both the segment and the AMA will benefit from an increased voice within the policymaking body.

WPS membership has increased over the past five years. Overall, continuous efforts have been made to increase member engagement in section policymaking activities (net increase of 85 percent) and to promote participation in networking and professional development opportunities. Engagement through AMA communication channels (i.e., monthly member newsletters, AMA social channels, and AMA web) help create awareness of AMA as well as WPS resources and events of significance to women in medicine. Special communications during Women's History Month and Women in Medicine Month have helped develop member sentiment and resulted in new member conversions.

Since 2017, there have been a total of 15 openings and 38 applications for WPS GC positions. These positions were filled by election and/or appointment. Since the inception of the WPS policy committee in 2016, there have been consistent inquiries and/or requests to join the committee. The most notable increase occurred in 2022, where the committee size increased by 92 percent (from 12 members in 2021 to 23 members in 2022). WPS members can join the committee by sending an email to section staff. The number of WPS HOD Handbook Review volunteers increased consistently over the last five years. In 2022, there was a 145 percent increase in volunteers for the Annual and Interim meetings (combined). WPS members can join

through the Annual and Interim meeting registration or by sending an email to section staff. Handbook Review volunteers have an opportunity to serve as the Chair of each review committee.

Criterion 6: Accessibility - Provides opportunity for members of the constituency who are otherwise under-represented to introduce issues of concern and to be able to participate in the policymaking process within the AMA House of Delegates (HOD).

Board Report 19-A-22, Demographic Report of the House of Delegates and AMA Membership, indicates that female physicians are slightly under-represented among delegates and alternate delegates (35.4 percent) compared to AMA members (38.6 percent) and total physicians and medical students in the United States (36 percent). Moreover, the 2021 CLRPD report indicates that female physicians are under-represented among delegates. Women represent 38 percent of all AMA members, and only 30.7 percent of delegates are female. Additionally, women make up 35.5 percent of the total physicians and medical students in the United States. This report further notes that women physicians make up 36.1perrcent of AMA members across the states; however, only 28.1 percent of state delegates and alternates are women.

Between year-end 2016 and year-end 2020, female physician representation among alternate delegates and AMA Councils, Sections and Special Groups increased by 9.9- and 9.4- percentage points, respectively. Representation of female physicians on the AMA Board (35 percent) reflects a five-percentage point increase and is comparable to AMA members and total physicians and medical students in the United States.

The WPS convenes an HOD Handbook Review Committee prior to each WPS business meeting. The committee reviews reports and resolutions that have been submitted to the HOD and identifies issues relevant to the WPS or that are of timely significance to the profession of medicine. The committee recommendations are shared during the WPS business meeting, which convenes prior to the opening of the HOD. Overall, this process allows for discussion and development of a position, which then guides the WPS delegate and alternate delegate as they testify on the section's behalf.

CLRPD DISCUSSION

AMA Policy G-615.002, "AMA Member Component Groups," states that "Delineated Sections will allow a voice in the house of medicine for large groups of physicians, who are connected through a unique perspective, but may be under-represented. These sections will often be based on demographics or mode of practice." The AMA is well positioned to represent and address the specific interests and needs of defined physician groups, with benefits to those groups and the Association as a whole.

The CLRPD commends the WPS for focusing on issues/concerns of women physicians as well as women's health for patients and for offering numerous activities focused on these areas of medicine and health care. While strides have been made among women physicians in leadership positions, these physicians remain under-represented. Additionally, the current climate in the United States, including lack of access to care, contributes to prevailing/escalating women health issues, which are of critical importance. Therefore, these concerns remain priorities for the section. The WPS serves its constituents by bringing professional issues unique to women physicians to the forefront of organized medicine, and by providing targeted educational programs and resources for the policymaking process.

The structure of the section has been consistent with its objectives and activities, (e.g., processes for HOD handbook review and submission of resolutions, and member participation in the WPS online forum and educational sessions at annual and interim meetings), which reflects thoughtful consideration when the section was formed. The WPS is comprised of members from an identifiable segment of AMA membership and the general physician population and represents a substantial number of members; however, these physicians remain under-represented compared to total AMA and U.S. populations of physicians and medical students. AMA Physician Masterfile data indicate that the number of women physicians and medical students has grown steadily for a decade, highlighting the alignment of the WPS with potential AMA membership growth.

The WPS meetings, elections, and educational sessions are well attended and demonstrate increasing engagement, while strategies are in place to further increase participation. The population of potential WPS members continues to expand. The AMA has benefited from an increased voice of WPS members within the policymaking body of the Association. CLRPD members noted that three of the past six AMA presidents were female physicians. Further, since the WPS was initiated, and the Women Physicians Congress that preceded the section, more women physicians have reached the highest level of leadership within the Association than previously recorded.

The section provides numerous opportunities for members of the constituency to introduce issues of concern and participate in the HOD policymaking process. The WPS has continually pursued ways to improve member communications and the resolution process, thereby encouraging member involvement. The WPS provides a formal structure for women physicians to participate directly in the deliberations of the HOD and impact policy.

In closing, CLRPD members determined that the WPS meets all criteria. The Council thanks WPS leadership, section members, and staff for their thoughtful work on the reapplication process, their continued contributions to ensure that the perspectives of women physicians remain prominent in the AMA policymaking process, and all their efforts on behalf of women physicians and female patients in the United States.

RECOMMENDATION

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Women Physicians Section through 2028 with the next review no later than the 2028 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Within current budget

REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Compensation Committee Report, I-2023

Subject: REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Presented by: Claudette Dalton, MD, Chair

Referred to: Reference Committee F

This report by the committee at the November 2023 Interim Meeting includes one recommendation and documents the compensation paid to Officers for the period July 1,2022 through June 30, 2023, including 2022 calendar year IRS reported taxable value of benefits, perquisites, services, and in-kind payments for all Officers.

BACKGROUND

At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on Trustee Compensation, currently named the Committee on Compensation of the Officers, (the "Committee"). The Officers are defined in the American Medical Association's (AMA) Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the HOD, Article V refers simply to "Officer," which includes all 21 members of the Board among whom are President, President-Elect, Immediate Past President, Secretary, Speaker and Vice Speaker of the HOD, collectively referred to in this report as Officers.) The composition, appointment, tenure, vacancy process and reporting requirements for the Committee are covered under the AMA Bylaws. Bylaws 2.13.4.5 provides:

> The Committee shall present an annual report to the House of Delegates recommending the level of total compensation for the Officers for the following year. The recommendations of the report may be adopted, not adopted, or referred back to the Committee, and may be amended for clarification only with the concurrence of the Committee.

At A-00, the Committee and the Board jointly adopted the American Compensation Association's definition of total compensation which was added to the Glossary of the AMA Constitution and Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an individual for work performance, including: (a) all forms of money or cash compensation; (b) benefits; (c) perquisites; (d) services; and (e) in-kind payments.

Since the inception of this Committee, its reports document the process the Committee follows to ensure that current or recommended Officer compensation is based on sound, fair, cost-effective compensation practices as derived from research and use of independent external consultants, expert in Board compensation. Reports beginning in December 2002 documented the principles the Committee followed in creating its recommendations for Officer compensation.

CASH COMPENSATION SUMMARY

The cash compensation of the Officers shown in the following table will not be the same as compensation reported annually on the AMA's IRS Form 990s because Form 990s are based on a calendar year. The total cash compensation in the summary is compensation for the days these officers spent away from home on AMA business approved by the Board Chair. The total cash compensation in the summary includes work as defined by the Governance Honorarium, Per Diem for Representation and Telephone Per Diem for External Representation. Detailed definitions are in the Appendix.

The summary covers July 1, 2022 to June 30, 2023.

AMA Officers	Position	Total Compensation	Total Days
David H Aizuss, MD	Officer	$ 69,800	46
Toluwalase A Ajayi, MD	Officer	$ 70,500	42.5
John H. Armstrong, MD	Officer	-	2.5
Madelyn E. Butler, MD	Officer	$ 79,600	54
Alex Ding, MD, MS, MBA	Officer	$ 69,800	53
Willarda V Edwards, MD, MBA	Officer	$ 81,000	52.5
Lisa Bohman Egbert, MD	Vice Speaker, House of Delegates	$ 141,200	97
Jesse M Ehrenfeld, MD, MPH	President-Elect	$ 284,960	93
Scott Ferguson, MD	Officer	$ 74,700	53
Sandra Adamson Fryhofer, MD	Chair	$ 283,080	99.5
Gerald E Harmon, MD	Immediate Past President	$ 284,960	111
Drayton Charles Harvey	Officer	$ 74,000	49
Marilyn Heine, MD	Officer	$ 73,300	48
Pratistha Koirala, MD	Officer	$ 67,000	42
Ilse R Levin, DO, MPH & TM	Officer	$ 74,700	46.5
Thomas J Madejski, MD	Officer	$ 83,800	60
Bobby Mukkamala, MD	Chair	$ 97,100	68.5
Harris Pastides, PhD, MPH	Public Board Member Officer	$ 69,800	37.5
Jack Resneck, Jr, MD	President	$ 290,160	141.5
Bruce A Scott, MD	Speaker, House of Delegates	$ 113,900	92.5
Aliya Siddiqui, MS	Officer	-	3
Michael Suk, MD, JD, MPH, MBA	Secretary	$ 79,600	75
Willie Underwood, III, MD, MSc, MPH	Chair- Elect	$ 207,480	92.5

President, President-Elect, Immediate Past President, and Chair
In 2022-2023, each of these positions received an annual Governance Honorarium which was paid in monthly increments. These four positions spent a total of 445 days on approved Assignment and Travel, or 111.3 days each on average.

Chair-Elect
This position received a Governance Honorarium of approximately 75% of the Governance Honorarium provided to the Chair.

All Other Officers
All other Officers received cash compensation, which included a Governance Honorarium of $67,000 paid in monthly installments.

Assignment and Travel Days
As defined, these are Travel Days that are approved by the Board Chair to externally represent the AMA and for Internal Representation above 11 days. These days were compensated at a per diem rate of $1,400. The total Assignment and Travel Days for all Officers (excluding the President, President-Elect, Immediate Past President and Chair) were 1,015.

EXPENSES

Total expenses paid for period, July 1, 2022 – June 30, 2023, was $967,741, without use of upgrade allowance of $5,000 for Presidents and $2,500 all other Officers per position per term. Total upgrade allowances used for the period were $28,166.

BENEFITS, PERQUISITES, SERVICES, AND IN-KIND PAYMENTS

Officers are able to request benefits, perquisites, services, and in-kind payments, as defined in the "AMA Board of Trustees Standing Rules on Travel Expenses." These non-taxable business expense items are provided to assist the Officers in performing their duties.

- AMA Standard laptop computer or iPad
- American Express card (for AMA business use)
- Combination fax/printer/scanner (reimbursable up to $250)
- An annual membership to the airline club of choice offered each year during the Board member's tenure
- Personalized AMA stationery, business cards, and biographical data for official use

Additionally, all Officers are eligible for $305,000 term life insurance and are covered under the AMA's $500,000 travel accident policy and $10,000 individual policy for medical costs arising out of any accident while traveling on official business for the AMA. Life insurance premiums paid by the AMA are reported as taxable income. Also, travel assistance is available to all Officers when traveling more than 100 miles from home or internationally.

Secretarial support, other than that provided by the AMA's Board office, is available up to defined annual limits as follows: President, during the Presidential year, $15,000, and $5,000 each for the President-Elect, Chair, Chair-Elect, and Immediate Past President per year. Secretarial expenses incurred by other Officers in conjunction with their official duties are paid up to $750 per year per Officer. This is reported as taxable income.

Officers are also eligible to participate in a service provided to AMA employees by Care@Work through Care.com. This service offers referral services at no cost and back-up care for children and adults up to 10 days a calendar year at a subsidized rate. If a Board member uses back-up care, it will be reported to the IRS as taxable income.

Calendar year taxable life insurance and taxable secretarial fee reported to the IRS totaled $41,394 and $44,750 respectively for 2022. An additional $6,625 was paid to third parties for secretarial services during 2022.

METHODOLOGY

Early in 2023, the Committee commissioned Ms. Becky Glantz Huddleston, an expert in board compensation with WTW, to review and update the 2018 research on compensation of the Officers focusing on the leadership positions: President, President-Elect, Immediate Past President, Chair and Chair-Elect. The purpose of the review was to ensure the leadership roles are compensated appropriately for the work performed on behalf of the AMA.

The Committee's review and subsequent recommendations for leadership compensation are based on the principle of the value of the work performed as affirmed by the HOD. In addition, the following additional guidelines were followed:

- Compensation should take into account that the AMA is a complex organization when comparing compensation provided to Board members by for-profit and by complex not-for-profit of similar size and complexity.
- Compensation should be aligned with long term interests of AMA members and fulfillment of the fiduciary responsibilities of the Officers.
- Officers should be adequately compensated for their value, time and effort.
- Compensation should reinforce choices and behaviors that enhance effectiveness.

The process the Committee followed along with the principles previously noted, is consistent with IRS recommended guidelines for determining reasonable and competitive levels of compensation.

The Committee, with the assistance of Ms. Huddleston developed their recommendations based on:

- The current compensation structure.
- Review and analysis of leadership compensation for the past two terms so that the data reflects more of a 'normal' post-Covid schedule.
- Pay practices for leadership positions at for-profit and not-for-profit organizations similar to the AMA who pay and their Board members.
- A collaborative, deliberative and objective review process.

FINDINGS

The Committee notes that the Board leadership roles President, President-Elect, Immediate Past President, Chair, and Chair-Elect continue to make significant time commitments in supporting our AMA in governance and representation function and that representations work is unique to AMA leadership and officer roles.

AMA's leadership roles have a significant level of responsibility, resulting in a time commitment well above that required by other not-for-profit boards. As a result, to assess AMA compensation levels versus the not-for-profits compensation levels, a two-year average hourly rate was determined for each AMA leadership position aligned with the hourly rate for the Chair position at other not-for-profit organizations and associations. The three President and Chair-Elect positions are unique to the AMA and as such, these roles were also aligned to the external data of the Chair position.

The report concluded that while leadership compensation structure is generally aligned with the external market data, modest increases are appropriate to better align AMA leadership compensation to the market median hourly rate of the peer group. In determining its recommendation, the Committee considered the importance of the President's role in externally

representing the AMA while keeping in mind the AMA's Compensation Philosophy for Officers that requires a consideration of a volunteerism component in their compensation while fairly compensating leadership for the level of fiduciary responsibilities and the time commitment required of the roles. As such, the Committee is recommending a modest increase of 3% for the President's honorarium and 2% for all other leadership honoraria, recognizing that this will be the first increase in six years.

RECOMMENDATIONS

The Committee on Compensation of the Officers recommends the following recommendation be adopted and the remainder of this report be filed:

1. That the President honorarium be increased by 3% and that the President-Elect, Immediate Past-President, Chair and Chair-Elect honoraria be increased by 2% effective July 1, 2024. These increases result in the following Honoraria:

POSITION	**GOVERNANCE HONORARIUM**
President	$298,865
Immediate Past President	$290,659
President-Elect	$290,659
Chair	$285,886
Chair-Elect	$211,630

Fiscal Note: $29,861

APPENDIX

Definition of Governance Honorarium Effective July 1, 2017:

The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board Committee meetings, task forces, subcommittees, Board orientation, development and media training, Board calls, sections, councils, or other internal representation meetings or calls, and any associated review or preparatory work, and all travel days related to all meetings as noted up to eleven (11) Internal Representation days.

Definition of Per Diem for Representation effective July 1, 2017:

The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating, achievement of the respective organization goals such as the AMA Foundation, PCPI, etc. or for Internal Representation days above eleven (11). The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather-related travel delays. Per Diem for Chair-assigned representation and related travel is $1,400 per day.

Definition of Telephone Per Diem for External Representation effective July 1, 2017:

Officers, excluding the Board Chair and the President(s) who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation days above eleven (11), receive a per diem for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for those meetings would require the approval of the Chair of the Board. The amount of the Telephonic Per Diem will be ½ of the full Per Diem which is $700.

REPORT OF THE SPEAKERS

Speakers Report 02-I-23

Subject:	Extending Online Forum Trial Through A-24
Presented by:	Lisa Bohman Egbert, MD, Speaker; and John H. Armstrong, MD, Vice Speaker
Referred to:	Reference Committee F

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

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

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

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

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

For I-23, the Speakers have redefined the deadlines for resolution submission to enable the single posting of the entire handbook (without an addendum), minus the exempted resolutions. Likewise, the entire handbook was made available for comments on the Online Forum for its 14 day window. In addition, the Speaker instructed reference committees and their staff to enhance their

preliminary documents to better *"inform the discussion at the in-person reference committee"* hearings. The outcome of these changes is yet to be determined.

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

RECOMMENDATION:

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(I-23)

Introduced by: Medical Student Section

Subject: Carbon Pricing to Address Climate Change

Referred to: Reference Committee F

Whereas, the World Health Organization, NIH, and multiple meta-analyses of thousands of studies and millions of mortality cases all estimate that climate change will contribute to hundreds of thousands of deaths annually from 2030 to 2050, due to chronic and communicable diseases, malnutrition, and heat stress[1-9]; and

Whereas, carbon pricing places a price on carbon dioxide emissions through either carbon taxes or cap-and-trade systems to economically incentivize their reduction and mitigate their contribution to climate change[10-16]; and

Whereas, William Nordhaus won the 2018 Nobel Prize in Economics for demonstrating that global carbon pricing with full international participation would be the most efficient and effective method for reducing greenhouse gas emissions, although his model also showed that if only half of the world's carbon emitters participated, costs would increase by 150%[15-22]; and

Whereas, the 2019 Economists' Statement on Carbon Dividends signed by 3,500 economists, including 4 former US Federal Reserve Chairs, 15 former US Council of Economic Advisors Chairs, and 28 Nobel laureates, states that "a carbon tax offers the most cost-effective lever to reduce carbon emissions at the scale and speed that is necessary"[23]; and

Whereas, carbon pricing reduces harmful air pollution and creates revenue that can be reinvested in healthcare, public health, and energy efficiency[21,23-27]; and

Whereas, a Stanford Energy Modeling Forum study used 11 economic models, which all concluded that a carbon tax would substantially reduce emissions with no major risk to economic growth (a maximum of only 0.1%)[28]; and

Whereas, Ireland's carbon tax has reduced emissions by 15% since 2008, including a 7% decrease in 2011 even as their economy grew that year[29-32]; and

Whereas, Australia's 2012 carbon tax drastically decreased emissions and coal use but was repealed in 2014, immediately resulting in rebound emission and coal increases[33-35]; and

Whereas, California's cap-and-trade system regulates emissions and increases alternative energy use, resulting in a return to 1990 emission levels 4 years ahead of schedule[24,26,36-37]; and

Whereas, the Regional Greenhouse Gas Initiative (RGGI) cap-and-trade system across 12 states decreased emissions by 35% over 5 years, compared to only 12% in other states[24,38]; and

Whereas, carbon pricing is used by 52 national or regional governments, who comprise 20% of global greenhouse gas emissions[24,39-42]; and

Whereas, our AMA declared climate change a public health crisis and "will advocat[e] for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at carbon neutrality by 2050…"; therefore be it

RESOLVED, that our American Medical Association amend D-135.966 by addition and deletion to read as follows:

> Declaring Climate Change a Public Health Crisis D-135.966
> Our AMA:
> 1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.
> 2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.
> 3. Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge or making a similar commitment to lower its own greenhouse gas emissions.
> 4. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050.
> 5. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.
> 6. Our AMA will advocate for federal and state carbon pricing systems and for US support of international carbon pricing.
> 7. Our AMA will work with the World Medical Association and interested countries' medical associations on international carbon pricing and other ways to address climate change. (Modify Current HOD Policy)

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

Received: 09/11/2023

REFERENCES

1. Butler, Colin D. "Climate Change, Health and Existential Risks to Civilization: A Comprehensive Review (1989‑2013)." International Journal of Environmental Research and Public Health 15.10 (2018): International Journal of Environmental Research and Public Health, Vol.15(10).
2. Bono, D, and G Guiliani. Impacts of Summer 2003 Heat Wave in Europe - UNISDR. UNEP , Mar. 2004, www.unisdr.org/files/1145_ewheatwave.en.pdf.
3. Information on Potential Economic Effects Could Help Guide Federal Efforts to Reduce Fiscal Exposure, GAO-17-720: Published: Sep 28, 2017. Publicly Released: Oct 24, 2017.
4. Kjellstrom, Tord, et al. "Public Health Impact of Global Heating Due to Climate Change: Potential Effects on Chronic Non-Communicable Diseases." International Journal of Public Health, vol. 55, no. 2, 2009, pp. 97–103., doi:10.1007/s00038-009-0090-2.
5. Portier et al., 2017 C.J. Portier, T.K. Thigpen, S.R. Carter, C.H. Dilworth, A.E. Grambsch, J. Gohlke, ..., T. Maslak A human health perspective on climate change: A report outlining the research needs on the human health effects of climate change Environmental Health Perspectives/National Institute of Environmental Health Sciences (2017)
6. Bono, D, and G Guiliani. Impacts of Summer 2003 Heat Wave in Europe - UNISDR. UNEP , Mar. 2004, www.unisdr.org/files/1145_ewheatwave.en.pdf.

7. Bunker, Aditi, et al. “Effects of Air Temperature on Climate-Sensitive Mortality and Morbidity Outcomes in the Elderly; a Systematic Review and Meta-Analysis of Epidemiological Evidence.” EBioMedicine, vol. 6, 2016, pp. 258–268., doi:10.1016/j.ebiom.2016.02.034.
8. “AR5 Synthesis Report: Climate Change 2014.” *AR5 Synthesis Report: Climate Change 2014 - IPCC*, www.ipcc.ch/report/ar5/syr/.
9. “Climate Change.” *United Nations*, 2019, www.un.org/en/sections/issues-depth/climate-change/.
10. Feldman, D. R., et al. “Observational Determination of Surface Radiative Forcing by CO2 from 2000 to 2010.” *Nature*, vol. 519, no. 7543, 2015, pp. 339–343., doi:10.1038/nature14240.
11. Bauska, Thomas K., et al. “Links between Atmospheric Carbon Dioxide, the Land Carbon Reservoir and Climate over the Past Millennium.” *Nature Geoscience*, vol. 8, no. 5, 2015, pp. 383–387., doi:10.1038/ngeo2422.
12. “Overview of Greenhouse Gases.” *EPA*, Environmental Protection Agency, 11 Apr. 2019, www.epa.gov/ghgemissions/overview-greenhouse-gases.
13. “Erratum: Continental-Scale Temperature Variability during the Past Two Millennia.” Nature Geoscience, vol. 6, no. 6, 2013, pp. 503–503., doi:10.1038/ngeo1849.
14. “What Is Carbon Pricing?” *Carbon Pricing Dashboard*, The World Bank, carbonpricingdashboard.worldbank.org/what-carbon-pricing.
15. Nordhaus, W. (2008). *A Question of Balance: Weighing the Options on Global Warming Policies*. New Haven; London: Yale University Press. Retrieved from http://www.jstor.org/stable/j.ctt1npzkh
16. Nordhaus, W.D. (2007). *To Tax or Not to Tax: Alternative Approaches to Slowing Global Warming. Review of Environmental Economics and Policy* Volume 1, Issue 1, 2007. Retrieved from: https://pdfs.semanticscholar.org/a3e0/e01cedc232aa656109b94895615c2128ccb4.pdf.
17. Organization for Economic Development (OECD) and World Bank Group (WBG) (2015). *The Faster Principles for Successful Carbon Pricing: An approach based on initial experience.* Report retrieved from: https://www.oecd.org/environment/tools-evaluation/FASTER-carbon-pricing.pdf
18. Leach, A. House of Commons, Canada. (2018). Evidence, Standing Committee on Finance (Meeting 151, 42nd Parliament, 1st Session) Ottawa, Canada: House of Commons.
19. Press release: The Prize in Economic Sciences 2018. NobelPrize.org. Nobel Media AB 2019. Wed. 13 Mar 2019. <https://www.nobelprize.org/prizes/economic-sciences/2018/press-release/>
20. Karp, L., & Zhang, J. (2005). Regulation of Stock Externalities with Correlated Abatement Costs, 32, 273-299. Retrieved March 13, 2019, from https://pdfs.semanticscholar.org/8043/a476ea1fbb0d6b8910f256dd5a061d08f29c.pdf.
21. Metcalf, G. E., & Weisbach, D. (2009). The design of a carbon tax. Harvard Environmental Law Review, 33, 499–556.
22. Gleckman, H. (2018, October 10). Bill Nordhaus, The Nobel Prize, Climate Change And Carbon Taxes. Retrieved from https://www.forbes.com/sites/howardgleckman/2018/10/10/bill-nordhaus-the-nobel-prize-climate-change-and-carbon-taxes/#6a4377d76a03.
23. Akerlof, George, et al. “ECONOMISTS’ STATEMENT ON CARBON DIVIDENDS.” *The Wall Street Journal*, 17 Jan. 2019.
24. Narassimhan, Easwaran, et al. “Carbon Pricing in Practice: a Review of Existing Emissions Trading Systems.” *Journal of Climate Policy*, vol. 18, no. 8, 6 May 2018, pp. 967–991., doi:10.1080/14693062.2018.1467827.
25. McFarland, JR. et al. OVERVIEW OF THE EMF 32 STUDY ON U.S. CARBON TAX SCENARIOS. Climate Change Economics. 2018 Mar.; 9(1):1-37.
26. “California Cap and Trade.” *Center for Climate and Energy Solutions*, 16 Mar. 2018, www.c2es.org/content/california-cap-and-trade/.
27. Frank, C. Pricing Carbon: A Carbon Tax or Cap-And-Trade? *Planet Policy*. 2014 Aug.
28. Fawcett, Allen A., et al. “Introduction To The Emf 32 Study On U.s. Carbon Tax Scenarios.” *Climate Change Economics*, vol. 09, no. 01, 2018, p. 1840001., doi:10.1142/s2010007818400018.
29. Bruin, Kelly De, and Aykut Mert Yakut. “The Economic and Environmental Impacts of Increasing the Irish Carbon Tax.” Economic & Social Research Institute, 2018, doi:10.26504/rs79.
30. “Where Carbon Is Taxed.” *Carbon Tax Center*, www.carbontax.org/where-carbon-is-taxed/#Ireland. Accessed March 13 2019.
31. “Sharp Drop in Greenhouse Gas Emissions in 2011 for Ireland's Emissions Trading Companies.” *EPA - Environmental Protection Agency*, 10 Apr. 2012, www.epa.ie/newsandevents/news/2012/name,47662,en.html.
32. Rosenthal, Elisabeth. “Carbon Taxes Make Ireland Even Greener.” *The New York Times*, 27 Dec. 2012, www.nytimes.com/2012/12/28/science/earth/in-ireland-carbon-taxes-pay-off.html
33. Nadel, Steven. *Learning from 19 Carbon Taxes: What Does the Evidence Show?* ACEEE Summer Study on Energy Efficiency in Buildings, 2016.
34. Australia. Department of the Environment. *Quarterly Update of Australia’s National Greenhouse Gas Inventory: September 2014.*”, Commonwealth of Australia, 2015.
35. Taylor, Lenore. “Politics in 2014: the Coalition Dished out Slogans, and Its Sentence Is Clear.” *The Guardian*, 19 Dec. 2014, www.theguardian.com/australia-news/2014/dec/19/politics-in-2014-the-coalition-dished-out-slogans-and-its-sentence-is-clear?CMP=share_btn_tw.
36. Woo, C.k., et al. “Electricity Price Behavior and Carbon Trading: New Evidence from California.” *Applied Energy*, vol. 204, 2017, pp. 531–543., doi:10.1016/j.apenergy.2017.07.070.
37. “California Cap and Trade.” *Center for Climate and Energy Solutions*, 24 Aug. 2021, https://www.c2es.org/content/california-cap-and-trade.
38. “Elements of RGGI.” *Welcome|RGGI,Inc.*, 2019,www.rggi.org/program-overview-and-design/elements.
39. Ramstein, Céline, et al. “State and Trends of Carbon Pricing 2018.” *International Bank for Reconstruction and Development, The World Bank* , 2018, doi:10.1596/978-1-4648-1292-7.
40. Ambasta, Anshula, and Jonathan J. Buonocore. “Carbon Pricing: A Win-Win Environmental and Public Health Policy.” *Canadian Journal of Public Health*, vol. 109, no. 5-6, 2018, pp. 779–781., https://doi.org/10.17269/s41997-018-0099-5.
41. Parry, Iam. “Back to Basics: What Is Carbon Taxation? – IMF F&D.” *IMF*, June 2019, https://www.imf.org/en/Publications/fandd/issues/2019/06/what-is-carbon-taxation-basics#:~:text=While%20addressing%20climate%20change%20by,result%20from%20local%20air%20pollution.

42. Plumer, Brad, and Nadja Popovich. “These Countries Have Prices on Carbon. Are They Working?” *The New York Times*, The New York Times, 2 Apr. 2019, https://www.nytimes.com/interactive/2019/04/02/climate/pricing-carbon-emissions.html.

RELEVANT AMA POLICY

D-135.966 Declaring Climate Change a Public Health Crisis
1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.
2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.
3. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting. [Res. 420, A-22]

D-135.963 Climate Change and Human Health
1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.
2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.
3. Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge or making a similar commitment to lower its own greenhouse gas emissions.
4. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050.
5. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting. [CSAPH Rep. 2, I-22]

H-135.973 Stewardship of the Environment
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support. [CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution:606
(I-23)

Introduced by: Medical Student Section

Subject: Prevention of Healthcare-Related Scams

Referred to: Reference Committee F

Whereas, the FBI defines health fraud scams as including false marketing and impersonation, such as “convincing people to provide their health insurance identification number and other personal information to bill for non-rendered services, steal their identity, or enroll them in a fake benefit plan” and ”providing or billing for health services or equipment without a license”[1]; and

Whereas, the National Council on Aging lists health-related scams, such as fraudulent Medicare services, in their top ten scams targeting seniors, with victims losing a median of $800 per Medicare impersonation scam in 2022 (increasing from $500 in 2018)[2,3]; and

Whereas, scams increased during the COVID pandemic, specifically luring older individuals to disclose sensitive information and purchase fraudulent COVID treatments[4-5]; and

Whereas, in 2021, the FTC reported over 75,000 healthcare-related fraud events, totaling a loss of nearly $20 million by victims, and another 400,000 impersonations of government entities (particularly HHS and CMS officials), resulting in over $1 million in losses[3]; and

Whereas, federal and state officials have warned about increases in scams expected due to Medicaid unwinding as the COVID public health emergency ends[6-8]; and

Whereas, while scams can build distrust between patients and health professionals or government agencies, studies (including a randomized controlled trial) demonstrate that educational efforts on avoiding scams significantly increase fraud detection by consumers without decreasing trust in legitimate communications[9-12]; therefore be it

RESOLVED, that our American Medical Association encourage relevant parties to educate patients and physicians on healthcare-related scams, including how to avoid and report them. (New HOD Policy)

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

Received: 09/27/2023

REFERENCES

1. Health Fraud Scams. FDA. Published January 31, 2023. Accessed March 6, 2023. https://www.fda.gov/consumers/health-fraud-scams
2. Fischer SH, David D, Crotty BH, Dierks M, Safran C. Acceptance and use of health information technology by community-dwelling elders. Int J Med Inform. 2014;83(9):624-635. doi:10.1016/j.ijmedinf.2014.06.005
3. Consumer Sentinel Network Data Book 2022. Federal Trade Commission. Published February 22, 2023. Accessed March 6, 2023. https://www.ftc.gov/reports/consumer-sentinel-network-data-book-2022

4. Payne BK. Criminals Work from Home during Pandemics Too: a Public Health Approach to Respond to Fraud and Crimes against those 50 and above. Am J Crim Just. 2020;45(4):563-577. doi:10.1007/s12103-020-09532-6
5. Al-Qahtani, Ali F., and Stefano Cresci. "The COVID-19 scamdemic: A survey of phishing attacks and their countermeasures during COVID-19." IET Information Security 16.5 (2022): 324-345.
6. Tolbert J, Ammula M. 10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision. KFF. Published February 22, 2023. Accessed March 6, 2023. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/
7. State officials warn that large-scaled Medicaid disenrollment could draw scams. Delaware First Media. Published March 6, 2023. Accessed March 6, 2023. https://www.delawarepublic.org/politics-government/2023-03-06/state-officials-warn-that-large-scaled-medicaid-disenrollment-could-draw-scams
8. IRS Criminal Investigation warns taxpayers about new wave of COVID-19 scams as second round of Economic Impact Payments are delivered | Internal Revenue Service. Accessed March 6, 2023. https://www.irs.gov/compliance/criminal-investigation/irs-criminal-investigation-warns-taxpayers-about-new-wave-of-covid-19-scams-as-second-round-of-economic-impact-payments-are-delivered
9. Burton A, Cooper C, Dar A, Mathews L, Tripathi K. Exploring how, why and in what contexts older adults are at risk of financial cybercrime victimisation: A realist review. Experimental Gerontology. 2022/03/01/ 2022;159:111678. doi:https://doi.org/10.1016/j.exger.2021.111678
10. Robb CA, Wendel S. Who Can You Trust? Assessing Vulnerability to Digital Imposter Scams. J Consum Policy (Dordr). 2023;46(1):27-51. doi:10.1007/s10603-022-09531-6
11. Tang Z, Miller AS, Zhou Z, Warkentin M. Does government social media promote users' information security behavior towards COVID-19 scams? Cultivation effects and protective motivations. Government Information Quarterly. 2021/04/01/ 2021;38(2):101572. doi:https://doi.org/10.1016/j.giq.2021.101572
12. Hatfield JM. Social engineering in cybersecurity: The evolution of a concept. Computers & Security. 2018/03/01/ 2018;73:102-113. doi:https://doi.org/10.1016/j.cose.2017.10.008

RELEVANT AMA POLICY

H-315.983 Patient Privacy and Confidentiality

13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned. [BOT Rep. 9, A-98; Reaffirmation I-98; Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99; Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01; Reaffirmed: BOT Rep. 19, I-01; Appended: Res. 524, A-02; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: BOT Rep. 24, I-04; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed: CEJA Rep. 6, A-11; Reaffirmed in lieu of Res. 705, A-12; Reaffirmed: BOT Rep. 17, A-13; Modified: Res. 2, I-14; Reaffirmation: A-17; Modified: BOT Rep. 16, A-18; Appended: Res. 232, A-18; Reaffirmation: I-18; Reaffirmed: Res. 219, A-21; Reaffirmed: Res. 229, A-21; Reaffirmed: BOT Rep. 12, I-21; Reaffirmed: BOT Rep. 22, A-22; Reaffirmation: A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 608
(I-23)

Introduced by: Senior Physicians Section

Subject: Confronting Ageism in Medicine

Referred to: Reference Committee F

Whereas, research has shown a strong link between ageism, in the form of negative stereotypes, prejudice and discrimination toward older people, and risks to their physical and mental health[1]; and

Whereas, ageism refers to the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) towards others or oneself based on age[2]; and

Whereas, only 8.5 percent of people worldwide in 2023 are aged 65 and over, but this percentage is projected to increase to nearly 17 percent of the world's population by 2050[3]; and

Whereas, the American Medical Association Senior Physicians Section has 62,000 senior physician members 65 years of age and above; and

Whereas, awareness of the issues and challenges of aging are needed to change subconscious stereotypes that people hold onto; and

Whereas, advocacy, that begins with education and prevention by the AMA, can help to prevent negative subconscious attitudes, i.e. stigmas, from developing and continuing; therefore be it

RESOLVED, that our American Medical Association develop practical interventions to combat ageism as a part of AMA's health equity policy (Directive to Take Action); and be it further

RESOLVED, that our AMA develop with other interested organizations educational materials, including a podcast, on ageism that can be distributed to medical, nursing and allied health schools, GME programs and CME/CNE providers to advocate for the importance of early interventions in the minimalizations and mistreatment of others (Directive to Take Action); and be it further

RESOLVED, that our AMA conduct outreach and collaboration with national senior governmental and private organizations to help educate the public and legislators on the significance of ageism and its subtleties of discrimination, inequities, and exclusions. (Directive To Take Action).

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

Received: 09/27/23

REFERENCES

1. Burnes, D., Sheppard, C., Henderson Jr. C.R., Wassel, M., Cope, R., Barber, C., & Pillemer, K. (2019). Interventions to Reduce Ageism Against Older Adults: A Systematic Review and Meta-Analysis. *American Journal of Public Health, 109 (8)*, E1-E9.
2. World Health Organization. (2021). Global Report on Ageism. https:///www.who.int/news-room/questions-and-answers/item/ageing-ageism.
3. NIH (2016, March 28) World's Older Population Grows Dramatically | National Institutes of Health (NIH) [Press Release]

RELEVANT AMA POLICY

Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions H-65.951
Our AMA adopted the following guidelines for healthcare organizations and systems, including academic medical centers, to establish policies and an organizational culture to prevent and address systemic racism, explicit and implicit bias and microaggressions in the practice of medicine:

GUIDELINES TO PREVENT AND ADDRESS SYSTEMIC RACISM, EXPLICIT BIAS AND MICROAGGRESSIONS IN THE PRACTICE OF MEDICINE
Health care organizations and systems, including academic medical centers, should establish policies to prevent and address discrimination including systemic racism, explicit and implicit bias and microaggressions in their workplaces.
An effective healthcare anti-discrimination policy should:

- Clearly define discrimination, systemic racism, explicit and implicit bias and microaggressions in the healthcare setting.
- Ensure the policy is prominently displayed and easily accessible.
- Describe the management's commitment to providing a safe and healthy environment that actively seeks to prevent and address systemic racism, explicit and implicit bias and microaggressions.
- Establish training requirements for systemic racism, explicit and implicit bias, and microaggressions for all members of the healthcare system.
- Prioritize safety in both reporting and corrective actions as they relate to discrimination, systemic racism, explicit and implicit bias and microaggressions.
- Create anti-discrimination policies that:
  - Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.).
  - Define expected and prohibited behavior.
  - Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and implicit bias and microaggressions.
  - Ensure privacy and confidentiality to the reporter.
  - Provide a confidential method for documenting and reporting incidents.
  - Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action.
- These policies should include:
  - Taking every complaint seriously.
  - Acting upon every complaint immediately.
  - Developing appropriate resources to resolve complaints.
  - Creating a procedure to ensure a healthy work environment is maintained for complainants and prohibit and penalize retaliation for reporting.
  - Communicating decisions and actions taken by the organization following a complaint to all affected parties.
  - Document training requirements to all the members of the healthcare system and establish clear expectations about the training objectives.

In addition to formal policies, organizations should promote a culture in which discrimination, including systemic racism, explicit and implicit bias and microaggressions are mitigated and prevented. Organized medical staff leaders should work with all stakeholders to ensure safe, discrimination-free work environments within their institutions.

Tactics to help create this type of organizational culture include:
- Surveying staff, trainees and medical students, anonymously and confidentially to assess:
  - Perceptions of the workplace culture and prevalence of discrimination, systemic racism, explicit and implicit bias and microaggressions.
  - Ideas about the impact of this behavior on themselves and patients.
- Integrating lessons learned from surveys into programs and policies.
- Encouraging safe, open discussions for staff and students to talk freely about problems and/or encounters with behavior that may constitute discrimination, including racism, bias or microaggressions.
- Establishing programs for staff, faculty, trainees and students, such as Employee Assistance programs, Faculty Assistance Programs, and Student Assistance Programs, that provide a place to confidentially address personal experiences of discrimination, systemic racism, explicit or implicit bias or microaggressions.
- Providing designated support person to confidentially accompany the person reporting an event through the process.

Citation: Res. 003, A-21

Towards Diversity and Inclusion: A Global Nondiscrimination Policy Statement and Benchmark for our AMA H-65.946
Our AMA reaffirms its commitment to complying with all applicable laws, rules or regulations against discrimination on the basis of protected characteristics, including Title VII of the Civil Rights Act, The Age Discrimination in Employment Act, and the Americans with Disabilities Act, among other federal, state and local laws, and will provide updates on its comprehensive diversity and inclusion strategy as part of the annual Board report to the AMA House of Delegates on health equity.
Citation: BOT Rep. 5, I-22

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
Citation: CCB/CLRPD Rep. 3, A-14, Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17; Modified: Res. 013, A-22; Reaffirmed: BOT Rep. 5, I-22

Retirement and Hiring Practices H-25.996
It is urged that physicians, individually and through their constituent, component, and specialty medical societies, continue to stress the need to reappraise policies calling for compulsory retirement and age discrimination in hiring from the standpoint of health among older people, and that they participate actively and lend medical weight in the efforts of other groups to create a new climate of opportunity for the older worker.
Citation: Committee on Aging Report, I-62; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed CSAPH Rep.2, A-08; Modified CCB Rep. 01, A-18.

Reference Committee J

Report(s) of the Council on Medical Service

01 ACO REACH
02 Health Insurers and Collection of Patient Cost-Sharing
03 Strengthening Network Adequacy
05 Medicaid Unwinding Update
06 Rural Hospital Payment Models
07 Sustainable Payment for Community Practices

Resolutions

801 Improving Pharmaceutical Access and Affordability
802 Improving Nonprofit Hospital Charity Care Policies
803 Improving Medicaid and CHIP Access and Affordability
804 Required Clinical Qualifications in Determining Medical Diagnoses and Medical Necessity
805 Medication Reconciliation Education
806 Evidence-Based Anti-Obesity Medication as a Covered Benefit
807 Any Willing Provider
808 Prosthodontic Coverage after Oncologic Reconstruction
809 Outsourcing of Administrative and Clinical Work to Different Time Zones – An Issue of Equity, Diversity, and Inclusion
811 Expanding the Use of Medical Interpreters
812 Indian Health Service Improvements
813 Strengthening Efforts Against Horizontal & Vertical Consolidation
814 Providing Parity for Medicare Facility Fees
815 Long-Term Care and Support Services for Seniors
817 Expanding AMA Payment Reform Work and Advocacy to Medicaid and other non-Medicare payment modules for Pediatric Healthcare and Specialty Populations
818* Amendment to AMA policy on healthcare system reform proposals
819 Amend Virtual Credit Card Policy
820 Affordability and Accessibility of Treatment of Overweight and Obesity

***Not yet reviewed for consideration by the Resolution Committee**

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-23

Subject: ACO REACH
(Resolution 822-I-22)

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee J

At the 2022 Interim Meeting, the House of Delegates referred Resolution 822, Monitoring of Alternative Payment Models within Traditional Medicare. Introduced by the Medical Student Section, the resolution asked the American Medical Association (AMA) to: 1) "monitor the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) program for its impacts on patients and physicians in Traditional Medicare, including the quality and cost of health care and patient/provider choice, and report back to the House of Delegates on the impact of the ACO REACH demonstration program annually until its conclusion; " 2) "advocate against any Medicare demonstration project that denies or limits coverage or benefits that beneficiaries would otherwise receive in Traditional Medicare; " and 3) "develop educational materials for physicians regarding the ACO REACH program to help physicians understand the implications of their or their employer's participation in this program and to help physicians determine whether participation in the program is in the best interest of themselves and their patients."

The report of Reference Committee J from the 2022 Interim meeting recommended that Policies H-160.915, D-385.953, H-373.998, and D-160.923 be reaffirmed in lieu of Resolution 822-I-22. In this report, the Council provides background information on the ACO REACH program and addresses common misconceptions about the program, summarizes extensive AMA policy and concurs with the sentiment of Reference Committee J at the 2022 Interim meeting regarding reaffirmation of policy in lieu of Resolution 822-I-22.

BACKGROUND

Accountable Care Organizations (ACOs) were developed to reform the regular Medicare payment system by making a model available that links payment to the quality of care and not just the number of services delivered. Holistically, the goal of the ACO programs is to improve the patient care experience, improve population health, and reduce per capita costs of health care. The Medicare Physician Group Practice Demonstration program, which began in 2005, was the Centers for Medicare & Medicaid Services' (CMS) first attempt at an ACO model. Under this model, physicians were awarded bonus payments for improving cost efficiency and for their performance on different care quality measures. Results for this program were mixed. In 2010, the Affordable Care Act (ACA) formally introduced the ACO model as a permanent addition to the Medicare program, not just a demonstration. The ACA also created the CMS Innovation Center, which has evaluated ACO models, in addition to the permanent Medicare Shared Savings Program (MSSP). For example, in January 2012, Medicare launched the Pioneer ACO program, and this was followed by the introduction of the Global and Professional Direct Contracting (GPDC) Model, which preceded ACO REACH.[1]

ACO REACH is a voluntary Centers for Medicare and Medicaid Innovation (CMMI) model scheduled to operate for four years from January 2023 to December 2026. ACO REACH is a redesign of the GPDC model in response to feedback and Administration priorities. ACO REACH is intended to better reflect CMMI's focus on advancing health equity and improving beneficiary care. ACO REACH retains the basic design elements of the GPDC global and professional tracks and adds new requirements to advance equity, promote physician governance, and protect beneficiaries. To continue participation in ACO REACH, participants in the GPDC model needed to meet ACO REACH model requirements by January 1, 2023. Appendix A provides a summary of the differences between the GPDC and ACO REACH models.

Changes to the ACO REACH governance structure include an increase in physician and other participating health professionals' membership on each ACO's governing board from 25 percent to 75 percent. Each board must also include a separate beneficiary and consumer advocate with voting rights. In the ACO REACH model, CMS has increased monitoring and compliance requirements to track and respond to issues that may arise.[2]

The ACO REACH model has specific health equity requirements for participation. CMS requires all participating ACOs to develop a health equity plan and collect beneficiary-reported demographic and social needs data. Additionally, CMS has implemented an enhanced health equity benchmark to incentivize care delivery to underserved populations and has increased the range of services that can be provided by nurse practitioners under the model. For example, in ACO REACH, nurse practitioners can certify the need for hospice care; certify the need for diabetic shoes; order and supervise cardiac rehabilitation; establish, review, sign, and date home infusion therapy plans of care; and make referrals for nutrition therapy. The Council encourages continued monitoring of these expanded services and emphasizes that all patient care be performed under the supervision of a physician. Finally, under the ACO REACH model, CMS has reduced the benchmark discount from a maximum of 5 percent to 3.5 percent and has reduced the quality withhold from 5 percent to 2 percent.[3]

ACO REACH MISCONCEPTIONS

The Council believes it is crucial to address misconceptions about ACO REACH in order to effectively evaluate the program's impact.

First, it is important to recognize that this model is a time-limited model test and does not replace regular Medicare. During its implementation from January 2023 to December 2026, ACO REACH will be continuously evaluated to monitor its impact. Only if the model is shown to improve quality without increasing costs, reduce costs without negatively impacting quality, or improve quality and reduce costs will expansion or extension of the program be considered.

Second, ACO REACH beneficiaries continue to be covered by regular Medicare, and not Medicare Advantage (MA). Beneficiaries may receive care from any Medicare physician of their choice and can switch physicians at any time.[4]

Third, beneficiaries will only be included in the program if they already receive a majority of their primary care services from an ACO REACH participating physician or if they voluntarily notify CMS that they wish to be assigned to an ACO REACH participating physician. Accordingly, attribution in ACO REACH is similar to that in existing MSSP models. ACOs must alert beneficiaries who have been aligned to an ACO and inform them of their right to opt-out of CMS data sharing with the ACO.[5] It should be noted that despite their data not being shared with CMS

directly, these patients will still be included in ACO REACH as long as they receive a majority of their care from a physician participating in ACO REACH. Program enrollment does not change covered benefits and patients can still see and receive any service covered by fee-for-service Medicare.

Fourth, CMS has implemented a monitoring plan to protect beneficiaries and address potential program integrity risks from bad actors. ACO REACH participants will be subject to audits of charts, medical records, implementation plans, and other data.[6]

DIRECT CONTRACTING ENTITIES AND CODING CONCERNS

The transition to ACO REACH addresses issues with the GPDC model and transparency, specifically related to upcoding. Under the Direct Contracting Entity (DCE) model, there were strong incentives for plans to "upcode" patient diagnoses, which affects the risk-adjusted payments plans receive. A 2020 study from the Department of Health and Human Services (HHS), shows that enrollees in Medicare Advantage plans generate 6 percent to 16 percent higher diagnosis-based risk scores than they would under regular Medicare where diagnoses do not affect most provider payments.[7] The HHS study estimates that upcoding generates billions of dollars in excess public spending and significant distortions to both health care entity and individual consumer behavior. Critics of GPDC caution that these newer ACO models could employ similar tactics to those used by MA where plans add unnecessary diagnosis codes to inflate risk scores of Medicare beneficiaries, resulting in a higher payment from Medicare.[8]

Lawmakers in Congress expressed concern with automatically including DCEs with a history of fraudulent behavior and suggested that CMS halt participation by any organizations that have committed health care fraud and terminate DCEs that do not meet the new standards for the program. Under the implementation of ACO REACH, CMMI will more stringently monitor compliance to ensure that there are no inappropriate coding practices.[9] Additionally, in February 2022, the AMA signed on to a letter encouraging ongoing transparency and stability in all value-based care models.

AMA POLICY AND ADVOCACY

The AMA has an extensive policy portfolio regarding ACOs and alternative payment models (APMs). Policy H-160.915 affirms the AMA's ACO principles. These principles are inclusive of all aspects of participating in an ACO, and this policy addresses many of the concerns raised by Resolution 822-I-22. Importantly, H-160.915 affirms that the goal of an ACO is to increase access to care, improve the quality of care, and ensure the efficient delivery of care, with the physician's primary ethical and professional obligation being the well-being and safety of the patient. Additionally, the principles affirm that physician and patient participation in an ACO should be voluntary rather than a mandatory assignment to an ACO by Medicare. Any physician organization (including an organization that bills on behalf of physicians under a single tax identification number) or any other entity that creates an ACO must obtain the written affirmative consent of each physician to participate in the ACO. Physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid, or a private payer or being admitted to a hospital medical staff. Furthermore, H-160.915 addresses concerns about equity by affirming that the ACO benchmark should be risk-adjusted for the socioeconomic and health status of the patients that are assigned to each ACO, such as income/poverty level, insurance status prior to Medicare enrollment, race, and ethnicity and health status.

Policy D-160.923 states that the AMA will seek objective, independent data on ACOs and release a whitepaper regarding their effect on cost savings and quality of care. In response to this policy, the AMA released Accountable Care Organizations: How to Perform Due Diligence and Evaluate Contractual Agreements.

Policy H-373.998 affirms the AMA's support for patient choice in their health care. Specifically, this policy states that individuals should have freedom of choice of physician and/or system of health care delivery and where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system.

Policy H-160.892 states that the AMA encourages studies into the effect of hospital integrated system ACOs' ability to generate savings and the effect of these ACOs on medical staff and potential consolidation of medical practices.

Policy D-385.963 states that the AMA advises physicians to make informed decisions before starting, joining, or affiliating with an ACO. Additionally, this policy states that the AMA will develop a toolkit that provides physicians best practices for starting and operating an ACO, such as governance structures, organizational relationships, and quality reporting and payment distribution mechanisms.

Policy H-180.944 affirms that health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

Policy D-385.952(2) was recently amended at the 2023 Annual Meeting and states that the AMA supports APMs that link quality measures and payments to outcomes specific to vulnerable and high-risk populations, reductions in health care disparities, and functional improvements, if appropriate, and will continue to encourage the development and implementation of physician-focused APMs that provide services to improve the health of vulnerable and high-risk populations and safeguard patient access to medically necessary care, including institutional post-acute care.

Finally, Policy H-160.912 defines "team-based health care" as the provision of health care services by a physician-led team who works collaboratively to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care.

DISCUSSION

Referred Resolution 822-I-22 asked the AMA to: 1) "monitor the ACO REACH program for its impacts on patients and physicians in Traditional Medicare, including the quality and cost of health care and patient/provider choice, and report back to the House of Delegates on the impact of the ACO REACH demonstration program annually until its conclusion;" 2) "advocate against any Medicare demonstration project that denies or limits coverage or benefits that beneficiaries would otherwise receive in Traditional Medicare;" and 3) "develop educational materials for physicians regarding the ACO REACH program to help physicians understand the implications of their or their employer's participation in this program and to help physicians determine whether participation in the program is in the best interest of themselves and their patients." The first Resolve clause is addressed by ongoing AMA Advocacy efforts and the Council's ongoing work to review these programs and keep the House informed of any concerns with this or any other demonstration project. The Council will continue to monitor the outcomes of ACO REACH and continue to update the House as needed. The second Resolve clause is addressed by Policy

D-385.952(2), which the Council recommends reaffirming. The third Resolve clause is addressed by the 2019 AMA whitepaper titled: "Accountable Care Organizations: How to Perform Due Diligence and Evaluate Contractual Agreements."

The AMA has longstanding, overarching principles to guide ACO participation. The Council believes that it is not necessary to develop novel policy referencing each new ACO model, as the guidelines apply to each new model in perpetuity. The AMA's principles affirm that patient and physician participation in an ACO should be voluntary – one of the concerns articulated in Resolution 822-I-22. These principles are inclusive of all aspects of participating in an ACO.

Resolution 822-I-22 raised several concerns with the ACO REACH model, including that the model could worsen the quality of patient care and increase costs by incentivizing ACO REACH entities to restrict care and engage in upcoding, which can be built into MA plans. Under ACO REACH, CMMI will closely monitor compliance with coding practices, addressing upcoding concerns laid out by the resolution.

CMS plans to continuously monitor the ACO REACH program and AMA policy encourages studies into the effect of hospital integrated system ACOs' ability to generate savings (H-160.892) and affirms that the AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives (D-385.963). As an example of monitoring the ongoing program, CMS received stakeholder feedback and has announced changes to address concerns beginning in 2024. The changes include financial protections for midyear changes to benchmarks, additions to the Health Equity Benchmark Adjustment to account for more patient characteristics, and updates to its risk adjustment policies. Specifically, there was concern that the current model favored patients who live in rural areas, which tend to be less racially and ethnically diverse. CMS has updated the formula to determine payments to physicians to better account for patients who live in urban areas. The new formula will take into account the number of beneficiaries who get a Medicare Part D low-income subsidy as well as the state-based version of the Area Deprivation Index, not just the national version.[10,11]

Additionally, Resolution 822-I-22 expressed concern about the equity of the ACO REACH model. Not only was this model designed with a specific focus on health equity, the AMA has policy clearly affirming support for promoting health equity (H-180.944).

Given the scope expansion under ACO REACH that allows nurse practitioners to certify the need for hospice care, certify the need for diabetic shoes, order and supervise cardiac rehabilitation, establish, review, sign, and date home infusion therapy plans of care, and make referrals for medical nutrition therapy, the Council recommends reaffirming Policy H-160.912 which highlights the importance of a physician-led care team.

Finally, it is important to recognize that ACO REACH took effect in January 2023. There is not yet sufficient data to analyze the impact of this model, and it would be premature to draw any conclusions at this time. The Council supports continued AMA monitoring of the effects of ACO REACH, a request sufficiently supported by the AMA policy we recommend for reaffirmation.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 822-I-22, and the remainder of the report be filed:

1. That our American Medical Association reaffirm the following policies:
    a. Policy H-160.915, "Accountable Care Organization Principles"
    b. Policy H-373.998, "Patient Information and Choice"
    c. Policy H-160.892, "Effects of Hospital Integrated System Accountable Care Organizations"
    d. Policy D-385.963, "Health Care Reform Physician Payment Models"
    e. Policy H-180.944, "Plan for Continued Progress Toward Health Equity"
    f. Policy H-160.912, "The Structure and Function of Interprofessional Health Care Teams"
    g. Policy D-385.952, "Alternative Payment Models and Vulnerable Populations" (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1]Tu, T, et al. Origins and Future of Accountable Care Organizations. Brookings Institution and Leavitt Partners. May 2015. https://www.brookings.edu/wp-content/uploads/2016/06/impact-of-accountable-careorigins-052015.pdf
[2]CMS.gov. ACO REACH Overview. Accessed: July 6, 2023. https://innovation.cms.gov/innovation-models/aco-reach#:~:text=The%20ACO%20Realizing%20Equity%2C%20Access%2C%20and%20Community%20Health%20(REACH,Accountable%20Care%20Organization%2C%20or%20ACO.
[3]*Ibid.*
[4]The ACO Reach Model: Myths and Facts. Health Care Transformation Task Force. Accessed: July 18, 2023. https://hcttf.org/wp-content/uploads/2022/04/ACO-REACH-Myths-and-Facts.pdf
[5]*Ibid.*
[6]*Ibid.*
[7]Geruso, M. and Timothy Layton. Upcoding: Evidence from Medicare on Squishy Risk Adjustment. HHS Public Access. March 2020. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7384673/pdf/nihms-1007327.pdf
[8]King, R. CMS Overhauls Direct Contracting Model to include new requirements on governance, health equity in 2023. Fierce Healthcare. February 24, 2022. https://www.fiercehealthcare.com/payers/cms-overhauls-direct-contracting-model-include-new-requirements-governance-and-health-equity
[9]*Ibid.*
[10]Healthcare Finance News. ACO REACH now includes financial protections from midyear benchmark changes. August 15, 2023. https://www.healthcarefinancenews.com/news/aco-reach-now-includes-financial-protections-midyear-benchmark-changes
[11]Politico Pro. CMS to change health equity measures for key payment model. August 14, 2023. https://subscriber.politicopro.com/article/2023/08/cms-to-change-health-equity-measures-for-key-payment-model-00111182

Appendix A
Comparing GPDC to the ACO REACH Model

Comparing GPDC to the ACO REACH MODEL		
	Original Global Professional Direct Contracting (GPDC) Model (PY2021-PY2022)	**ACO Realizing Equity, Access, and Community Health (REACH) Model (PY2023-PY2026)**

Model Goals	• Improve beneficiary access to providers who are personally engaged in their healthcare delivery.
	• Provide strong incentives to improve quality of care by shifting payment away from fee-for-service towards value-based capitated payments.
	• Allow organizations with prior ACO experience, innovative organizations taking risk in MA or Managed Medicaid, and organizations that focus on complex beneficiary populations to participate.
		• Improve the focus on:
		  • Promoting health equity and addressing historical healthcare disparities for underserved communities.
		  • Continuing the momentum of provider-led organizations in risk-based models.
		  • Protecting beneficiaries and the model with more participant vetting, monitoring and greater transparency

Participants	• Model participants are called Direct Contracting Entities (DCEs) but are equivalent to ACOs.	• Model participants referred to as REACH ACOs.
Governance	• Participating providers generally must hold at least 25% of the governing board voting rights. • Each DCE's governing board must include a beneficiary representative and a consumer advocate, though these representatives may be the same person and neither is required to hold voting rights.	• Participating providers generally must hold at least 75% of the governing board voting rights. • Each REACH ACO governing board must include a beneficiary representative and a consumer advocate, who must hold governing board voting rights and must be different people.
Health Equity	• No policies explicitly promoting health equity.	• Requirement for all REACH ACOs to develop a Health Equity Plan that must include identification of health disparities and specific actions intended to mitigate the health disparities identified. • Introduction of a health equity benchmark adjustment to better support care delivery and coordination for patients in underserved communities. • Requirement for all ACOs to collect beneficiary-reported demographic and social needs data. • New Benefit Enhancement to increase the range of services that may be ordered by Nurse Practitioners to improve access.
Discount for Global	• Global DCEs receive 100% of gross savings/losses. A discount is applied to the benchmark before gross savings/losses are calculated, which helps guarantee shared savings for CMS. There is no discount for Professional DCEs.	• Reduced discount rate for Global ACOs to 3-3.5% beginning in PY2023 will further CMS' goal of increasing participation in full risk FFS initiatives.
Quality Withhold	• The quality withhold applied to the benchmarks of both Professional DCEs and Global DCEs is 5%.	• Quality hold for both Professional ACOs and Global ACOs is reduced to 2%.

Risk Adjustment	• Two policies protect against risk coding growth:
	  • The "Coding Intensity Factor" (CIF) limits risk score growth across the entire model. The CIF applies to all DCEs to limit risk score growth to the average prior to the start of the model.
	  • A "Risk Score Growth Cap" limits a DCE's risk score growth to +/- 3% over a 2-year period. The DCE-specific caps on over-coding ensure DCEs are coding appropriately and limit gaming.
		• Two changes to the "Risk Score Growth Cap" further mitigate potential inappropriate risk score gains:
		  • Adopt a static reference year population for the remainder of the model performance period.
		  • Cap the REACH ACO's risk score growth relative to the DCE's demographic risk score growth, so the +/- 3% cap is appropriately adjusted based on demographic changes in the underlying population over time. (Currently risk score cap is based on HCC growth – this would cap HCC growth relative to demographic growth.)

Monitoring/ Compliance	• Robust monitoring of all DCEs includes:
	  • Monitoring for all levels of care provided,
	  • Compliance audits conducted throughout the year,
	  • Investigation of beneficiary complaints, and
	  • Collection of beneficiary surveys (CAHPS) annually to measure changes in beneficiary satisfaction.
		• Additional monitoring and compliance efforts and analytics will:
		  • Assess annually whether beneficiaries are being shifted into or out of MA.
		  • Examine ACO's risk score growth to identify inappropriate coding practices.
		  • Monitor for noncompliance with prohibitions against anti-competitive behavior and misuse of beneficiary data.
		  • Increase use of data analytics to monitor use of services over time and compared to a reference population to assess changes in beneficiaries' access to care, including stinting on care.
		  • Review marketing materials regularly to ensure information on the Model is accurate and beneficiaries understand their rights and freedom of choice.
		  • Verify annually that REACH ACO websites are up to date and provide required information.
		  • Audit annually REACH ACO contracts with providers to learn more about their downstream arrangements and identify any concerns.
		  • Investigate on a rolling basis any beneficiary and provider complaints and grievances in coordination with 1-800-Medicare, the Innovation Center liaison on models in the Medicare Beneficiary Ombudsman team, CMS regional offices, and others as appropriate.

Benefits and Protections for Medicare Beneficiaries	• Benefits (applies to all Performance Years of the model) include:
	  • A higher quality of care and greater clinical support and care coordination for beneficiaries.
	  • "Benefit Enhancements" and "Beneficiary Engagement Incentives" offered under the model (e.g., telehealth, post-discharge home visits and waiver of the homebound requirement, Part B cost-sharing support, concurrent care for beneficiaries that elect hospice care).
	• Beneficiary protections (applies to all Performance Years of the model:
	  • All aligned beneficiaries retain full Original Medicare benefits and can see any Medicare physician.
	  • Beneficiaries are proactively notified on an annual basis of their alignment to a DCE/ACO and that their benefits have not changed.
	  • Beneficiaries retain all FFS Medicare channels for raising concerns or reporting complaints.	

Modified from: CMS.gov. Comparing GPDC to the ACO REACH Model. Accessed: July 26, 2023. https://innovation.cms.gov/media/document/gpdc-aco-reach-comparison

Appendix B
ACO Comparison Chart

ACO Comparison Chart

This chart details the main elements of Medicare Shared Savings Program (MSSP) and Realizing Equity, Access, and Community Health (REACH) ACOs

Reflects policies in effect for 2023

	MSSP Basic Level A	MSSP Basic Level B	MSSP Basic Level C	MSSP Basic Level D	MSSP Basic Level E	MSSP Enhanced	REACH Professional	REACH Global
Number of ACOs	27	124	9	10	125	161	24	108
Length of contract	Five years						2021 starters = 5 years + 9 months 2022 starters = 5 years 2023 starters = 4 years	
Participation opportunities	Annual MSSP application cycle opens each spring. ACOs must submit a notice of intent to apply (NOIA) in order to be eligible to submit a full application.						No future application cycles planned at this time.	
Status under MACRA	MIPS APM				Advanced APM			
Governance requirements	ACO participants must hold at least 75% control over the governing board. Each ACO's governing board must include at least one Medicare FFS beneficiary who is served by the ACO, and this beneficiary representative must have full voting rights.						Participant providers must hold at least 75% of governing board voting rights. Each ACO's governing board must include a beneficiary representative and a separate consumer advocate, each with full voting rights.	
Financial Structure								
	MSSP Basic Level A	**MSSP Basic Level B**	**MSSP Basic Level C**	**MSSP Basic Level D**	**MSSP Basic Level E**	**MSSP Enhanced**	**REACH Professional**	**REACH Global**
Risk-sharing arrangement	1st dollar savings up to 40% No loss sharing	1st dollar savings up to 40% No loss sharing	1st dollar savings up to 50% 1st dollar losses at 30%	1st dollar savings up to 50% 1st dollar losses at 30%	1st dollar savings up to 50% 1st dollar losses at 30%	1st dollar savings up to 75% 1st dollar losses at 40– 75%	1st dollar savings and losses at 50%	1st dollar savings and losses at 100%
Shared savings cap	10% of updated benchmark					20% of updated benchmark	Gross (S/L): / Cap (S/L): < 5% / 50% 5%-10% / 35% 10%-15% / 15% > 15% / 5%	Gross (S/L): / Cap (S/L): < 25% / 100% 25%-35% / 50% 35%-50% / 25% > 50% / 10%
Shared losses cap	Not applicable		Lesser of 2% of total Medicare Parts A & B FFS revenue or 1% of updated benchmark	Lesser of 4% of total Medicare Parts A & B FFS revenue or 2% of updated benchmark	Lesser of 8% of total Medicare Parts A & B FFS revenue or 4% of updated benchmark	15% of updated benchmark		
Discount or MSR/MLR	MSR will be 2% to 3.9% depending on number of assigned beneficiaries. Smaller ACOs have higher MSR (5,000 assigned beneficiaries = 3.9% MSR) and larger ACOs have lower MSR, (2% MSR for ACOs with 60,000+ assigned beneficiaries). MLR not applicable.		Prior to entering a two-sided model, the ACO must select its MSR/MLR as part of the application cycle. The choices are: • 0% MSR/MLR • Symmetrical MSR/MLR in a 0.5 percent increment between 0.5 and 2.0% • Symmetrical MSR/MLR that varies based on the number of beneficiaries assigned to the ACO.				• No MSR/MLR • No discount	○ No MSR/MLR ○ Discount applied to the PY benchmark: 3% (PY2023-2024) 3.5% (PY2025-2026)

NAACOS. ACO Comparison Chart. Accessed: August 16, 2023. https://www.naacos.com/assets/docs/pdf/2023/ACO-ComparisonChart2023.pdf

	Beginning in 2024, low revenue ACOs in the Basic Track may share in a portion of savings if the MSR is not exceeded; Levels A & B at 20%; Levels C, D, & E at 25%			
Transition to two-sided model	New, inexperienced ACOs may participate in Basic Level A for a full 5-year agreement period. In a subsequent agreement period, inexperienced ACOs that remain eligible are permitted to progress through Basic Levels A-E, which provides 2 additional years under upside-only (7 years total before downside risk). If ineligible to continue in the glidepath for the second agreement period, ACOs can participate in Level E for all 5 years of the agreement period.	Optional for all ACOs. ACOs may transition back to Level E from Enhanced.	No one-sided model under ACO REACH.	

Benchmark	CMS establishes and rebases MSSP ACO benchmarks based on expenditures from three benchmark years leading up to an agreement period using four beneficiary categories (ESRD, disabled, aged/dual, and aged/non-dual). CMS incorporates regional expenditures into benchmarks starting in an ACO's initial performance year. ACOs with spending higher than their region have a regional adjustment weight of 15%, ACOs with spending lower than their region receive a weight of 35% in the first agreement year. If an ACO is considered a re-entering ACO, CMS will apply the regional adjustment weight that was used in the most recent agreement.
	
	Beginning in 2024, CMS will:
	• Incorporate a prospective administrative growth factor based on US per capita cost to update an ACO's benchmark each performance year, creating a new three-way blend. The new update factor would look as follows:
	  ▪ Two-way blend = (National Update Factor x National Weight) + (Regional Update Factor x (1 – National Weight))
	  ▪ Three-way blend = [PY1 ACPT x (1/3)] + [PY1 Two-Way Blend x (2/3)]
	• Account for an ACO's prior savings when establishing benchmarks for renewing and re-entering ACOs.
	• Reduce the cap on negative regional adjustments from -5 to -1.5 percent.
			Prospective blend of historical spending and adjusted Medicare Advantage Rate Book
			• Standard ACOs using claims-based alignment: fixed 3-year baseline period (2017-19), with application of a trend adjustment and geographic adjustment
			• Standard ACOs using voluntary alignment, New Entrant ACOs, & High Needs ACOs: only regional expenditures through PY2024 (historical expenditures incorporated beginning PY2025)
			A health equity benchmark adjustment will be applied based on aligned beneficiaries' social risk. Additional details on benchmark calculations	

Risk adjustment	CMS uses an ACO's prospective HCC risk score to adjust the benchmark for changes in severity and case mix in the assigned beneficiary population between BY3 and the performance year. Positive adjustments in prospective HCC risk scores are subject to a cap of 3 percent for each agreement period. Beginning in 2024, CMS will account for changes in demographic risk scores before applying the 3 percent cap and the +3 percent cap will apply in aggregate across the four enrollment types (ESRD, disabled, aged/dual, and aged/non-dual)		CMS will risk adjust historical baseline, regional expenditures, and capitated payments • For Standard & New Entrant ACOs: CMS-HCC prospective risk adjustment model • High Needs ACOs: CMMI-HCC concurrent risk adjustment model for aged & duals, CMS-HCC prospective risk adjustment model for ESRD To control potential increases in coding intensity and risk score growth, CMS will use a normalization factor, a Coding Intensity Factor, and a risk score cap. Additional details on risk adjustment	
Payment options	CMS makes all FFS payments		Primary Care Capitation (PCC) = monthly payments for certain primary care services ~2-7% of TCOC (CMS pays	Optional PCC or Total Care Capitation (TCC) = 100% Parts A & B services for aligned beneficiaries

							claims for all other services) • Fee reduction required for Participant Providers, optional for Preferred Providers • Optional Advanced Payment (APO) up to 100% of benchmark w/ reconciliation	• Fee reduction required for Participant Providers, optional for Preferred Providers
Reconciliation	Full performance year reconciliation following full claims run out period						Capitation payments not reconciled against actual claims. APO payments reconciled against actual claims. For ACOs electing TCC, CMS will reconcile TCC withhold against actual expenditures incurred by aligned beneficiaries for services provided outside of TCC arrangement.	
Beneficiaries and Alignment								
	MSSP Basic Level A	**MSSP Basic Level B**	**MSSP Basic Level C**	**MSSP Basic Level D**	**MSSP Basic Level E**	**MSSP Enhanced**	**REACH Professional**	**REACH Global**
Minimum number of beneficiaries	5,000						**Standard ACOs:** 5,000 (≥ 3,000 "alignable" beneficiaries in at least one base year) **New Entrant ACOs:** 2,000 in PY23, 3,000 in PY24, 5,000 in PY25-26 (max. 3,000 "alignable" beneficiaries in any base year) **High Needs Population ACOs:** 500 in PY23, 750 in PY24, 1,200 in PY25, 1,400 in PY26	
Beneficiary alignment	• Prospective or preliminary prospective with retrospective reconciliation (elected annually) • Claims-based and voluntary ○ Voluntary alignment takes precedence over claims-based						• Prospective • Claims-based and voluntary (may market voluntary alignment) ○ Voluntary alignment takes precedence over claims-based ○ Voluntary alignment through MyMedicare.gov takes precedence over Attestation-Based Voluntary Alignment ○ Option to add voluntarily aligned beneficiaries quarterly	

Beneficiary notification requirements	ACOs must include posted signs in all ACO participant facilities notifying beneficiaries that its providers are participating in MSSP. Each agreement period, ACOs must furnish a written notice to beneficiaries prior to or at the first primary care visit: • For ACOs under preliminary prospective assignment—send to all FFS beneficiaries prior to or at the first primary care visit during the first performance year that the beneficiary is seen by an ACO participant. • For ACOs under prospective assignment—send to all assigned beneficiaries prior to or at the firs primary care visit. Within 180 days of providing the notice or at the next primary care visit, ACOs must follow-up with beneficiaries and offer a meaningful opportunity to ask questions and engage with an ACO representative.						Each performance year, ACOs must send CMS-drafted and/or approved letters to all prospectively aligned patients by the date specified by CMS.	
Quality								
	MSSP Basic Level A	**MSSP Basic Level B**	**MSSP Basic Level C**	**MSSP Basic Level D**	**MSSP Basic Level E**	**MSSP Enhanced**	**REACH Professional**	**REACH Global**
Measures	GPRO Web Interface (WI) reporting will sunset after PY 2024. Now through PY 2024, ACOs may report WI, eCQMs/MIPS CQMs, or both (those reporting both will receive the higher of the two scores). The WI will no longer be a reporting option for PY 2025 or later. • WI reporting: 10 total measures (7 clinical quality measures, 2 administrative claims measures, CAHPS for MIPS) • eCQMs/MIPS CQMs: 6 total measures (3 clinical quality measures, 2 administrative claims measures, CAHPS for MIPS) *Note: CMS may suppress certain measures in certain performance years* NAACOS remains concerned with the timeline and strategy to shift to all payer/eCQM reporting and the NAACOS Digital Quality Measurement Task Force has provided recommendations to CMS on this issue.						• Standard & New Entrant ACOs: assessed on 4 measures (3 administrative claims measures and the ACO CAHPS Survey) • High Needs ACOs: Timely Follow-Up measure is replaced with Days at Home for Patients with Complex, Chronic Conditions	
Scoring	In order to earn maximum shared saving, an ACO must meet or exceed the 30th percentile among all MIPS quality performance category scores in 2021-2023 and meet or exceed the 40th percentile each year after. ACOs that do not meet this threshold may share in a portion of savings by achieving a quality performance score equivalent to the 10th percentile (individual measure performance benchmark) or higher on at least one outcome measure. The ACO's final sharing rate would be scaled by multiplying the maximum sharing rate for the ACO's track/level by the ACO's quality performance score, which includes any health equity bonus points.						• 2% benchmark withhold can be earned back through quality scores • Total Quality Score (0-100%) = initial quality score adjusted for continuous improvement/sustained exceptional performance (CI/SE) and health equity data reporting (HEDR) • Highest performers eligible for a bonus	
EHR use	At least 75% of ACOs' eligible clinicians as defined under MACRA must use Certified EHR Technology (CEHRT), using an annual attestation process.						ACOs must document that at least 75% of Participant Providers that are eligible clinicians use Certified EHR Technology (CEHRT)	
Compliance and Waivers								
	MSSP Basic Level A	**MSSP Basic Level B**	**MSSP Basic Level C**	**MSSP Basic Level D**	**MSSP Basic Level E**	**MSSP Enhanced**	**REACH Professional**	**REACH Global**
Compliance programs	ACO must have a compliance plan that meets the requirements of 42 C.F.R. § 425.300, including: a designated compliance official who is not legal counsel to the ACO; anonymous reporting of suspected compliance violations, both by ACO members, employees and contractors regarding internal ACO matters and to law enforcement where the law may be violated; and compliance training.							
Monitoring efforts	CMS monitors and assesses the performance of ACOs, their ACO participants, and ACO providers/suppliers through: • Analysis of financial and quality data reported by the ACO as well as aggregate annual and quarterly reports • Analysis of any beneficiary/provider complaints • Audits (i.e., analysis of claims, chart review, beneficiary survey reviews, coding audits, on-site compliance reviews)						In addition to MSSP monitoring, CMS will monitor REACH ACOs for: • Beneficiaries being shifted to MA • Excessive risk score growth/ inappropriate coding practices • Service use over time Full list of monitoring efforts	

Available waivers	Not applicable	• **SNF 3-day Rule**—Waives 3-day inpatient stay requirement prior to SNF admission. CMS waives 3-star quality rating requirement for providers under swing bed arrangements. • **Telehealth**—Waives typical geographic restrictions count patients' homes as originating sites. (*Only available to ACOs under prospective assignment*)	• **SNF 3-day Rule**—SNF must be Participant or Preferred Provider and have quality rating of 3+ stars • **Telehealth**—Same as MSSP • **Home visits** – care management and post-discharge • **Chronic Disease Management Reward Program** • **Provision of home health** services to beneficiaries not "homebound" • **Nurse Practitioner Services Benefit** ****Hospice Benefit**— Waive requirement to give up curative care (****only for Global*)
Allowable beneficiary incentives	Not applicable	**Beneficiary Incentive Program** —Allows ACOs to provide a limited "cash equivalent" incentive to eligible beneficiaries who receive qualifying primary care services. May not be limited to a subset of beneficiaries or services. **In-kind incentives** — There must be a reasonable connection between items/services and beneficiary's medical care; must be preventive care items/services or advance a clinical goal of the beneficiary; must not be a Medicare-covered item/service	• **Cost sharing support** for Part B services tailored to specific categories of services and/or beneficiaries • **In-kind items or services**—may include home blood pressure monitors, vouchers for OTC medications, transportation vouchers, wellness programs, etc.
Policies to promote health equity	**Health equity quality adjustment:** Beginning PY2023, CMS will award up to 10 bonus points to the quality performance score for ACOs delivering high quality care to underserved populations. Bonus points are only available to ACOs reporting eCQMs/MIPS CQMs. Additional details on the bonus calculation can be found on p. 14-15 here. **Advance Investment Payments (AIPs):** Beginning PY2024, CMS will provide advance shared savings payments to new, inexperienced, low revenue ACOs, modeled after the ACO Investment Model (AIM). AIPs will consist of a one-time upfront payment $250,000 and quarterly payment calculated per beneficiary over the first 2 years of an ACO's agreement period. ACOs will be able to apply for AIPs as part of the MSSP application cycle. More information can be found on p. 9-12 here.		• Health Equity Plan requirement • Health equity benchmark adjustment • Requirement to collect and report beneficiary-reported demographic and SDOH data • Application scores include ACOs' demonstrated ability to provide high quality care to underserved communities

Additional Resources								
	MSSP Basic Level A	**MSSP Basic Level B**	**MSSP Basic Level C**	**MSSP Basic Level D**	**MSSP Basic Level E**	**MSSP Enhanced**	**REACH Professional**	**REACH Global**
NAACOS resources	NAACOS MSSP webpage, NAACOS Analysis of the 2023 MPFS, NAACOS Quality webpage						NAACOS ACO REACH webpage, Summary of REACH Financial Specifications, REACH FAQs	
CMS resources	Shared Savings Program webpage, Information for ACOs, Information for Providers, Program Guidance & Specifications, Program Data, MSSP News						REACH Model webpage, Model Factsheet, Financial operating guide, Quality measurement methodology, Provider management guide	

Appendix C – Policy Appendix
Policies Recommended for Reaffirmation

Accountable Care Organization Principles H-160.915
Our AMA adopts the following Accountable Care Organization (ACO) principles:
1. Guiding Principle - The goal of an ACO is to increase access to care, improve the quality of care and ensure the efficient delivery of care. Within an ACO, a physician's primary ethical and professional obligation is the well-being and safety of the patient.
2. ACO Governance - ACOs must be physician-led and encourage an environment of collaboration among physicians. ACOs must be physician-led to ensure that a physician's medical decisions are not based on commercial interests but rather on professional medical judgment that puts patients' interests first.
A. Medical decisions should be made by physicians. ACOs must be operationally structured and governed by an appropriate number of physicians to ensure that medical decisions are made by physicians (rather than lay entities) and place patients' interests first. Physicians are the medical professionals best qualified by training, education, and experience to provide diagnosis and treatment of patients. Clinical decisions must be made by the physician or physician-controlled entity. The AMA supports true collaborative efforts between physicians, hospitals and other qualified providers to form ACOs as long as the governance of those arrangements ensures that physicians control medical issues.
B. The ACO should be governed by a board of directors that is elected by the ACO professionals. Any physician-entity [e.g., Independent Physician Association (IPA), Medical Group, etc.] that contracts with, or is otherwise part of, the ACO should be physician-controlled and governed by an elected board of directors.
C. The ACO's physician leaders should be licensed in the state in which the ACO operates and in the active practice of medicine in the ACO's service area.
D. Where a hospital is part of an ACO, the governing board of the ACO should be separate, and independent from the hospital governing board.
3. Physician and patient participation in an ACO should be voluntary. Patient participation in an ACO should be voluntary rather than a mandatory assignment to an ACO by Medicare. Any physician organization (including an organization that bills on behalf of physicians under a single tax identification number) or any other entity that creates an ACO must obtain the written affirmative consent of each physician to participate in the ACO. Physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid or a private payer or being admitted to a hospital medical staff.
4. The savings and revenues of an ACO should be retained for patient care services and distributed to the ACO participants.
5. Flexibility in patient referral and antitrust laws. The federal and state anti-kickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs. This is particularly important for physicians in small- and medium-sized practices who may want to remain independent but otherwise integrate and collaborate with other physicians (i.e., so-called virtual integration) for purposes of participating in the ACO. The ACA explicitly authorizes the Secretary to waive requirements under the Civil Monetary Penalties statute, the Anti-Kickback statute, and the Ethics in Patient Referrals (Stark) law. The Secretary should establish a full range of waivers and safe harbors that will enable independent physicians to use existing or new organizational structures to participate as ACOs. In addition, the Secretary should work with the Federal Trade Commission to provide explicit exceptions to the antitrust laws for ACO participants. Physicians cannot completely transform their practices only for their Medicare patients, and antitrust enforcement could prevent them from creating clinical integration structures involving their privately insured patients. These waivers and safe harbors should be allowed where appropriate to exist beyond the end of the initial agreement between the ACO and CMS so that any new

organizational structures that are created to participate in the program do not suddenly become illegal simply because the shared savings program does not continue.
6. Additional resources should be provided up-front in order to encourage ACO development. CMS's Center for Medicare and Medicaid Innovation (CMI) should provide grants to physicians in order to finance up-front costs of creating an ACO. ACO incentives must be aligned with the physician or physician group's risks (e.g., start-up costs, systems investments, culture changes, and financial uncertainty). Developing this capacity for physicians practicing in rural communities and solo-small group practices requires time and resources and the outcome is unknown. Providing additional resources for the up-front costs will encourage the development of ACOs since the 'shared savings' model only provides for potential savings at the back-end, which may discourage the creation of ACOs (particularly among independent physicians and in rural communities).
7. The ACO spending benchmark should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.
A. The ACO spending benchmark, which will be based on historical spending patterns in the ACO's service area and negotiated between Medicare and the ACO, must be risk-adjusted in order to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill.
B. The ACO benchmark should be risk-adjusted for the socioeconomic and health status of the patients that are assigned to each ACO, such as income/poverty level, insurance status prior to Medicare enrollment, race, and ethnicity and health status. Studies show that patients with these factors have experienced barriers to care and are more costly and difficult to treat once they reach Medicare eligibility.
C. The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating cost factors (i.e., hospital wage index) and physician HIT costs.
D. The ACO benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient socioeconomic and health status factors.
E. In addition to the shared savings earned by ACOs, ACOs that spend less than the national average per Medicare beneficiary should be provided an additional bonus payment. Many physicians and physician groups have worked hard over the years to establish systems and practices to lower their costs below the national per Medicare beneficiary expenditures. Accordingly, these practices may not be able to achieve significant additional shared savings to incentivize them to create or join ACOs. A bonus payment for spending below the national average would encourage these practices to create ACOs and continue to use resources appropriately and efficiently.
8. The quality performance standards required to be established by the Secretary must be consistent with AMA policy regarding quality. The ACO quality reporting program must meet the AMA principles for quality reporting, including the use of nationally-accepted, physician specialty-validated clinical measures developed by the AMA-specialty society quality consortium; the inclusion of a sufficient number of patients to produce statistically valid quality information; appropriate attribution methodology; risk adjustment; and the right for physicians to appeal inaccurate quality reports and have them corrected. There must also be timely notification and feedback provided to physicians regarding the quality measures and results.
9. An ACO must be afforded procedural due process with respect to the Secretary's discretion to terminate an agreement with an ACO for failure to meet the quality performance standards.
10. ACOs should be allowed to use different payment models. While the ACO shared-savings program is limited to the traditional Medicare fee-for-service reimbursement methodology, the Secretary has discretion to establish ACO demonstration projects. ACOs must be given a variety of payment options and allowed to simultaneously employ different payment methods, including fee-for-service, capitation, partial capitation, medical homes, care management fees, and shared savings. Any capitation payments must be risk-adjusted.

11. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient Satisfaction Survey should be used as a tool to determine patient satisfaction and whether an ACO meets the patient-centeredness criteria required by the ACO law.
12. Interoperable Health Information Technology and Electronic Health Record Systems are key to the success of ACOs. Medicare must ensure systems are interoperable to allow physicians and institutions to effectively communicate and coordinate care and report on quality.
13. If an ACO bears risk like a risk bearing organization, the ACO must abide by the financial solvency standards pertaining to risk-bearing organizations.
(Res. 819, I-10; Reaffirmation: A-11; Reaffirmed: Res. 215, A-11; Reaffirmation: I-12; Reaffirmed: CMS Rep. 6, I-13; Reaffirmed: Sub. Res. 711, A-15; Reaffirmation: I-15; Reaffirmation: A-16; Reaffirmation: I-17; Reaffirmation: A-19)

Patient Information and Choice H-373.998
Our AMA supports the following principles:
1. Greater reliance on market forces, with patients empowered with understandable fee/price information and incentives to make prudent choices, and with the medical profession empowered to enforce ethical and clinical standards which continue to place patients' interests first, is clearly a more effective and preferable approach to cost containment than is a government-run, budget-driven, centrally controlled health care system.
2. Individuals should have freedom of choice of physician and/or system of health care delivery. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system.
3. In order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to the provision of such services, procedures, and products. There should be a similar requirement that insurers make available in a standard format to enrollees and prospective enrollees information on the amount of payment provided toward each type of service identified as a covered benefit.
4. Federal and/or state legislation should authorize medical societies to operate programs for the review of patient complaints about fees, services, etc. Such programs would be specifically authorized to arbitrate a fee or portion thereof as appropriate and to mediate voluntary agreements and could include the input of the state medical society and the AMA Council on Ethical and Judicial Affairs.
5. Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians and/or health plans of their choice.
6. Efforts should continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and the patient/physician relationships, at the forefront.
(BOT Rep. QQ, I-91; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: Ref. Cmte. A, A-93; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: CMS Rep. G, A-93; Reaffirmed: Sub. Res. 701, A-93; Sub. Res. 125, A-93; Reaffirmation: A-93; Reaffirmed: BOT Rep. 25, I-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: CMS Rep. 5, I-93; Reaffirmed: CMS Rep. 10, I-93; Reaffirmed: Sub. Res. 107, I-93; Reaffirmed: BOT Rep. 46, A-94; Reaffirmed: Sub. Res. 127, A-94; Reaffirmed: Sub. Res 132, A-94; Reaffirmed: BOT 16, I-94; BOT Rep. 36, I-94; Reaffirmed: CMS Rep. 8, A-95; Reaffirmed: Sub. Res. 109, A-95; Reaffirmed: Sub. Res. 125, A-95; Reaffirmed by Sub. Res. 107, I-95; Reaffirmed: Sub. Res. 109, I-95; Reaffirmed by Rules & Credentials Cmte., A-96; Reaffirmation: I-96; Reaffirmation: A-97; Reaffirmed: Rules & Credentials Cmte., I-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmation: I-98; Reaffirmed: CMS Rep. 9, A-98; Reaffirmation: A-99; Reaffirmation: A-00; Reaffirmation: I-00; Reaffirmation: A-04; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmation: A-07;

Reaffirmation: A-08; Reaffirmed: CMS Rep. 4, A-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmation: I-14; Reaffirmed: CMS Rep. 4, A-15; Reaffirmation: A-17; Reaffirmed: Res. 108, A-17; Reaffirmation: A-19; Reaffirmed in lieu of: Res. 112, A-19)

Effects of Hospital Integrated System Accountable Care Organizations H-160.892
Our AMA encourages studies into the effect of hospital integrated system Accountable Care Organizations' (ACOs) ability to generate savings and the effect of these ACOs on medical staffs and potential consolidation of medical practices.

Health Care Reform Physician Payment Models D-385.963
1. Our AMA will: (a) work with the Centers for Medicare and Medicaid Services and other payers to participate in discussions and identify viable options for bundled payment plans, gain-sharing plans, accountable care organizations, and any other evolving health care delivery programs; (b) develop guidelines for health care delivery payment systems that protect the patient-physician relationship; (c) make available to members access to legal, financial, and ethical information, tools and other resources to enable physicians to play a meaningful role in the governance and clinical decision-making of evolving health care delivery systems; and (d) work with Congress and the appropriate governmental agencies to change existing laws and regulations (e.g., antitrust and anti-kickback) to facilitate the participation of physicians in new delivery models via a range of affiliations with other physicians and health care providers (not limited to employment) without penalty or hardship to those physicians.
2. Our AMA will: (a) work with third party payers to assure that payment of physicians/healthcare systems includes enough money to assure that patients and their families have access to the care coordination support that they need to assure optimal outcomes; and (b) will work with federal authorities to assure that funding is available to allow the CMMI grant-funded projects that have proven successful in meeting the Triple Aim to continue to provide the information we need to guide decisions that third party payers make in their funding of care coordination services.
3. Our AMA advises physicians to make informed decisions before starting, joining, or affiliating with an ACO. Our AMA will provide information to members regarding AMA vetted legal and financial advisors and will seek discount fees for such services.
4. Our AMA will develop a toolkit that provides physicians best practices for starting and operating an ACO, such as governance structures, organizational relationships, and quality reporting and payment distribution mechanisms. The toolkit will include legal governance models and financial business models to assist physicians in making decisions about potential physician-hospital alignment strategies. The toolkit will also include model contract language for indemnifying physicians from legal and financial liabilities.
5. Our AMA will continue to work with the Federation to identify, publicize and promote physician-led payment and delivery reform programs that can serve as models for others working to improve patient care and lower costs.
6. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
7. Our AMA will work with states to: (a) ensure that current state medical liability reform laws apply to ACOs and physicians participating in ACOs; and (b) address any new liability exposure for physicians participating in ACOs or other delivery reform models.
8. Our AMA recommends that state and local medical societies encourage the new Accountable Care Organizations (ACOs) to work with the state health officer and local health officials as they develop the electronic medical records and medical data reporting systems to assure that data needed by Public Health to protect the community against disease are available.
9. Our AMA recommends that ACO leadership, in concert with the state and local directors of public health, work to assure that health risk reduction remains a primary goal of both clinical practice and the efforts of public health.

10. Our AMA encourages state and local medical societies to invite ACO and health department leadership to report annually on the population health status improvement, community health problems, recent successes and continuing problems relating to health risk reduction, and measures of health care quality in the state.

Plan for Continued Progress Toward Health Equity H-180.944
Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity. (BOT Rep. 33, A-18; Reaffirmed: CMS Rep. 5, I-21)

The Structure and Function of Interprofessional Health Care Teams H-160.912
1. Our AMA defines 'team-based health care' as the provision of health care services by a physician-led team of at least two health care professionals who work collaboratively with each other and the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care.
2. Our AMA will advocate that the physician leader of a physician-led interprofessional health care team be empowered to perform the full range of medical interventions that she or he is trained to perform.
3. Our AMA will advocate that all members of a physician-led interprofessional health care team be enabled to perform medical interventions that they are capable of performing according to their education, training and licensure and the discretion of the physician team leader in order to most effectively provide quality patient care.
4. Our AMA adopts the following principles to guide physician leaders of health care teams:
a. Focus the team on patient and family-centered care.
b. Make clear the team's mission, vision and values.
c. Direct and/or engage in collaboration with team members on patient care.
d. Be accountable for clinical care, quality improvement, efficiency of care, and continuing education.
e. Foster a respectful team culture and encourage team members to contribute the full extent of their professional insights, information and resources.
f. Encourage adherence to best practice protocols that team members are expected to follow.
g. Manage care transitions by the team so that they are efficient and effective, and transparent to the patient and family.
h. Promote clinical collaboration, coordination, and communication within the team to ensure efficient, quality care is provided to the patient and that knowledge and expertise from team members is shared and utilized.
i. Support open communication among and between the patient and family and the team members to enhance quality patient care and to define the roles and responsibilities of the team members that they encounter within the specific team, group or network.
j. Facilitate the work of the team and be responsible for reviewing team members' clinical work and documentation.
k. Review measures of ‘population health’ periodically when the team is responsible for the care of a defined group.
5. Our AMA encourages independent physician practices and small group practices to consider opportunities to form health care teams such as through independent practice associations, virtual networks or other networks of independent providers.
6. Our AMA will advocate that the structure, governance and compensation of the team should be aligned to optimize the performance of the team leader and team members.
(Joint CME-CMS Report., I-12; Reaffirmation: I-13; Reaffirmed: CMS Rep. 1, I-15; Reaffirmed: BOT Action in Response to Referred for Decision: Res. 718, A-17)

Alternative Payment Models and Vulnerable Populations D-385.952
Our AMA: (1) supports alternative payment models (APMs) that link quality measures and payments to outcomes specific to vulnerable and high-risk populations, reductions in health care disparities, and functional improvements, if appropriate; (2) will continue to encourage the development and implementation of physician-focused APMs that provide services to improve the health of vulnerable and high-risk populations and safeguard patient access to medically necessary care, including institutional post-acute care.
(CMS Rep. 10, A-19; Modified: Rep. 04, A-23; Reaffirmation: Res. 111, A-23)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-I-23

Subject: Health Insurers and Collection of Patient Cost-Sharing (Resolution 823-I-22)

Presented by: Sheila Rege, MD Chair

Referred to: Reference Committee J

At the November 2022 Interim Meeting, the House of Delegates referred Resolution 823, "Health Insurers and Collection of Co-pays and Deductibles," which was sponsored by the Private Practice Physicians Section and asked:

> That our American Medical Association (AMA) advocate for legislation and/or regulations to require insurers to collect co-pays and deductibles in fee-for-service arrangements directly from patients with whom the insurers are contractually engaged and pay physicians the full contracted rate unless physicians opt-out to collect on their own.

This report provides an overview of cost-sharing, highlights the impact of cost-sharing collection for physicians, including unique concerns for emergency physicians, explores alternatives to cost-sharing collections, and presents a policy recommendation consistent with Resolution 823-I-22.

DEDUCTIBLES AND OTHER COST-SHARING

Cost-sharing is a general term for the portion of annual health care costs that patients are responsible for paying "out-of-pocket" and may include deductibles, copays and/or coinsurance. Deductibles are paid before the full insurance coverage begins, while copays and coinsurance limit patient costs once the deductible is met.[1] Patients are responsible for all of these forms of cost-sharing and typically they are collected by the physician, practice, or hospital where the care was provided. Cost-sharing began in the United States in the mid-20th century as a response to patient desire for coverage beyond inpatient care and insurer concern that first-dollar comprehensive insurance could result in unsustainably high premiums. Since cost-sharing was collected at the point-of-service, physicians' offices and hospitals have traditionally been responsible for the collection of cost-sharing.[2]

A deductible is the amount that a patient must pay annually before the insurance plan covers the cost of care. Deductible amounts vary significantly by plan, but the average deductible for individual employer-provided coverage is just under $1,800.[3] High-deductible health plans (HDHPs) often have higher deductibles with individual health plans ranging between $1,500 and $7,500. Marketplace health plans range significantly by metal rating with "Bronze" plans annual deductible averaging just under $7,500 and "Platinum" plans averaging just $45. The Medicare Part B deductible is currently $226 annually. Plans with lower monthly premiums tend to have higher deductible amounts and those with higher monthly premiums tend to have lower deductible amounts. Often plans have both individual and family deductibles. Importantly, many plans cover certain services before the patient has met the deductible. For example, all Marketplace and many

private plans cover the full cost of certain preventive services before the beneficiary meets the deductible.[4] During the deductible phase, patient out-of-pocket charges are limited to the approved contracted rate of their health plan.

A copay is a fixed amount that patients pay for a covered health service once the deductible has been met.[5] Copays typically range from $15-$25 for a routine, in-network visit to the physician's office and are paid at the time of the visit. Patients who have not met their deductibles will pay the full allowable amount for the visit to the physician's office. The amount of a copay varies by plan and by the service rendered. As with deductibles, typically health insurance plans that have lower monthly premiums have higher copays and those with higher monthly premiums have lower copayments. Coinsurance is the percentage of costs paid by the patient for covered health care services after the deductible has been met. Coinsurance rates average approximately 20 percent for employer-sponsored insurance and is exactly 20 percent for Medicare Part B plans. Cost-sharing cannot be routinely waived or reduced by physicians/practices for either public or private plans, but payment plans may be acceptable in cases of financial hardship.

Cost-sharing may also vary by site of service (inpatient vs outpatient vs emergency). For patients who are receiving inpatient care, cost-sharing is typically based on length of stay, per-stay, or per-day basis once the patient has been formally admitted for inpatient care. All of the aforementioned specifics hinge on the patient receiving care from an in-network physician/provider. Should an out-of-network physician provide care, many insurance plans have additional/higher cost-sharing responsibilities for the patient.

PHYSICIAN IMPACT

While many physicians experience the adverse impact of collecting cost-sharing, private practices, especially small and rural practices, tend to face more extreme challenges. Net physician practice revenue is often reduced not only from unpaid cost-sharing, but also from the administrative overhead associated with billing and collection. These activities take staff away from more direct patient care activities and can be a drain on a practice's financial resources. Small private and rural practices often have smaller operating budgets and struggle more than larger practices to cover these increased administrative costs.

Uncompensated and partially paid care, such as when cost-sharing payments are not made, can stem from a number of factors with uninsured or underinsured patients often having the largest impact.[6] Regardless of the root cause of uncompensated care, it is estimated that the lost revenue can reach billions annually.[7] Patients with HDHPs, which typically have higher deductibles have significantly contributed to the growth in uncompensated care.[8]

Another factor behind uncompensated care in the United States is the lack of affordability of health care nationally.[9] Not only are these costs high, but they are also on the rise. For example, in 2021, health care costs accounted for 18 percent of the U.S. Gross Domestic Product, up from five percent in 1960.[18] As a result, many Americans have experienced medical debt. Twenty-three million American adults, about 9 percent, hold medical debt with about half of those reporting owing more than $2,000.[10] The lack of affordability of American health care is a contributor to the issues that many physicians face when seeking to collect co-pays and deductibles from patients.

COST-SHARING AND EMTALA

While the collection of cost-sharing is not prohibited by the Emergency Medical Treatment and Labor Act (EMTALA), any collection done during an emergency department (ED) visit cannot

interfere, impede, or delay the medical screening exam (MSE) or stabilizing care. The collection of patient cost-sharing in EDs is complicated and, in some situations, nearly impossible to pursue. As a result, many EDs determine that the collection of cost-sharing is not worth the investment that is needed to ensure that collection is done in a legal and respectful manner.

The regulation around ED copay collection, combined with Medicaid underfunding, Medicare's lack of an inflation adjustment, and uninsured patients seeking care, lead to emergency physicians providing uncompensated care about 55 percent of the time.[11] While the collection of copays and coinsurance are complicated in an emergency setting, the principles remain the same. A copay is still a set amount, typically between $50-$200 for an ED visit, and coinsurance is still a set percentage that the patient pays, usually ranging from 10-50 percent, as long as the deductible has been met. The collection of cost-sharing can be difficult enough in non-emergency settings, and the regulations around prevention of delay to MSE/stabilizing care further complicate the issue making it even harder to collect in emergency settings.

ALTERNATIVE COST-SHARING COLLECTIONS STRATEGIES AND OPTIONS

Some physician practices routinely use collections services. While this alternative still involves physician responsibility in collecting the cost-sharing, the onus of the specific collections actions falls on the agency. Collections agencies are contracted with the physician practice to collect on past-due or delinquent accounts.[12] Typically, agencies are paid via a contingency fee, which is only collected after the overdue account is settled. For physicians who are experiencing considerable financial challenges due to writing off accounts receivable as bad debt, or the difference between what patients are billed and what is actually paid, collections agencies may provide a viable alternative.

However, it is important that physicians are careful to ensure that selected agencies represent practices in a responsible manner and will not engage in undue patient harassment. Concerns surrounding the impact of overly aggressive collections agencies on not only patient financials, but also on the patient-physician relationship, are widespread and unfortunately founded.[19] Additionally, it is not uncommon for physicians to see minimal returns on collections sent to agencies as these agencies can charge significant fees to collect debts. On average, collections agencies charge a fee between 20 percent and 40 percent of what is collected. However, in certain situations, like when a debt is older, the collections agency may charge a higher percentage. When charging a percentage of the debt, agencies will only be paid if the debt is collected. Some agencies use a flat fee system where they charge between $15-$25 per account regardless of if the debt is actually collected.[13] Finally, collections agencies are utilized only after the physician/office has made attempts to collect payment, meaning that the physician/practice has already accrued costs to attempt collections. Due to the lack of return and the potential harms to patient financials, physician and practice reputation, and the patient-physician relationship collections agencies may not be the best alternative method for many physicians/practices to collect cost-sharing.

Another potential solution to physicians' collection of cost-sharing is the use of insurance-controlled collection systems. Collections systems like InstaMed, Flywire, Zelis, and MedPilot are patient payment programs that work to collect payments from patients for physicians, primarily through electronic means. These systems, utilized by companies like UnitedHealthcare, Blue Cross Blue Shield, and other major insurance companies, allow physicians to avoid the potential for bad debt.

Although these types of systems may help physicians and their practices in collecting cost-sharing, they can result in unintentional adverse impacts. For example, physicians may find that there is a

loss of business autonomy in turning over control of collections to insurers. Physicians often do not have a choice in if they want to receive payments in this manner, which further limits physician autonomy. Additionally, while there is little price transparency as to the specific cost to the practice, these services do come at an additional cost to the provider. Finally, as mentioned in CMS Report 9-A-19 physicians utilizing these programs are often pressured to sign up to receive costs via standard electronic fund transfers (EFTs). Should a physician choose not to sign up for EFTs, payments will be issued through a virtual credit card, which often comes with a substantial fee, often between 2-5 percent of the total payment. Due to the potential impacts on physician autonomy, this may not be the best solution to the collection of cost-sharing for most practices. More detailed information about this business model and its impacts can be found in CMS Report 9-A-19.

RELEVANT AMA POLICY AND RESOURCES

The AMA has a number of policies that work to ensure that care is affordable and patients are able to maintain affordable insurance coverage. Policy H-165.838 works to reform health systems to ensure that all Americans have coverage that is affordable and minimizes unnecessary costs and administrative burden. Additionally, Policy H-165.828 focuses more specifically on ensuring the affordability of health insurance for all Americans. This policy outlines the AMA's support for the ACA and suggests modifications to ensure that Americans are both educated about insurance choices and have access to coverage. Each of these policies work to ensure that coverage is expanded and help to reduce the cost of health care to patients as well as uncompensated care.

AMA policy also supports physician autonomy in practice type. Policy H-385.926 encourages physician practice autonomy through the growth of the patient-physician contract, support for physician choice in method of earning (fee-for-service, salary, capitation, etc.), and physician choice over charged fees. Finally, the AMA has policy that specifically addresses HDHPs and the complications that physicians face when collecting cost-sharing from patients covered by these plans. Policy H-165.849 outlines the AMA's opposition to plans that require physicians to bill patients, instead of more efficient methods, and outlines plans to engage with HDHP representatives to discuss the increasing difficulty for physicians to collect cost-sharing.

The AMA also has developed a variety of resources to help physicians navigate the complicated world of collecting cost-sharing. First, the AMA has a set of tools that are designed to help physicians manage patient payments, including a point-of-care pricing toolkit, resources on maximizing post-visit collections, and a how-to-guide for selecting a practice management system. Second, the AMA has developed a resource to support physicians in contracting with payers, Contracting 101 and hosted two webinars related to payer contracting, Payor and Contracting 101 Webinar and Payor and Contracting 201 Webinar. Each of these contracting resources are a part of the AMA's larger Private Practice Playbook: Resources.

DISCUSSION

The collection of cost-sharing is an extremely complicated and taxing process that physicians are required to navigate in order to receive full contracted compensation for services rendered. The Council believes that requiring physicians to engage in collecting cost-sharing negatively impacts physicians, with a particularly strong impact on those working in smaller private and rural practices. Accordingly, the Council concurs with the sentiment of Resolution 823-I-22.

AMA efforts to support physicians practicing in the current system of cost-sharing have included a series of resources, which were created to guide physicians in the steps of not only collecting cost-

sharing, but also in establishing fair and manageable contracts with payers. In addition to the guidance on payer contracting, the AMA has also established relatively extensive resources to assist physicians in navigating the collection of cost-sharing from patients. For example, these resources outline methods of point-of-care collections that have been shown to increase cash flow while also reducing billing and overhead costs, administrative burdens, and bad debt. In addition to the point-of-care collection resources, the AMA also provides information on how to maximize collections post-visit and how to select a practice management system. All of these resources are designed to assist physicians in navigating the complex and taxing process of collecting cost-sharing. However, it is clear that physicians still struggle with cost-sharing collection.

While cost-sharing seems to be a permanent fixture in health care payments, there are potential methods of collection that could ease the burden placed on physicians. As mentioned in this report, physicians are able to utilize collections agencies as a means to collect cost-sharing from patients. However, this may not be a method that all physicians are comfortable utilizing due to the potential negative impacts on patients and the physician-patient relationship. Another existing alternative to the traditional physician-collected cost-sharing system is insurance-controlled systems. These aforementioned systems are run by insurers, which may limit physician autonomy and may increase cost, but may be advantageous for physicians who struggle to collect cost-sharing. The Council specifically believes that alternative methods of collecting cost-sharing in which the onus is placed on insurers is likely to be advantageous for physicians and their practices.

Therefore, the Council recommends the adoption of an amended resolution 823-I-22. Specifically, the Council's recommended amendment allows for enduring policy to support insurers collecting patient cost-sharing, rather than physicians. The Council agrees that physicians should have the ability to opt-out of insurer collection.

Finally, in order to ensure that there are no unexpected adverse impacts on the health insurance coverage status of Americans, the Council recommends the reaffirmation of Policy H-165.838 which outlines the AMA's commitment to enact health insurance coverage for all Americans in a manner that is both affordable and accessible. The reaffirmation of this policy will reiterate the AMA's support to ensure that all Americans have access to affordable health insurance and that this would not be negated by the implementation of an insurance-controlled cost-sharing collections system.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 823-I-22, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support requiring health insurers to collect patient cost-sharing and pay physicians their full contracted amount for the health care services provided, unless the physicians opt-out to collect such cost-sharing on their own. (New HOD Policy)

2. That our AMA reaffirm Policy H-165.838, which details the AMA's ongoing support for affordable and accessible insurance coverage. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] Deductible. Health Care.gov. 2023. https://www.healthcare.gov/glossary/deductible/
[2] Hoffman B. Restraining the Health Care Consumer: The History of Deductibles and Co-payments in U.S. Health Insurance. *Social Science History.* 2006 Dec. doi: 10.1215/01455532-2006-007. https://www.cambridge.org/core/journals/social-science-history/article/abs/restraining-the-health-care-consumer/7DBF541C18ACCE37FDA26DFEFC7F0B02
[3] Health Insurance Deductible. Health Insurance.org. 2023. https://www.healthinsurance.org/glossary/health-insurance-deductible/
[4] Medicare Costs. Medicare.gov. 2023. https://www.medicare.gov/basics/costs/medicare-costs
[5] Copayment. *Health Care.gov*. 2023. https://www.healthcare.gov/glossary/co-payment/
[6] Under D. Resolving Uncompensated Care: Artificial Intelligence Takes on One of Healthcare's Biggest Costs. *Health Catalyst.* 2018. https://www.healthcatalyst.com/insights/uncompensated-care-resolving-major-healthcare-cost
[7] Coughlin T A, Samuel-Jakubos H, Garfield R. Sources of Payment for Uncompensated Care for the Uninsured. *Kaiser Family Foundation.* 2021 April 06. https://www.kff.org/uninsured/issue-brief/sources-of-payment-for-uncompensated-care-for-the-uninsured/
[8] Smith M. High-deductible and skinny health insurance plans drive medical debt. American Hospital Association. 2023 March 20. https://www.aha.org/news/blog/2023-03-20-high-deductible-and-skinny-health-insurance-plans-drive-medical-debt
[9] Culter D. The World's Costliest Health Care and What America Might Do About It. *Harvard Magazine.* 2020 May-June. https://www.harvardmagazine.com/2020/05/feature-forum-costliest-health-care
[10] Rae M, Claxton G, Amin K, Wager E, Ortaliza J, Cox C. The Burden of Medical Debt in the United States. *Kaiser Family Foundation.* 2022 March 10. https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/
[11] Kang H, Bastian ND, Riordan JP. Evaluating the Relationship between Productivity and Quality in Emergency Departments. J Healthc Eng. 2017; 2017:9626918. doi:10.1155/2017/9626918. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5559952/
[12] How to Select a Collection Service. *American Medical Association.* 2019. https://shorturl.at/afgIY
[13] How Much Do Collections Agencies Charge. *Fair Capital.* 2023. https://www.thefaircapital.com/post/collection-agencies-fee#:~:text=How%20much%20can%20you%20expect,profit%20margins%20for%20the%20agency.

REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (I-23)
Strengthening Network Adequacy
(Reference Committee J)

EXECUTIVE SUMMARY

Almost a decade after presenting Council on Medical Service Report 4-A-14, the Council self-initiated this report to strengthen and supplant existing American Medical Association (AMA) policy on the adequacy of health plan networks and the accuracy of provider directories. Although network adequacy must be monitored across all types of health plans, the use of limited networks has become increasingly common in Medicare Advantage, Medicaid managed care, and Affordable Care Act marketplace plans. This report provides an overview of federal and state network adequacy requirements and oversight; addresses the role of telehealth in network adequacy; describes efforts to use network adequacy requirements to improve health equity; summarizes AMA policy and advocacy; and presents policy recommendations.

Network adequacy refers to a health plan's ability to provide access to in-network physicians and hospitals to meet enrollees' health care needs. While acknowledging the challenges involved to ensuring network adequacy without adding substantially to the cost of insurance, the Council believes that regulators should take a multilayered approach that includes meaningful standards, transparency of network breadth and in-network physicians and hospitals, parameters around out-of-network care, and effective monitoring and enforcement. Among the large number of AMA policies addressing network adequacy, out-of-network care, and provider directory accuracy, four are recommended for reaffirmation: Policies H-285.908, H-285.904, H-285.902, and H-285.911, which are appended to this report.

Seven recommendations for new AMA policy ask our AMA to encourage and/or support: 1) a minimum federal network adequacy standard; 2) the use of multiple criteria to evaluate the sufficiency of provider networks; 3) the development and promulgation of assessment tools that allow consumers to compare insurance plans; 4) requirements for reporting to regulators and prominently displaying important network adequacy information, including the breadth of a plan's network and instructions for filing complaints; 5) the use of claims data, audits, secret shopper programs, and complaints to monitor network adequacy, and appointment wait times; 6) counting in-network physicians who provide both in-person and telehealth services towards network adequacy requirements on a very limited bases when their physical practice does not meet time and distance standards (while affirming the AMA does not support counting telehealth-only physicians towards network adequacy requirements); and 7) regulation to hold health plans accountable for network inadequacies, including through the use of corrective action plans and substantial financial penalties.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-23

Subject: Strengthening Network Adequacy

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee J

During the development of Council on Medical Service Report 6-A-23, Health Care Marketplace Plan Selection, the Council identified provider network adequacy as a key factor in maintaining healthy competition and choice in Affordable Care Act (ACA) marketplace plans. In that report, the Council highlighted concerns about the ability of patients to see certain physicians who are listed in provider directories as in-network but for whom access is limited because they are not accepting new patients or do not have timely appointments available. Because similar critiques have plagued other types of plans—most notably Medicare Advantage (MA) and Medicaid managed care organization (MCO) plans—the Council developed this self-initiated report on strengthening network adequacy, which provides overviews of federal and state network adequacy requirements, summarizes AMA policy and advocacy, and presents policy recommendations.

BACKGROUND

Access to physicians, hospitals, and other health care providers to obtain evidence-based, high-quality health care depends on a range of factors, including the breadth, size, and distribution of a plan's provider network. Health insurers manage the quantity and quality of providers and facilities in their networks and may limit the number of those in-network, or contract with less expensive providers and facilities, to manage utilization and contain costs. Although network adequacy should be monitored across all health plans, the use of narrow networks has become increasingly common in MA, Medicaid, and ACA marketplace plans as insurers compete for customers by offering lower-cost plans with limited networks.

According to a recent Kaiser Family Foundation survey, more than a quarter (26 percent) of insured adults reported that an in-network physician they wanted to see in the last year did not have appointments available and 14 percent of respondents said their insurance did not cover a particular physician or hospital they needed.[1] Additionally, nearly a quarter (23 percent) of survey respondents indicated that it was at least somewhat difficult to understand where to find out which physicians and hospitals are covered in their plan's network.[2] Provider directory inaccuracies also remain problematic for patients and physicians as some plans' networks may appear more robust by including physicians who are not in-network or who are unavailable or unwilling to provide services. While directory inaccuracies and network inadequacy are two different problems, directory inaccuracy may complicate efforts to address network inadequacy and is often considered along with network adequacy efforts.

Network adequacy generally refers to a health plan's ability to provide access to in-network physicians, other clinicians, and facilities to meet enrollees' health care needs. Establishing network adequacy standards is an important regulatory tool used to ensure that health plans

contract with an appropriately sized and distributed provider population. Federal and state qualitative standards generally require health plans to attest that networks include sufficient physicians and facilities to enable enrollees to access care within reasonable distances and timeframes. Notably, no national standard exists for network adequacy or network size, or what constitutes a sufficient network, and standards—and their enforcement—can vary significantly across states and plan types. The most common measures are time and distance standards outlining the maximum length of time and distance a patient should have to travel in order to see an in-network physician. Alternative network adequacy measures attempting to more accurately reflect the experience of a patient seeking in-network services include requirements that plans use secret shopper surveys to evaluate provider availability or employ maximum appointment wait times to ensure that appointments are available in a timely manner. Although midlevel providers may be in a provider network if permitted under state law, health plans must meet network adequacy requirements for physicians and measurement should be limited to physicians for physician services.

As described in the following sections, regulation and oversight of network adequacy vary by insurance type. Although MA plans are federally regulated, states are primarily responsible for regulating commercial plans offered in individual and small group markets; federal minimum requirements may apply, including in states relying on the federally facilitated marketplace rather than a state-based marketplace. States also regulate network adequacy in Medicaid in accordance with federal standards and generally have broad discretion to oversee Medicaid MCOs. Self-insured plans are exempt from most state insurance laws but must comply with a limited set of federal regulations.

The AMA maintains that although state regulators should have flexibility to regulate health plan provider networks, minimum federal standards are also needed, especially in light of inaction in many states to update and/or enforce network adequacy requirements. A state's network adequacy standards affect patients' access to care and also health insurance markets, and regulators overseeing insurer networks must try to balance access to care concerns and premium costs without interfering in local market dynamics.[3,4]

Medicare Advantage (Part C) Plans

Although traditional Medicare generally allows seniors to visit any physician or hospital that accepts Medicare patients, access for MA (Part C) beneficiaries is limited to physicians and hospitals within a plan's network. A 2017 analysis found that one in three MA enrollees were in a narrow physician network, defined as participation of less than 30 percent of physicians in the county, with access most restricted for psychiatrists.[5] A 2023 study found that almost two-thirds of psychiatrist networks in MA plans were narrow in 2019, and significantly narrower than in Medicaid MCO and marketplace plans. Further, more than half of the counties that had data available had no MA network psychiatrists.[6] Inadequate MA networks across all specialty and facility types are concerning since more than 30 million people were enrolled in MA plans this year, representing half of the total Medicare population.[7]

Network Adequacy Requirements: While it is accepted practice for MA plans to establish provider networks, federal regulations require these plans to demonstrate that a network is sufficient to provide access to covered services.[8] If patients need services that are not available within the plan's network, the Centers for Medicare & Medicaid Services (CMS) requires plans to arrange for patients to obtain services outside of the plan's network at in-network cost-sharing.

MA network adequacy criteria include 29 provider specialty types and 13 facility types that must be available to enrollees consistent with federal minimum number, time, and distance standards. MA network adequacy is assessed at the county level, and standards vary by county type (large metro, metro, micro, rural or counties with extreme access issues) based on population and density thresholds. Minimum physician and other health provider ratios, or the number of providers required per 1,000 enrollees, are determined annually for each specialty type based on Medicare utilization patterns.[9] In large metro and metro counties, for example, plans must contract with at least 1.67 primary care physicians per 1,000 enrollees and 1.42 primary care physicians per 1,000 enrollees in all other counties.[10] Beginning in 2024, plans must include an adequate supply of clinical psychologists, licensed clinical social workers, and prescribers of medication for opioid use disorder in their networks subject to time, distance, and minimum provider standards.

Maximum time (in minutes) and distance (in miles) standards require MA plans to ensure that at least 85 percent of enrollees in micro, rural, or counties with extreme access issues, and 90 percent of enrollees in large metro, metro, and micro counties, have access to at least one provider/facility of each specialty type within the published time and distance standards. Maximum time and distance standards (Table 1) and minimum provider ratios (Table 2) can be found in the Code of Federal Regulations, Title 42, Chapter IV, Subpart B, Part 422, Subpart C § 422.116.[11]

AMA Advocacy: The AMA has consistently advocated that CMS adopt a suite of policy proposals to enhance network adequacy, provider directory accuracy, network stability, and communication with patients about MA plans' physician networks. In recent communications with CMS, the AMA has urged the agency to:

- Require plans to report the percentage of physicians in the network, broken down by specialty and subspecialty, who actually provided services to plan members during the prior year;
- Publish the research supporting the adequacy of minimum provider ratios and maximum time and distance standards;
- Measure the stability of networks by calculating the percentage change in the physicians in each specialty in an MA plan's network compared to the previous year and over several years;
- Ban no-cause terminations of MA network physicians during the initial term or any subsequent renewal term of a physician's participation contract within an MA plan; and
- Update the Health Plan Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey to include questions assessing patients' actual access to care, including whether they are able to find in-network physicians accepting new patients and maintain utilization of physicians who have longitudinally provided them treatment; the distance needed to travel to obtain care; the average time to get an appointment; and the ability to obtain care at an in-network hospital where the patient's physician has staffing privileges.

The AMA has also recommended that CMS create a network adequacy task force that would allow CMS to engage with patients, physicians (including those in-network), and other stakeholders to review and strengthen MA network adequacy policies. Finally, the AMA has recommended that CMS adopt several policy changes to improve communications with consumers about MA plans so that people shopping for plans can more easily discern differences among provider networks and understand what they are purchasing.

Medicaid Managed Care Plans

Medicaid MCOs, which manage the care of more than 70 percent of Medicaid patients,[12] have also faced ongoing criticisms regarding network adequacy and true access to care. For example, a recent

Health Affairs study found that care was highly concentrated in Medicaid managed care networks, with a small number of primary care and specialty physicians providing most of the care to enrollees in the four states that were studied. The authors concluded that current network adequacy standards might not reflect actual access and that new methods are needed to account for physicians' willingness to serve Medicaid patients.[13] Additionally, a meta-analysis of 34 audit studies showed that Medicaid is associated with a 1.6-fold lower likelihood in successfully scheduling a primary care appointment and a 3.3-fold lower likelihood in successfully scheduling a specialty appointment when compared with private plans.[14] As the AMA has consistently noted in communications to CMS, access to primary and specialty care is a perennial issue faced by Medicaid enrollees which can be especially problematic in rural and underserved areas.

Network Adequacy Requirements: Network adequacy standards for Medicaid MCOs differ by state, but must meet standards set forth in federal regulations specifying that state Medicaid agencies must develop and publish a quantitative network adequacy standard for different provider types (adult and pediatric), including primary care, OB/GYN, mental health and substance use disorder (SUD), specialists as designated by the state, hospital, and pharmacy. In developing network adequacy standards, states are supposed to consider numerous elements related to network adequacy, including anticipated Medicaid enrollment; the expected utilization of services; characteristics and health care needs of specific Medicaid populations; the numbers and types of network providers required to furnish the contracted Medicaid services; numbers of network providers who are not accepting new Medicaid patients; and the geographic location of network providers and Medicaid enrollees, considering distance, travel time, and the means of transportation ordinarily used by Medicaid patients.[15]

Most states have time and distance standards in place along with a range of other network adequacy requirements that vary by state. In recent rulemaking for Medicaid and Children's Health Insurance Program managed care plans, CMS proposed requiring states to implement maximum appointment wait times for primary care (15 business days), outpatient mental health/SUD (10 days), and OB/GYN care (15 days); use secret shopper surveys to evaluate whether wait times and provider directory requirements are being met; conduct payment analyses that compare Medicaid MCO payment rates for certain services as a percentage of Medicare rates; implement a remedy plan for any MCO that has an access issue; and enhance existing state website requirements for content and ease of use.

Federal regulations currently require state Medicaid agencies to monitor MCO compliance with network adequacy standards, including through an annual validation of the adequacy of each network (by the external quality review organization engaged by the state agency) and annual submission of documentation of the adequacy of its MCO networks to CMS. CMS does not require minimum provider ratios for Medicaid managed care plans, as it does for MA plans, although some states have established such ratios that apply to Medicaid plans.

AMA Advocacy: The AMA has advocated for strong network adequacy standards at the federal level, and in states, at the request of state medical associations. Among other things, the AMA has advocated for active approval of networks prior to insurance products going to market; state enforcement of network adequacy requirements; transparency of network standards; and the use of quantitative standards, including time and distance standards, minimum provider-to-enrollee ratios, wait time maximums, and access to alternative office hour (e.g., evening and weekend) requirements. The AMA has also encouraged CMS to require that time and distance standards incorporate travel on public transportation to access services and has noted that additional quantitative and qualitative standards would help enable regulators to also assess the adequacy of a network and whether there is sufficient diversity among providers to meet the needs and

preferences of enrollees. The AMA has encouraged CMS to closely monitor state implementation of network adequacy standards and consider federal minimum requirements in the future.

ACA Marketplace Plans

CMS has previously acknowledged the proliferation of narrow networks among exchange plans, and the U.S. Government Accountability Office (GAO) has cited several studies demonstrating varying degrees of challenges facing enrollees attempting to access in-network providers, most commonly mental health specialists.[16] While marketplace plans with restricted networks may be popular with some consumers because their premium prices are lower, purchasers of these plans may not be aware that the provider network is narrow and that they may have trouble getting needed care from in-network physicians, hospitals, and other providers.

Network Adequacy Requirements: The ACA requires that health plans certified as Qualified Health Plans (QHPs) in ACA marketplaces maintain provider networks that are sufficient in number and types of providers to assure that all services, including mental health and SUD services, are accessible to enrollees without unreasonable delay.[17] Provider networks of marketplace plans also must include "essential community providers" (ECPs) to serve predominately lower-income and medically underserved individuals. Additionally, QHPs participating in the federally facilitated exchange must comply with time and distance standards and, beginning in 2025, they must meet maximum appointment wait time standards.[18]

Similar to MA network adequacy regulations, time and distance standards for plans on the federally-facilitated exchange are based on county type and are outlined for provider and facility types in Tables 3.1 and 3.2, on pages 12-14, of CMS' guidance for plan year 2023.[19] The AMA has supported the time and distance standards, suggested additional provider types, and further urged CMS to separate outpatient clinical behavioral health into outpatient clinical mental health and outpatient treatment for SUD to ensure patient access to appropriate providers. For plan year 2023, CMS also proposed assessing network adequacy using appointment wait time standards (15 days for routine primary care; 30 days for specialty care; and 10 days for behavioral health at least 90 percent of the time), although implementation of this requirement has been delayed until 2025.[20]

QHPs participating in the federally facilitated marketplace had in earlier years been required to submit provider networks to CMS for review; however, 2018 rulemaking by CMS ended this practice, effectively deferring most oversight to states, accreditation bodies, and the issuers themselves. After a federal court ruled against this change, CMS resumed its reviews and currently oversees the network adequacy of QHPs on the federally facilitated marketplace through annual certification and compliance reviews, targeted reviews stemming from complaints, and provider directory reviews.[21]

In 2016, CMS began implementing a network breadth pilot for QHPs in four states (Maine, Ohio, Tennessee, and Texas) intended to help CMS understand how consumers use network breadth information in making plan choices. During open enrollment, consumers in the four states see information classifying the relative breadth of the plans' provider networks, as compared to other exchange plans in the county, for adult primary care providers, pediatricians, and hospitals. Network breadth is classified as either "basic" (less than 30 percent of available providers), "standard" (between 30 and 70 percent of providers), or "broad" (70 percent or more of providers).[22] Data from this pilot would be useful to policymakers and regulators across all plan types; however, it had not yet been made publicly available at the time this report was written.

AMA Advocacy: Although CMS stated earlier this year that additional time was needed to develop guidance for appointment wait time standards, the AMA has strongly supported wait time requirements and urged CMS to implement them as soon as possible. The AMA maintains that maximum wait time standards are critical because they address access problems related to in-network physicians and other clinicians who are not accepting new patients or do not have appointments available in the timeframe needed. Importantly, the AMA has also urged CMS to consider additional tools to measure sufficiency of networks that move beyond insurer attestation including audits, secret shopper programs, and patient interviews and surveys.

The AMA also strongly supported CMS rulemaking for plan year 2024 that added two new ECP categories—mental health facilities and SUD treatment centers—so that all communities, including those that are lower income or medically underserved, have affordable, convenient, and timely access to mental health and SUD treatment. The AMA further urged CMS to consider additional ways to expand access to mental health and SUD services in underserved communities, including through network adequacy and mental health and SUD parity enforcement. The AMA also supported rulemaking by CMS for 2024 and beyond to extend the 35 percent provider participation threshold to two major ECP categories: Federally Qualified Health Centers and family planning providers. These changes will increase provider choice and access to care for low-income and medically underserved consumers, and with regard to family planning providers, are especially important in states that have banned abortion services.

Finally, the AMA has supported CMS' proposals to strengthen network adequacy standards for QHPs and has repeatedly advocated for the establishment of a federal minimum standard for QHPs. The AMA has urged CMS not to limit network adequacy requirements to QHPs in federally facilitated exchanges but to apply them to all marketplace plans.

State Network Adequacy Standards

In addition to federal standards, many states have established network adequacy standards for various types of health plans. Historically, most states monitored the network adequacy of health maintenance organization plans more closely than plans with broader networks, such as preferred provider organizations, although some states have put strong standards in place to supplement the aforementioned federal requirements. In part because of state variability in network adequacy oversight, the National Association of Insurance Commissioners (NAIC) revised its network adequacy model law in 2015 and urged states to adopt it; however, few states have done so and efforts to establish and enforce substantive network adequacy standards has been somewhat limited. The NAIC model law includes a general qualitative standard that requires networks to be sufficient in numbers and appropriate types of providers to assure that all covered services are accessible without unreasonable travel or delay, as well as several positive provisions. The AMA has offered a redlined version to state medical associations as a model bill, under which regulators would be required to review and approve networks before they go to market; network adequacy would be measured using multiple, measurable standards; and telehealth would not be used to meet network adequacy requirements.

State implementation of quantitative network adequacy standards has increased over the years and, as of 2021, 30 states had established at least one such standard, most commonly time and distance standards (in 29 states) while at least 15 states had established maximum wait times.[23] A handful of states now require a minimum ratio of certain types of providers to enrollees, although these requirements vary depending on the state. For example, West Virginia requires one primary care provider per 500 enrollees; Colorado and Illinois require a primary care provider to enrollee ratio of 1:1,000; New Mexico requires a ratio of one primary care provider for every 1,500 people; and a

minimum ratio of 1:2,000 is required in California, Connecticut, Delaware, Maine, and South Carolina.[24] A table summarizing state network adequacy laws can be found on the National Association of State Legislatures' website.

Importantly, the content and strength of state network adequacy standards, and state monitoring and compliance efforts, vary significantly across states, as do the tools used to enforce the standards. Some states require plans in violation of standards to take corrective action but typically do not take more punitive action, even if authorized to do so. The Illinois Department of Insurance stands out as an exception, as recent enforcement efforts included assessing fines against a major insurer for excluding a large clinic from its network.[25]

Although states have often relied on patient complaints and insurer attestation to comply with state standards, interest in the use of data to assess network adequacy is increasing. For example, some states require plans to submit certain data elements annually and whenever the composition of a plan substantively changes to help regulators identify network access problems. Additionally, regulators in some states review claims data, such as from an all-payer claims database (APCD), to assess utilization norms, patterns of out-of-network care, who is (and is not) providing care to enrollees, and the network's overall stability and adequacy. New Hampshire was the first state to use APCD data to determine the network breadth of private health plans by calculating the share of all available providers in a county that participate in a plan's network.[26] The New Hampshire Insurance Department also reviews APCD data to identify the services being provided in order to assess utilization and categorize providers. When APCD data are available, the use of claims-based metrics can play an important role in improving the accuracy of network adequacy assessments.

Mental Health and Substance Use Disorder and Network Adequacy

There are many complexities as to why individuals with a mental illness or SUD do not receive care, but network inadequacy and the high cost of out-of-network care are among the key reasons[27] and, notably, inadequate networks are even more pervasive for children seeking behavioral health care.[28] Networks for mental health and substance use disorders present unique issues given that patients with a mental illness or substance use disorder may be at increased risk of acute harm without evidence-based care. Although treatment for mental health conditions and substance use disorder may begin in the emergency department, it is essential that in-network care is available in the patient's community.

In Colorado, regulators require plans to report multiple quantitative elements to help analyze network adequacy for substance use disorder providers, including the number of substance use disorder and opioid treatment programs in the network and the type of medications for opioid use disorder (MOUD) provided.[29] The Colorado regulation requires plans to submit this information for each county, which may not guarantee network adequacy but is essential data for regulators—and health plans—to understand where gaps may exist, and how regulators, the medical community and plans can work together to fill those gaps.

Telehealth and Network Adequacy

Increases in telehealth use since the Covid-19 pandemic have prompted ongoing policy discussions of the role telehealth plays in network adequacy and to what extent telehealth services and providers should count towards network adequacy standards. Although the AMA strongly supports integrating telehealth into the delivery of health care when clinically appropriate, integrating telehealth into network adequacy standards could potentially lead to fewer in-person physicians in a network and thereby limit access to in-person care. The AMA maintains that telehealth should be

a supplement to, and not a replacement for, in-person provider networks so that patients can always access in-person care if they choose. Moreover, telehealth is not appropriate for all services or patients, and it is often impossible for a physician to know whether a telehealth visit may necessitate in-person care. As such, the AMA has advocated that telehealth-only providers should generally not count towards network adequacy requirements.

State and federal regulators have taken a variety of approaches to account for the provision of telehealth in contracted networks and ensure that all care is clinically appropriate. Certain regulators have allowed plans some leniency to count telehealth towards network adequacy for specialties in short supply or if other conditions are met. In 2020, for example, CMS began allowing MA plans to use telehealth providers in several specialties (e.g., dermatology, psychiatry, endocrinology, otolaryngology, and others) to account for a 10 percent credit towards meeting network adequacy time and distance requirements. This year, CMS rulemaking for Medicaid MCOs proposed that telehealth appointments be counted towards network adequacy calculations only if the provider offers in-person appointments.

Depending on the state, insurers may be prohibited from using telehealth to demonstrate network adequacy or allowed to count telehealth towards time and distance standards, similar to MA plans. Still other states require only that plans report how they intend to use telehealth to meet network adequacy standards. Finally, some states may allow plans to use telehealth-only providers as an exception to network adequacy standards so that where in-person care is otherwise not available, telehealth-only providers can be used to support patients.

PROVIDER DIRECTORY ACCURACY

Provider directories are the most public-facing data that health plans provide and may be used by regulators to evaluate compliance with network adequacy standards. Patients obviously depend on accurate directories to successfully access care and, conversely, inaccurate or misleading provider information prevents patients from making informed decisions when selecting a plan. For physicians, directories are important resources for referrals and contracting and, as noted in the AMA's 2023 statement to the Senate Finance Committee, are plagued by high rates of inaccuracies that incorrectly state physicians' office locations and phone numbers, specialty, network status, and availability to see new patients. Substantial inaccuracies have been identified in provider directories across all types of insurance products, including employer-sponsored plans as well as MA, Medicaid, and marketplace plans. In the lead-up to a hearing on ghost networks and mental health care, Senate Finance Committee staff reviewed directories from 12 plans in 6 states and called 10 providers from each plan. Of the 120 providers contacted by phone, 33 percent were inaccurate, non-working numbers or unreturned calls and staff were only able to make appointments 18 percent of the time.

The AMA continues to advocate that policymakers and other stakeholders must take action to improve the data, reduce burden on physician practices, and protect patients from errors in real time. In response to a 2022 CMS Request for Information seeking public input on the concept of CMS establishing a National Directory of Healthcare Providers and Services, the AMA doubled down on its call for increased data standardization and highlighted a lack of data reporting standards as a barrier to accuracy. For example, each payer's directory requires that physicians provide different types of data, similar but named differently, or requires that physicians report their information using different data formats. The AMA advocates that CMS and state regulators should consider standardizing data elements as a means of improving accuracy. Because most enforcement of directory inaccuracies relies on patient reporting, which likely underestimates the problem, the AMA has also urged regulators to take a more active role in regularly reviewing and

assessing directory accuracy. As such, the AMA has advocated that regulators should: require plans to submit accurate network directories every year prior to the open enrollment period and whenever there is a significant change to the status of the physicians included in the network; audit directory accuracy more frequently for plans that have had deficiencies; take enforcement action against plans that fail to either maintain complete and accurate directories or have a sufficient number of in-network physician practices open and accepting new patients; encourage stakeholders to develop a common system to update physician information in their directories; and require plans to immediately remove from network directories physicians who no longer participate in their network.

The AMA also acknowledges that physicians and practices have a role to play in achieving accuracy but emphasizes that updating directories should not add to physicians' administrative burdens. In 2021, the AMA collaborated with CAQH to examine the pain points for both physicians and health plans in achieving directory accuracy and published Improving Health Plan Provider Directories: And the Need for Health Plan-Practice Alignment, Automation, and Streamlined Workflows, which identifies best practices and recommends practical approaches that both health plans and practices can implement. At a minimum for patients with mental illness or an SUD, health plans must ensure that provider directories provide accurate, timely information about whether a mental health or substance use disorder professional is accepting new patients. For substance use disorder providers, the directory also must state whether MOUD is offered, and if so, what type of MOUD is offered. Research indicates that 43 percent of people in substance use disorder treatment for nonmedical use of prescription painkillers have a diagnosis or symptoms of mental health disorders, particularly depression and anxiety, underscoring the importance of having available counseling and psychiatric care.[30]

IMPROVING HEALTH EQUITY

Patients and other health care stakeholders have expressed interest in including physician race and ethnicity data (REI) in provider directories and as a component of network adequacy requirements to advance health equity and ensure culturally competent care. The AMA recognizes that there are many reasons why patients may want to consider REI when choosing a physician, including connecting with physicians with whom they may relate and selecting plans that can help them accomplish their health goals. Although federal regulations do not require QHPs to have culturally diverse provider networks, Medicaid regulations require states developing MCO network adequacy standards to address the ability of network providers to communicate with limited English proficient enrollees in their preferred language and to accommodate enrollees with disabilities.[31] Federal regulations also require provider directories maintained by Medicaid MCOs to include information on the provider's cultural and linguistic capabilities, including languages offered, and this year CMS proposed similar requirements for MA plans. The AMA has supported such measures so that a patient can more easily determine in advance whether a provider can deliver care that will meet their cultural and linguistic needs.

The use of network adequacy standards to improve health equity has also been discussed by some states as well as the NAIC, whose special committee on race and insurance has been looking at access and affordability issues, including the use of network adequacy and provider directory information to promote equitable access to culturally competent health care.[32] As noted in an AMA letter to NAIC, designation of a physician's race was historically used as a tool to discriminate and exclude physicians and displaying REI and/or other personal information in provider directories has the potential to expose minoritized physicians to discrimination. The AMA has argued that guardrails be included in regulatory guidance so that the use of REI data by an insurer is limited,

transparent to the physician, evaluated for potential benefits and harms, and quickly discontinued if it causes harm.[33]

Legislation passed by the Colorado General Assembly creating the "Colorado Option" program required insurers offering standardized "Colorado Option" plans to have provider networks that are culturally responsive and reflect the diversity of the communities they serve.[34] Regulations implementing this provision require plans to collect demographic information—on race and ethnicity, sexual orientation, gender identity, and ability status—voluntarily submitted by network providers and their front office staff as well as plan enrollees who voluntarily provide such data.[35] Insurers are required to report that demographic data—in aggregate—to the state and describe their efforts to build a diverse and culturally responsive provider network. State regulations further require network provider directories to identify providers who are multilingual or employ multilingual front office staff and the languages spoken; whether a provider offers extended and weekend hours; and the accessibility of a provider's office and examination rooms for people with disabilities.[36]

Some network directories also provide REI information and/or proximity to public transportation, experience with specific patient populations, languages offered, and the ability to provide specific services. Although the AMA has generally supported the ability of physicians to voluntarily specify information that they want included in a provider directory, caution has been advised regarding the use of REI and other data in directories so that data collection is voluntary and appropriate safeguards are in place. The AMA has further advocated that insurers consider other ways to support diversification and health equity, such as investing in pathway programs from elementary schools to residency/fellowship programs.[37]

RELEVANT AMA POLICY

Network adequacy is addressed in Policy H-285.908, established via Council on Medical Service Report 4-I-14, which supports state regulators as the primary enforcer of network adequacy requirements, sets parameters for out-of-network care and insurer termination of in-network providers, and advocates that plans be required to document to regulators that they have met requisite network adequacy standards and that in-network adequacy is timely and geographically accessible. Policy H-285.911 similarly states that health insurance provider networks should be sufficient to provide meaningful access to all medically necessary and emergency care at the preferred, in-network level on a timely and geographically accessible basis.

Policy H-285.984 states that plans or networks that use criteria to determine the number, geographic distribution, and specialties of physicians be required to regularly report to the public on the impact that the use of such criteria has on the quality, access, cost, and choice of health care services. Policy D-285.972 supports monitoring the development of tiered, narrow, or restricted networks to ensure they are not inappropriately driven by economic criteria by the plans and that patients are not caused health care access problems based on the potential for a limited number of specialists in the resulting networks. Policy H-450.941 strongly opposes the use of tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards, certain physicians based on cost of care factors. Under Policy D-180.984, the AMA will work with state medical associations and other groups to evaluate on an annual basis and recommend measures for payers that should be publicly reported by payers including the number of primary and specialty physicians and consumer complaints.

Policy H-285.904 adopts principles related to unanticipated out-of-network care, including minimum coverage standards and payment parameters that insurers must meet, and also affirms

that state regulators should enforce such standards through active regulation of health plans. Policy H-180.952 opposes penalties implemented by insurers against physicians when patients independently choose to obtain out-of-network services.

Policy H-285.924 states that health plans should provide patients with a current directory of participating physicians through multiple media and continue to cover services provided by physicians who involuntarily leave a plan until an updated directory is available. Among several provisions regarding MA plans' provider directories, Policy H-285.902 urges CMS to conduct accuracy reviews and publicly report accuracy scores. Policy H-330.878 advocates for better enforcement of MA network regulations and maintenance by CMS of a publicly available database of physicians in network that states whether these physicians are accepting new patients.

Under Policy H-290.985, the AMA advocates that certain criteria be used in federal and state oversight of Medicaid managed care plans, including geographic dispersion and accessibility of participating physicians and other providers, and the ability of plan participating physicians to determine how many patients and which medical problems they will care for. Policy H-345.975 supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment as well as enforcement of the Mental Health Parity Act. H-160.949 addresses scope of practice and advocates for appropriate physician supervision of non-physician clinical staff. Policy H-480.937 opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians.

DISCUSSION

Network adequacy refers to a health plan's ability to provide access to in-network physicians and hospitals to meet enrollees' health care needs. Because inadequate networks create obstacles for patients seeking new or continued care and limit their choice of physicians and facilities, network adequacy standards and other requirements are used by regulators to ensure that health plan subscribers are able to access in-network care within reasonable distances and timeframes. Physicians and other providers are also impacted by the adequacy of a network and, although strong network adequacy standards should incentivize health plans to negotiate fairly, inadequate networks can negatively impact physicians' bargaining power. Furthermore, network inadequacies often lead to excessive appointment wait times and overburden many in-network physicians, contributing to increased burden and potential liability for delayed care. While acknowledging the challenges involved to ensuring network adequacy without adding substantially to the cost of insurance, the Council believes that regulators should take a multilayered approach to network adequacy that includes meaningful standards, transparency of network breadth and in-network physicians, hospitals, and other providers, parameters around out-of-network care, and effective monitoring and enforcement efforts.

The Council recommends seven new AMA policies to supplant and strengthen our existing network adequacy policies, and reaffirmation of four existing policies. Although state regulators are the primary enforcer of network adequacy requirements (Policy H-285.908), the Council recommends that our AMA support establishment and enforcement of a minimum federal network adequacy standard requiring health plans to contract with sufficient numbers and types of physicians and other providers, including for mental health and substance use disorders, such that both scheduled and unscheduled care may be provided without unreasonable travel or delay. The Council also recommends encouraging the use of multiple criteria to evaluate the sufficiency of health plan provider networks, including minimum physician-to-enrollee ratios and a clear standard for network appointment wait times. To facilitate informed decision-making among consumers

shopping for plans, the Council recommends encouraging the development and promulgation of network adequacy assessment tools that allow patients and employers to compare insurance plans.

Although transparency of health plan network adequacy is addressed in part by Policies H-285.908, D-285.972, and H-330.878, the Council seeks to strengthen AMA policy in this area by recommending that our AMA support requiring health plans to report annually and prominently display important information so it is accessible by enrollees as well as consumers shopping for plans, including the breadth of a plan's provider network; average wait times for primary care appointments and common specialty referrals; numbers of physicians treating mental health and substance use disorders who are accepting new patients; and instructions for enrollees to contact regulators to report access problems and other network adequacy complaints. Even with robust quantitative standards in place, the Council understands that some physicians may be booked or not accepting new patients and that additional tools are needed to measure true patient access to timely and quality in-network care. Accordingly, we recommend encouraging the use of claims data, audits, secret shopper programs, complaints, and enrollee surveys/interviews to monitor and validate in-network provider availability and wait times, network stability, and provider directory accuracy and to identify other access or quality problems.

State and federal regulators have taken a variety of approaches to addressing the role of telehealth in network adequacy, and the policy landscape across many states is evolving. The Council recommends new policy affirming that in-network physicians who provide both in-person and telehealth services may count towards health plan network adequacy requirements on a very limited basis when their physical practice does not meet time and distance standards, such as when there is a shortage of physicians in the needed specialty within the community. The AMA does not support counting physicians who only offer telehealth services towards network adequacy requirements.

It is also important to highlight that even vigorous standards and requirements will fail to strengthen network adequacy unless regulators take a more active role to ensure health plan compliance and patient access to care. Policy H-285.904, which advocates that state regulators should enforce network adequacy standards through active regulation of health plans, is recommended for reaffirmation. The Council further recommends supporting regulation to hold health plans accountable for network inadequacies through the use of corrective action plans and substantial financial penalties.

Several AMA policies (Policies H-285.902, H-285.924, and H-330.878) call for health plans to provide patients with accurate, complete, and up-to-date provider directories and AMA advocacy on this topic has been strong. Because outdated and inaccurate directories are an ongoing pain point that is burdensome for physicians and patients, we recommend reaffirmation of Policy H-285.902, which urges the CMS to take several steps to enhance provider directory accuracy and effectively communicate network information to patients. Similarly, several AMA policies address out-of-network care (Policies H-180.952, H-285.904, and H-285.908); Policy H-285.904, which outlines principles related to coverage and payment for out-of-network care and Policy H-285.908, which addresses out-of-network care as well as other elements of network adequacy, are recommended for reaffirmation. On this topic, the Council notes that the AMA continues its focus on the *No Surprises Act* and remains concerned that implementation of the statute does not support physicians' ability to meaningfully engage in dispute resolution, as Congress intended, because of the Administration's problematic reliance on the qualified payment amount (QPA) in arbitration, among other issues. As a result, health plans may feel emboldened to disengage from fair contract negotiations with physicians and network adequacy may suffer. While there have been successful

legal challenges to the Administration's flawed positions on the QPA among other aspects, the situation continues to be closely monitored.

Policy H-285.911, which advocates that provider networks be sufficient to provide meaningful access to subscribers for all medically necessary and emergency care, at the in-network benefit level, is also recommended for reaffirmation. Additional relevant AMA policies affirm that health plans should be required to inform physicians of criteria used to evaluate a physician for network inclusion (Policy H-285.984), prohibited from forming networks based only on economic criteria (Policy D-285.972), and required to notify providers at least 90 days prior to termination from a network (Policy H-285.908). Among other provisions, Policy H-285.908 directs the AMA to provide assistance (upon request) to state medical associations and disseminate model state legislation; accordingly, the AMA's model state legislation will be updated and made available to the Federation once new network adequacy policy is adopted. The Council also acknowledges that physician shortages across many specialties may impact the adequacy of some networks, especially in, but not limited to, rural areas. As stated previously, although midlevel providers may be in a provider network if permitted under state law, health plans must meet network adequacy requirements for physicians and measurement should be limited to physicians for physician services. Finally, the Council encourages physicians to report network adequacy violations to state departments of insurance, which may track complaints as part of their network adequacy assessments. Contact information for state departments of insurance can be found on the NAIC's website.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) support establishment and enforcement of a minimum federal network adequacy standard requiring health plans to contract with sufficient numbers and types of physicians and other providers, including for mental health and substance use disorder, such that both scheduled and unscheduled care may be provided without unreasonable travel or delay. (New HOD Policy)

2. That our AMA encourage the use of multiple criteria to evaluate the sufficiency of health plan provider networks, including but not limited to:
    a. Minimum physician-to-enrollee ratios across specialties, including mental health and substance use disorder providers who are accepting new patients;
    b. Minimum percentages of non-emergency providers available on nights and weekends;
    c. Maximum time and distance standards, including for enrollees who rely on public transportation;
    d. Clear standard for network appointment wait times across specialties, for both new patients and continuing care, that are appropriate to a patient's urgent and non-urgent health care needs; and
    e. Sufficient providers to meet the care needs of people experiencing economic or social marginalization, chronic or complex health conditions, disability, or limited English proficiency. (New HOD Policy)

3. That our AMA encourage the development and promulgation of network adequacy assessment tools that allow patients and employers to compare insurance plans and make informed decisions when enrolling in a plan. (New HOD Policy)

4. That our AMA support requiring health plans to report to regulators annually and prominently display network adequacy information so that it is available to enrollees and consumers shopping for plans, including:
    a. The breadth of a plan's provider network, by county and geographic region;
    b. Average wait times for primary and behavioral health care appointments as well as common specialty referrals;
    c. The number of in-network physicians treating substance use disorder who are actively accepting new patients, and the type of opioid use disorder medications offered;
    d. The number of in-network mental health physicians actively accepting new patients; and
    e. Instructions for consumers and physicians to easily contact regulators to report complaints about inadequate provider networks and other access problems. (New HOD Policy)

5. That our AMA encourage the use of claims data, audits, secret shopper programs, complaints, and enrollee surveys or interviews to monitor and validate in-network provider availability and wait times, network stability, and provider directory accuracy, and to identify other access or quality problems. (New HOD Policy)

6. That our AMA affirm that in-network physicians who provide both in-person and telehealth services may count towards health plan network adequacy requirements on a very limited basis when their physical practice does not meet time and distance standards, based on regulator discretion, such as when there is a shortage of physicians in the needed specialty within the community served by the health plan. The AMA does not support counting physicians who only offer telehealth services towards network adequacy requirements. (New HOD Policy)

7. That our AMA support regulation to hold health plans accountable for network inadequacies, including through use of corrective action plans and substantial financial penalties. (New HOD Policy)

8. That our AMA reaffirm Policy H-285.908, which supports state regulators as the primary enforcer of network adequacy requirements, sets parameters for out-of-network care and insurer termination of in-network providers, and advocates that plans be required to document to regulators that they have met requisite network adequacy standards including hospital-based physician specialties. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy H-285.904, which supports principles related to unanticipated out-of-network care and advocates that state regulators should enforce network adequacy standards through active regulation of health plans. (Reaffirm HOD Policy)

10. That our AMA reaffirm Policy H-285.902, which urges the Centers for Medicare & Medicaid Services to take several steps to ensure network adequacy, enhance provider directory accuracy, measure network stability, and effectively communicate provider network information to patients. (Reaffirm HOD Policy)

11. That our AMA reaffirm Policy H-285.911, which advocates that health insurance provider networks be sufficient to provide meaningful access to subscribers, for all medically necessary and emergency care, at the preferred, in-network benefit level on a timely and geographically accessible basis. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] Kaiser Family Foundation. KFF Survey of consumer experiences with health insurance. June 15, 2023. Available at: https://www.kff.org/private-insurance/poll-finding/kff-survey-of-consumer-experiences-with-health-insurance/.
[2] *Ibid*.
[3] Hempstead K. Marketplace Pulse: Medicaid and Marketplace Provider Networks. Robert Wood Johnson Foundation Brief, March 8, 2023. Available at: https://www.rwjf.org/en/insights/our-research/2023/03/marketplace-pulse-medicaid-and-marketplace-provider-networks.html
[4] Hall M and Ginsburg PB. A better approach to regulating provider network adequacy. Brookings Center for Health Policy and USC Schaeffer Center for Health Policy & Economics. September 2017. Available at: https://www.brookings.edu/research/a-better-approach-to-regulating-provider-network-adequacy/
[5] Kaiser Family Foundation. Medicare Advantage: How Robust Are Plans' Physician Networks? October 5, 2017. Available at: https://www.kff.org/medicare/report/medicare-advantage-how-robust-are-plans-physician-networks/
[6] Zhu JM, Meiselbach MK, Drake C, and Polsky D. Psychiatrist Networks in Medicare Advantage Plans are Substantially Narrower Than in Medicaid and ACA Markets. Health Affairs Vol. 42, No. 7. July 2023. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.01547?utm_medium=email&utm_source=hat&utm_campaign=journal&vgo_ee=FParS9VfxeoQ7v7N2A78fHeKIiVlV1suvrDGHwTzyVW1%2By8EeyWqcUYA%3ACeriL92AQifNk7Tk%2B%2F7T%2BXh0%2Bsm%2FRjXa
[7] Kaiser Family Foundation. Half of All Eligible Medicare Beneficiaries Are Now Enrolled in Private Medicare Advantage Plans. May 1, 2023. Available at: https://www.kff.org/policy-watch/half-of-all-eligible-medicare-beneficiaries-are-now-enrolled-in-private-medicare-advantage-plans/
[8] Code of Federal Regulations Title 42 Chapter IV Subchapter B Part 422 Subpart C § 422.116. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.116
[9] Centers for Medicare & Medicaid Services. Medicare Advantage Network Adequacy Criteria Guidance. Last Updated: Jan. 10, 2017. Available at: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf
[10] Code of Federal Regulations Title 42 Chapter IV Subchapter B Part 422 Subpart C § 422.116. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.116
[11] Code of Federal Regulations Title 42 Chapter IV Subchapter B Part 422 Subpart C § 422.116. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.116
[12] Kaiser Family Foundation. Medicaid Managed Care Network Adequacy & Access: Current Standards and Proposed Changes. June 15, 2023. Available at: https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-network-adequacy-access-current-standards-and-proposed-changes/
[13] Ludomirsky AB, Schpero WL, Wallace J et al. In Medicaid Managed Care Networks, Care Is Highly Concentrated Among A Small Percentage Of Physicians. *Health Affairs* Vol. 41, No. 5, May 2022. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01747
[14] Hsiang WR, Lukasiewicz A, Gentry M, et al. Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared With Private Insurance Patients: A Meta-Analysis. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*. 2019;56Available at: https://journals.sagepub.com/doi/full/10.1177/0046958019838118
[15] Code of Federal Regulations Title 42 Chapter IV Subchapter B Part 156 Subpart C § 156.230. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.68#p-438.68(b)
[16] U.S. Government Accountability Office. Private Health Insurance: State and Federal Oversight of Provider Networks Varies. December 2022. Available at: https://www.gao.gov/assets/gao-23-105642.pdf
[17] Code of Federal Regulations Title 42 Chapter IV Subchapter B Part 422 Subpart C § 422.116 Available at: https://www.law.cornell.edu/cfr/text/45/156.230
[18] Centers for Medicare & Medicaid Services. Fact Sheet: HHS Notice of Benefit and Payment Parameters for 2024 Final Rule. April 27, 2023. Available at: https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2024-final-rule

[19] Centers for Medicare & Medicaid Services, Center for Consumer Information & Insurance Oversight. 2023 Final Letter to Issuers in the Federally-facilitated Exchanges. April 28, 2022. Available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2023-Letter-to-Issuers.pdf
[20] *Ibid*.
[21] U.S. Government Accountability Office. Private Health Insurance: State and Federal Oversight of Provider Networks Varies. December 2022. Available at: https://www.gao.gov/assets/gao-23-105642.pdf
[22] National Association of Insurance Commissioners. Network Adequacy. Last updated June 1, 2023. Available at: https://content.naic.org/cipr-topics/network-adequacy
[23] The Commonwealth Fund. Ensuring the Adequacy of ACA Marketplace Plan Networks. Feb. 15, 2022. Available at: https://www.commonwealthfund.org/blog/2022/ensuring-adequacy-aca-marketplace-plan-networks
[24] National Conference of State Legislatures. Health Insurance Network Adequacy Requirements. Last updated April 27, 2023. Available at: https://www.ncsl.org/health/health-insurance-network-adequacy-requirements
[25] WCIA. Blue Cross Blue Shield Fined for Lack of Network Adequacy. Posted March 9, 2022. Available at: https://www.wcia.com/news/target3/blue-cross-blue-shield-fined-for-lack-of-network-adequacy/
[26] Kaiser Family Foundation. Network Adequacy Standards and Enforcement. Feb. 4, 2022. Available at: https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/
[27] Legal Action Center. New Report Reveals Worsening Disparities in Access to Substance Use Disorder and Mental Health Care. Nov. 20, 2019. Available at: https://www.lac.org/news/new-report-reveals-worsening-disparities-in-access-to-substance-use-disorder-and-mental-health-care
[28] Legal Action Center. New Report Reveals Worsening Disparities in Access to Substance Use Disorder and Mental Health Care. Nov. 20, 2019. Available at: https://www.lac.org/news/new-report-reveals-worsening-disparities-in-access-to-substance-use-disorder-and-mental-health-care
[29] Attachment 3 CCR 702-4-2-75-A - Medication-Assisted Treatment (MAT) Reporting Requirements. Available at: https://casetext.com/regulation/colorado-administrative-code/department-700-department-of-regulatory-agencies/division-702-division-of-insurance/rule-3-ccr-702-4-life-accident-and-health/section-3-ccr-702-4-2-life-accident-and-health-series-4-2-accident-and-health-general/regulation-3-ccr-702-4-2-75-concerning-requirements-for-reporting-medication-assisted-treatment-coverage/attachment-3-ccr-702-4-2-75-a-medication-assisted-treatment-mat-reporting-requirements
[30] Goldner EM, Lusted A, Roerecke M, Rehm J, Fischer B. Prevalence of Axis-1 psychiatric (with focus on depression and anxiety) disorder and symptomatology among non-medical prescription opioid users in substance use treatment: systematic review and meta-analyses. *Addict Behav*. 2014;39(3):520-531.
[31] Code of Federal Regulations Title 42 Chapter IV Subchapter B Part 438 Subpart B § 438.68. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.68#p-438.68(b)
[32] National Association of Insurance Commissioners. Special (EX) Committee on Race and Insurance. 2023 Adopted Changes. Available at: https://content.naic.org/cmte_ex_race_and_insurance.htm
[33] American Medical Association. Letter to National Association of Insurance Commissioners. Nov. 10, 2021. Available at: https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-11-10-Letter-to-NAIC-FINAL.pdf
[34] NAIC Special Committee on Race and Insurance. Colorado Option Culturally Responsive Provider Networks. Power Point Presentation by Colorado Option Director. Available at: https://content.naic.org/sites/default/files/inline-files/CO%20Presentation%20Culturally%20Competent%20Network.pdf
[35] Colorado Department of Regulatory Agencies, Division of Insurance. 3 CCR 702-4 Amended Regulation 4-2-80 Concerning Network Adequacy Standards and Reporting Requirements for Colorado Option Standardized Health Benefit Plans. Available at: https://drive.google.com/file/d/19pt8youGraXypyj9E3fp_Rytj2-y2mhL/view
[36] Colorado Department of Regulatory Agencies, Division of Insurance. 3 CCR 702-4 Amended Regulation 4-2-80 Concerning Network Adequacy Standards and Reporting Requirements for Colorado Option

Standardized Health Benefit Plans. Available at: https://drive.google.com/file/d/19pt8youGraXypyj9E3fp_Rytj2-y2mhL/view

[37] American Medical Association. Letter to National Association of Insurance Commissioners. Nov. 10, 2021. Available at: https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-11-10-Letter-to-NAIC-FINAL.pdf

APPENDIX

Policies Recommended for Reaffirmation

Network Adequacy H-285.908

1. Our AMA supports state regulators as the primary enforcer of network adequacy requirements.
2. Our AMA supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time.
3. Our AMA supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received.
4. Our AMA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
5. Our AMA advocates for regulation and legislation to require that out-of-network expenses count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies.
6. Our AMA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
7. Our AMA supports health insurers paying out-of-network physicians fairly and equitably for emergency and out-of-network bills in a hospital. AMA policy is that any legislation which addresses this issue should assure that insurer payment for such care be based upon a number of factors, including the physicians' usual charge, the usual and customary charge for such service, the circumstances of the care and the expertise of the particular physician.
8. Our AMA provides assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks.
9. Our AMA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities.
10. Our AMA advocates for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited.
11. Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible.
12. Our AMA supports requiring that health insurers that terminate in-network providers: (a) notify providers of pending termination at least 90 days prior to removal from network; (b) give to providers, at least 60 days prior to distribution, a copy of the health insurer’s letter notifying patients of the provider’s change in network status; and (c) allow the provider 30 days to respond to

and contest if necessary the letter prior to its distribution. (CMS Rep. 4, I-14; Reaffirmation I-15; Reaffirmed in lieu of Res. 808, I-15; Modified: Sub. Res. 811, I-15; Reaffirmed: CMS Rep. 03, A-17; Reaffirmed: Res. 108, A-17; Appended: Res. 809, I-17; Reaffirmed: Res. 116, A-18; Reaffirmation: A-19)

Out-of-Network Care H-285.904

1. Our AMA adopts the following principles related to unanticipated out-of-network care:
A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
H. Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.
2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.
3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges. (Res. 108, A-17; Reaffirmation: A-18; Appended: Res. 104, A-18; Reaffirmed in lieu of: Res. 225, I-18; Reaffirmation: A-19; Reaffirmed: Res. 210, A-19; Appended: Res. 211, A-19; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 236, A-22)

Ban on Medicare Advantage "No Cause" Network Terminations H-285.902

1. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) to further enhance the agency's efforts to ensure directory accuracy by: a. Requiring Medicare Advantage (MA) plans to submit accurate provider directories to CMS every year prior to the Medicare open enrollment period and whenever there is a significant change in the physicians included in the network; b. Conducting accuracy reviews on provider directories more frequently for plans that have had deficiencies; c. Publicly reporting the most recent accuracy score for each plan on Medicare Plan Finder; d. Indicating to plans that failure to maintain complete and accurate directories, as well as failure to have a sufficient number of physician practices open and accepting new patients, may

subject the MA plans to one of the following: (i) civil monetary penalties; (ii) enrollment sanctions; or (iii) incorporating the accuracy score into the Stars rating for each plan; e. Requiring MA plans immediately remove from provider directories providers who no longer participate in their network.
2. Our AMA urges CMS to ensure that network adequacy standards provide adequate access for beneficiaries and support coordinated care delivery by: a. Requiring plans to report the percentage of the physicians, broken down by specialty and subspecialty, in the network who actually provided services to plan members during the prior year; b. Publishing the research supporting the adequacy of the ratios and distance requirements CMS currently uses to determine network adequacy; c. Conducting a study of the extent to which networks maintain or disrupt teams of physicians and hospitals that work together; d. Evaluating alternative/additional measures of adequacy.
3. Our AMA urges CMS to ensure lists of contracted physicians are made more easily accessible by: a. Requiring that MA plans submit their contracted provider list to CMS annually and whenever changes occur, and post the lists on the Medicare Plan Finder website in both a web-friendly and downloadable spreadsheet form; b. Linking the provider lists to Physician Compare so that a patient can first find a physician and then find which health plans contract with that physician. Our AMA urges CMS to simplify the process for beneficiaries to compare network size and accessibility by expanding the information for each MA plan on Medicare Plan Finder to include: (i) the number of contracted physicians in each specialty and county; (ii) the extent to which a plan's network exceeds minimum standards in each specialty, subspecialty, and county; and (iii) the percentage of the physicians in each specialty and county participating in Medicare who are included in the plan's network.
4. Our AMA urges CMS to measure the stability of networks by calculating the percentage change in the physicians in each specialty and subspecialty in an MA plan's network compared to the previous year and over several years and post that information on Plan Finder.
5. Our AMA urges CMS to develop a marketing/communication plan to effectively communicate with patients about network access and any changes to the network that may directly or indirectly impact patients; including updating the Medicare Plan Finder website.
6. Our AMA urges CMS to develop process improvements for recurring input from in-network physicians regarding network policies by creating a network adequacy task force that includes multiple stakeholders including patients.
7. Our AMA urges CMS to ban "no cause" terminations of MA network physicians during the initial term or any subsequent renewal term of a physician's participation contract with a MA plan. (BOT Rep. 17, A-19; Reaffirmation: I-19; Modified: Speakers Rep. 1, A-21)

Health Insurance Safeguards H-285.911
Our AMA will advocate that health insurance provider networks should be sufficient to provide meaningful access to subscribers, for all medically necessary and emergency care, at the preferred, in-network benefit level on a timely and geographically accessible basis. (CMS Rep. 8, A-10; Reaffirmed in lieu of Res. 815, I-13; Reaffirmation I-15; Reaffirmed: CMS Rep. 03, A-17; Reaffirmed: Res. 108, A-17)

REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (I-23)
Medicaid Unwinding Update
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the House of Delegates adopted Policy D-440.912, American Medical Association (AMA) Public Health Strategy, which directed the AMA Board of Trustees to provide an update on loss of coverage and uninsurance rates following the return to regular Medicaid redeterminations and the end of the COVID-19 Public Health Emergency (PHE); the ensuing financial and administrative challenges experienced by physicians, physician practices, hospitals, and the health care system; and a report of actions taken by the AMA and recommendations for further action. This report describes Medicaid enrollment changes since the Medicaid continuous enrollment requirement ended, discusses potential impacts of the unwinding on physicians and hospitals, summarizes relevant AMA policy and advocacy, and presents policy recommendations.

The Medicaid unwinding has been described as the most significant nationwide coverage transition since the Affordable Care Act, with major implications for patients, physicians, and health equity. At the time this report was written, the Medicaid unwinding was still in its early stages; many states had been redetermining enrollee eligibility for only a few months; and information on whether individuals disenrolled from Medicaid/Children's Health Insurance Program (CHIP) had transitioned to other sources of coverage—or become uninsured—was limited. Over the coming months, millions of individuals are expected to be disenrolled from Medicaid/CHIP coverage which may in turn decrease patient volume as well as revenue for physicians, clinics, and hospitals treating large numbers of Medicaid/CHIP patients. The Council will continue to monitor unwinding data as it becomes available and recommend new policy and physician resources as needed. At this time, the Council recommends amending Policy H-290.955, which was adopted at the 2022 Annual Meeting via Council Report 3-A-22, Preventing Coverage Losses After the PHE Ends, by the addition of three new clauses that encourage state implementation of strategies to reduce inappropriate terminations from Medicaid/CHIP for procedural reasons; encourage states to provide continuity of care protections to patients transitioning from Medicaid or CHIP to a new health plan; and encourage state Medicaid agencies to make coverage status, including expiration of current coverage and information on pending renewals, accessible to physicians, clinics, and hospitals.

The Council also recommends reaffirmation of Policy H-165.855, which calls for the adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans and supports allowing for presumptive eligibility and retroactive coverage to the time at which an eligible person seeks care; and Policy H-165.823, which encourages states to pursue auto-enrollment in health insurance coverage.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-I-23

Subject: Medicaid Unwinding Update

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee J

At the 2023 Annual Meeting, the House of Delegates adopted Policy D-440.912, American Medical Association (AMA) Public Health Strategy, which directed the AMA Board of Trustees to provide an update on loss of coverage and uninsurance rates following the return to regular Medicaid redeterminations and the end of the COVID-19 Public Health Emergency (PHE); the ensuing financial and administrative challenges experienced by physicians, physician practices, hospitals, and the health care system; and a report of actions taken by the AMA and recommendations for further action. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2023 Interim Meeting.

This report provides an overview of Medicaid enrollment changes since the Medicaid continuous enrollment requirement ended, highlights federal policy and guidance, discusses challenges for physicians and other providers, summarizes AMA policy and advocacy, and presents policy recommendations.

BACKGROUND

At the 2022 Annual Meeting, while the Medicaid continuous enrollment requirement was still in effect and many states were planning for the impending onslaught of eligibility redeterminations, the Council on Medical Service presented Report 3-A-22, Preventing Coverage Losses After the PHE Ends, which established new AMA policy encouraging state and federal actions to prepare for and respond to the Medicaid unwinding (Policy H-290.955). Having recognized the potential for widespread coverage disruptions once the continuous enrollment requirement expired, the Council self-initiated Report 3-A-22 to ensure that the AMA had strong policy supportive of key state strategies for preventing coverage losses, including streamlining enrollment/redetermination processes; investing in outreach and enrollment assistance; adopting continuous eligibility policies; encouraging auto-enrollment in health insurance coverage; facilitating coverage transitions, including automatic transitions, to alternate sources of coverage; and federal and state monitoring and oversight. Taken together, these strategies would help ensure that, as states return to normal redeterminations, individuals who continue to be eligible for Medicaid and the Children's Health Insurance Program (CHIP) retain that coverage and those determined no longer eligible can seamlessly transition to other health insurance, such as subsidized Affordable Care Act (ACA) marketplace plans or employer-sponsored insurance (ESI).

During the PHE, the Families First Coronavirus Response Act required states to provide continuous coverage to nearly all Medicaid/CHIP enrollees as a condition of receiving a temporary federal medical assistance percentage (FMAP) increase. With disenrollments frozen, churn out of the program effectively ceased and enrollment increased nationally by 35 percent, from 70,875,069

in February 2020 to 93,876,834 in March 2023, after which the continuous enrollment requirement was lifted.[1] Most of this growth was in the Medicaid program, which increased by 22,634,781 individuals (35.3 percent), while CHIP enrollment increased during this period by 366,984 individuals (5.4 percent).[2] The Consolidated Appropriations Act of 2023 (CAA), which was signed into law in December 2022, established March 31, 2023 as the end date for the Medicaid continuous enrollment requirement and phased down the enhanced FMAP amount through December 2023.

Though challenging to quantify the impact on Medicaid enrollment once continuous enrollment was no longer required, the AMA and other interested parties understood that the number of people covered by Medicaid was likely to decrease substantially. The Robert Wood Johnson Foundation estimated that 18 million people would lose coverage during the 14-month unwinding period, including about 3.2 million children expected to transition from Medicaid to CHIP coverage, 9.5 million people who would turn to ESI, 3.8 million who would become uninsured, and one million who would be eligible for subsidized marketplace plans.[3] Estimates from the Kaiser Family Foundation (KFF) ranged from between eight and 24 million people who would be disenrolled from Medicaid during the unwinding period,[4] while the U.S. Department of Health and Human Services (HHS) projected that approximately 15 million Medicaid/CHIP enrollees would lose coverage.[5] According to the HHS analysis, an estimated 2.7 million people disenrolled from Medicaid would qualify for subsidized marketplace plans and 383,000 people would fall into the coverage gap (i.e., below poverty with income too low for ACA marketplace coverage and too high for the state's eligibility limit) in the 10 states that have not expanded Medicaid. HHS also predicted that 8.2 million disenrollments would be due to loss of eligibility while 6.8 million people would lose coverage for procedural reasons, such as the state Medicaid agency being unable to contact an enrollee or not receiving required documentation in time. Children and young adults as well as minoritized groups would be disproportionately impacted by the unwinding, according to the HHS analysis, including those who are African American or Latino.[6] A more recent analysis by the Congressional Budget Office projected that the unwinding would lead to gradual declines in Medicaid enrollment throughout 2023 and 2024, with an estimated 9.3 million people under age 65 transitioning from Medicaid to other sources of coverage, namely ESI and marketplace plans, while approximately 6.2 million people no longer enrolled in Medicaid would become uninsured.[7]

EARLY DATA ON MEDICAID/CHIP RENEWALS AND DISENROLLMENTS

According to the early data that was available at the time this report was written, renewal, disenrollment, and procedural termination rates vary substantially across states. However, a rapid rate of disenrollments in some states, coupled with high proportions of terminations for procedural reasons, is cause for potential concern. Centers for Medicare & Medicaid Services (CMS) data released on July 28, 2023 indicated that more than two million Medicaid/CHIP enrollees went through the renewal process in 18 states that completed renewals during the first month of the unwinding—April 2023.[8] Just over one million (45.5 percent) of these enrollees had their coverage renewed while more than 700,000 (32.2 percent) had their coverage terminated and the status of another 22 percent of enrollees was still pending.[9] Notably, procedural reasons were behind nearly four in five (79 percent) of those whose Medicaid/CHIP coverage was terminated. CMS also reported that 54,000 people previously covered by Medicaid or CHIP had enrolled in a marketplace plan in April 2023 while noting that more complete information on transitions to marketplace coverage is not expected for several months.[10]

Because Medicaid/CHIP enrollment data released from CMS are usually at least three months old, the Council also reviewed data from the KFF, which updates national Medicaid disenrollment numbers based on the most current data from at least 48 states publicly sharing those numbers and

the District of Columbia. According to KFF, as of September 12, 2023—just six months into the unwinding—over six million (6,428,000) Medicaid enrollees had been disenrolled from the program, almost three quarters (72 percent) for procedural reasons and just over a quarter due to an actual determination of ineligibility.[11] Texas had the highest rate of disenrollments, at 69 percent, over 70 percent of which were procedural, while only 9 percent of Michigan's completed renewals led to disenrollments. In the 16 states reporting the ages of those disenrolled from Medicaid, children made up approximately 42 percent of those disenrolled.[12]

Only limited data regarding the ability of individuals disenrolled from Medicaid/CHIP to re-enroll in Medicaid, if eligible, or obtain new coverage through ESI or marketplace plans were available at the time this report was written. Such data are expected to change over time and were not sufficient for the Council to draw meaningful conclusions regarding the impact of the unwinding on loss of coverage, transitions to new coverage, and uninsured rates, beyond the concerns expressed herein and in Council Report 3-A-22. In our review of the data, the Council was mindful that the early numbers are likely impacted by differences between state renewal plans and, most notably, the prioritization by some states to disenroll people already known to be ineligible for Medicaid/CHIP or have other health coverage (some of whom may be categorized as procedural terminations if they did not respond to inquiries from the state Medicaid agency or submit required paperwork). Still, concerns about improper or inappropriate procedural disenrollments are widespread and have led CMS to work with some states to temporarily pause these terminations and address potential problems with their renewal processes.[13]

In its 2022 report, the Council emphasized that the potential for coverage losses and the ability to transition those disenrolled from Medicaid to other affordable coverage would be highly dependent on each state's Medicaid policies and unwinding plans, and whether the state has expanded Medicaid. Though permitted to begin terminating coverage of Medicaid/CHIP enrollees in April 2023, only a handful of states did so, while others began disenrolling individuals in May or June and a dozen states waited until July to do so.[14] Therefore, the data available at the time this report was written were still very much evolving.

FEDERAL POLICY, GUIDANCE, AND RESOURCES

The CAA established new requirements that states must meet to receive the phased-down FMAP increase and gave CMS authority to require states to submit monthly unwinding data, such as the number of people whose coverage was terminated, the number of those terminated based on eligibility criteria versus for procedural reasons, plus call center volume and wait times. The CAA also authorized several enforcement mechanisms including corrective action plans, financial penalties, and requiring states to temporarily pause terminations.[15]

Leading up to the April 1, 2023 unwinding start date, CMS issued numerous fact sheets, guidance, policy and operational resources, best practices and strategies to support specific populations, and Medicaid/Marketplace coordination resources and began offering monthly "all state calls" to support states and territories as well as monthly partner education webinars. CMS also worked with states to assess compliance with Medicaid renewal requirements and adopt mitigation strategies to address areas of non-compliance, summaries of which can be found here. An assortment of outreach resources have been made available, including flyers that physicians can use to inform patients how to prepare for their renewal and direct patients deemed ineligible for Medicaid coverage to explore other coverage options. Notably, many state Medicaid agencies, state medical associations, and national medical specialty societies have also created resources to help physicians help patients retain coverage as the continuous enrollment requirement unwinds (e.g., American Academy of Pediatrics flyer, Michigan State Medical Society media release, and Illinois State

Medical Society event). Such resources are critical since, despite national and state campaigns to inform Medicaid enrollees about steps to take to retain Medicaid/CHIP coverage, consumer awareness and understanding of the unwinding and what it means for one's health coverage has been limited.[16]

In response to early data indicating high rates of procedural disenrollments, in June 2023, CMS announced an "all hands on deck" strategy to address the unwinding along with new flexibilities to help mitigate mass disenrollments. Specifically, the new flexibilities included allowing: 1) managed care plans to assist with completing renewal forms; 2) states to delay termination for one month while additional targeted outreach is performed; and 3) certain frontline entities such as pharmacies and community-based organizations to facilitate reinstatement of coverage based on presumptive eligibility criteria, among other flexibilities. HHS also encouraged states to maximize the use of alternative data sources, such as U.S. Postal Service data, to update enrollee contact information, increase *ex parte* renewal rates (which is when eligibility is confirmed administratively with third-party data), and facilitate reenrollment of people disenrolled for procedural reasons. In an accompanying letter to U.S. governors, the HHS Secretary urged state Medicaid agencies not to rush renewals and to instead take the full 12 months to initiate them, take full advantage of available federal flexibilities and waivers, and get creative in partnering with schools, faith-based organizations, and other community-based groups to perform targeted outreach.[17]

Other relevant federal policies impacting coverage transitions during the unwinding period include:

Mandatory Requirement for Medicaid/CHIP 12-Months Continuous Eligibility for Children: Continuous eligibility policies, which allow enrollees to maintain Medicaid/CHIP coverage for 12 months, have long been supported by the AMA as a strategy to reduce the churn that occurs when people lose coverage and then re-enroll within a short period of time. Although 24 states had adopted continuous Medicaid/CHIP eligibility for children by 2022, the CAA requires all states to implement continuous eligibility in Medicaid/CHIP for all children up to age 19, by January 1, 2024.

Extension of Enhanced Premium Tax Credit Subsidies for ACA Marketplace Plans: The Inflation Reduction Act, signed into law in August 2022, extended through 2025 the enhanced premium tax credits that were made available to eligible consumers under the American Rescue Plan Act of 2021. This advanceable and refundable credit, which the AMA supports, reduces the premium contribution for families with incomes between 100 and 150 percent of the federal poverty level (FPL) to zero and provides subsidies to 90 percent of people selecting marketplace plans.

Special Enrollment Opportunity (SEP) for Consumers Losing Medicaid/CHIP Coverage: CMS established an SEP for consumers losing Medicaid/CHIP coverage due to the unwinding of the continuous enrollment requirement. This SEP, which runs between March 31, 2023 and July 31, 2024, allows individuals and families to enroll in federally facilitated marketplace (HealthCare.gov) plans, if eligible, outside of the annual open enrollment period.[18] CMS, along with the Departments of Labor and Treasury, also sent a letter to employers, plan sponsors, and insurers encouraging them to match the steps taken by HealthCare.gov by allowing employees and their dependents who lose Medicaid/CHIP coverage to enroll anytime through July 31, 2024.

Fixing the "Family Glitch:" The AMA has long supported fixing the "family glitch" which was accomplished this year by regulations allowing family members of workers offered affordable self-only coverage to gain access to subsidized ACA marketplace coverage. Under the new rule, it is anticipated that nearly one million Americans will gain access to more affordable coverage.[19]

CHALLENGES FOR PHYSICIANS, PRACTICES, HOSPITALS AND HEALTH SYSTEMS

Since this report was written only a few months after the continuous enrollment requirement expired, meaningful data regarding the impact of Medicaid/CHIP coverage terminations on physicians, physician practices, hospitals and health systems is limited and still emerging. However, it is generally assumed that the unwinding will increase uninsured rates. The CBO estimates that the number of uninsured will increase from 23 million (uninsured rate of 8.3 percent) in 2023 to 28 million (10.1 percent) in 2027 and remain at that level, which is below the 12 percent uninsured rate in 2019, through 2033.[20]

In turn, physician practices, hospitals and health systems serving large numbers of Medicaid/CHIP patients or located in underserved communities—including rural areas—could disproportionately experience decreased patient volume and revenue losses in the coming months. Such effects may then impact the ability of some practices and facilities to employ staff and continue serving patients, particularly those covered by Medicaid or CHIP, which tend to pay physicians and other providers at rates lower than Medicare and commercial insurance, thus further exacerbating existing access inequities. For example, a January 2023 predictive analysis of the potential effects of the Medicaid unwinding on community health centers, which rely greatly on Medicaid revenue, estimated that the unwinding would decrease health center revenue by $1.5 to $2.5 billion, or four to seven percent, overall. As a result, the analysis posits that between 1.2 and 2.1 million fewer patients will be served and between 10.7 and 18.5 thousand fewer people will be employed by health centers.[21] Kaufman Hall summaries of data from more than 900 hospitals in the first months of the unwinding similarly found increases in both charity care and bad debt, as well as declines in volume, that are attributed by the authors to unwinding-related coverage losses.[22]

Additionally, physicians, hospitals, and other providers will likely see more and more patients who may not realize that they are no longer covered by Medicaid/CHIP, and are therefore uninsured, until they seek care. Most states do not provide renewal information to physicians and other providers or allow them to access such data via the Medicaid agency portal; however, Kentucky is an exception and even explains how providers can find patients' renewal dates online. Having such information in hand before an enrollee is at the practice for an appointment would be helpful to physicians who could then make sure a patient is aware of their Medicaid/CHIP renewal and coverage status.

AMA ACTIVITY

The AMA has consistently worked at both the state and federal levels to improve Medicaid and CHIP programs, expand Medicaid and CHIP coverage options, and generally make it easier for physicians to see Medicaid and CHIP patients. Since the ACA was enacted, AMA advocacy on Medicaid and CHIP has been guided by AMA policy, highlighted in the AMA's Plan to Cover the Uninsured, which seeks to extend the reach of coverage to the remaining uninsured, including individuals eligible for Medicaid/CHIP and adults who fall into the coverage gap. Consistent with AMA policy, the AMA continues to advocate for Medicaid expansion and three years of 100 percent federal funding for states that newly expand.

The AMA regularly comments on federal and state Medicaid proposals related to patient access to care and adequate physician payment, defined in AMA policy as a minimum of 100 percent of Medicare rates. The AMA has advocated that CMS ensure that states are maintaining Medicaid rate structures at levels that ensure sufficient physician participation, so that Medicaid patients can access appropriate, necessary care, including specialty and behavioral health services, in a timely

manner and within a reasonable distance to where they live. Specifically in response to the unwinding of the continuous enrollment requirement, the AMA also:

- Participates in the Connecting to Coverage Coalition, which represents a diverse collection of industry voices partnering to minimize coverage disruptions associated with the resumption of state Medicaid renewals;
- Meets with senior Administration officials to discuss the status of the unwinding and on-the-ground implications, AMA's role in educating physicians on CMS' new guidance and resources, and potential areas for future collaboration;
- Facilitates educational opportunities for the Federation, including a session in August 2023 at the AMA's State Advocacy Roundtable in which resources were shared and unwinding strategies were discussed;
- Shares CMS resources with the Federation and encourages members to participate in CMS' monthly webinars that are part of the agency's "all hands-on deck" strategy;
- Regularly distributes new unwinding information and guidance announcements from CMS and other sources through various AMA platforms and channels, including *AMA Today* and the AMA's biweekly Advocacy Update;
- Creates unwinding-specific resources for physicians, such as AMA issue briefs on Preventing Coverage Losses as the PHE Unwinds and COVID-19 flexibilities that ended when the PHE expired; and
- Submits comments to CMS on relevant notices of proposed rulemaking, such as proposals this year on special enrollment periods and standards for navigators and other consumer assisters; ensuring access to Medicaid services; and managed care access, finance, and quality.

RELEVANT AMA POLICY

Policies H-165.832 and H-165.855 support the adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans to limit patient churn and promote the continuity and coordination of patient care. Policy H-165.855 also supports allowing for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care. AMA policy also supports investments in outreach and enrollment assistance activities (Policies H-290.976, H-290.971, H-290.982 and D-290.982). The role of community health workers is addressed under Policy H-440.828, while Policy H-373.994 delineates guidelines for patient navigator programs. Policy D-290.979 directs the AMA to work with state and specialty medical societies to advocate at the state level in support of Medicaid expansion. Policy D-290.974 supports the extension of Medicaid and CHIP coverage to at least 12 months after the end of pregnancy. Policy H-290.958 supports increases in FMAP or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment.

Policy H-290.955 encourages states to facilitate transitions, including automatic transitions, from health insurance coverage for which an individual is no longer eligible to alternate health insurance coverage for which the individual is eligible; supports coordination between state agencies overseeing Medicaid, ACA marketplaces, and workforce agencies to help facilitate health insurance coverage transitions and maximize coverage; and supports federal and state monitoring of Medicaid retention and disenrollment, successful transitions to quality affordable coverage, and uninsured rates. Policy H-165.839 advocates that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information. Support for fixing the ACA's "family glitch" is addressed by Policy H-165.828, which also supports efforts to ensure clear and meaningful differences between plans offered on

health insurance exchanges. Policy H-165.824 supports increasing the generosity of premium tax credits as well as eliminating ACA's subsidy "cliff." Under Policy H-285.952, patients in an active course of treatment who switch to a new health plan should be able to receive continued transitional care from their treating out-of-network physicians and hospitals at in-network cost-sharing levels.

Policy H-165.823 supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets certain standards related to cost of coverage, individual consent, opportunity to opt-out after being auto-enrolled, and targeted outreach and streamlined enrollment. Under this policy, individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would therefore include individuals eligible for Medicaid/CHIP or zero-premium marketplace coverage. Policy H-165.823 also outlines standards that any public option to expand health insurance coverage, as well any approach to cover individuals in the coverage gap, must meet.

Under Policy H-165.824, the AMA supports adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits and encourages state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections. Policy H-165.824 further supports: (a) eliminating the subsidy "cliff," thereby expanding eligibility for premium tax credits beyond 400 percent of the FPL; (b) increasing the generosity of premium tax credits; (c) expanding eligibility for cost-sharing reductions; and (d) increasing the size of cost-sharing reductions.

Policy H-165.822 encourages new and continued partnerships to address non-medical, yet critical health needs and the underlying social determinants of health and supports continued efforts by public and private health plans to address social determinants of health. Policy H-180.944 states that health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

DISCUSSION

The Medicaid unwinding has been described as the most significant nationwide coverage transition since the ACA, with major implications for patients, physicians, and health equity. As noted by the Council in Report 3-A-22, eligibility redeterminations and resulting coverage losses may have a disproportionate impact on individuals of color and those with disabilities, and it is critical that states consider how best to avoid exacerbating existing health care inequities. Even if states adopt many of the strategies outlined in Council Report 3-A-22 to help prevent coverage losses (e.g., streamlining redeterminations, adopting continuous eligibility policies, encouraging auto-enrollment, and facilitating coverage transitions, etc.), the unwinding will be painful for many people who have relied on Medicaid/CHIP for their health coverage and may decrease patient volume and revenue for physicians, clinics, and hospitals who regularly provide care to large populations of Medicaid and CHIP patients.

At the time this report was written, the Medicaid unwinding was in its early stages; many states had been conducting renewals for only a few months; and information on transitions from Medicaid/CHIP to other coverage was limited. While state renewal approaches vary and may evolve over time, early data suggesting high rates of procedural terminations in some states are

concerning since an unknown—but potentially substantial—number of individuals (including children) still eligible for Medicaid/CHIP coverage may have been improperly disenrolled. The Council will continue to monitor unwinding data as it becomes available and recommend new AMA policy and physician resources as needed. At this time, the Council has identified three priority areas for new AMA policy development and advocacy: encouraging states to reduce inappropriate terminations from Medicaid/CHIP for procedural reasons; expand continuity of care protections for disenrolled individuals; and enable provider access to Medicaid/CHIP coverage and renewal information.

As the PHE continuous enrollment unwinds over the coming months, disenrollments from Medicaid/CHIP will continue, some based on eligibility and others for procedural reasons, and physicians and hospitals may encounter more patients who do not realize that they have lost Medicaid/CHIP coverage and are therefore uninsured. It is widely understood that even brief gaps in coverage can be costly in terms of interrupting continuity of care and necessary treatments, especially for patients with acute or chronic health conditions. To address concerns regarding procedural terminations of coverage for individuals still eligible for Medicaid, the Council recommends amending Policy H-290.955 to encourage state Medicaid agencies to implement strategies to reduce inappropriate procedural terminations, including automating renewal processes and following up with enrollees who have not responded to a renewal request before terminating coverage.

While many states require insurers to cover services for patients in an active course of treatment at in-network cost-sharing if their provider is terminated from an insurer network, fewer states require similar continuity of care protections for people switching health plans. Because Medicaid patients have higher rates of chronic disease and complex health conditions, the Council recommends encouraging states to provide continuity of care protections for Medicaid/CHIP enrollees transitioning to new health coverage and to recognize prior authorizations completed by the prior Medicaid/CHIP plan. The Council also recommends encouraging states to make Medicaid coverage status, including expiration of current coverage and information on pending renewals, accessible to physicians, clinics, and hospitals through the state Medicaid agency's portal or by other readily accessible means, so that providers can inform patients of upcoming renewals when they come in for appointments.

The Council further recommends reaffirmation of two AMA policies: 1) Policy H-165.855, which calls for the adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans and supports allowing for presumptive eligibility and retroactive coverage to the time at which an eligible person seeks care; and 2) Policy H-165.823, which encourages states to pursue auto-enrollment in health insurance coverage as a means of expanding coverage among individuals who may not know that they are eligible for a state's Medicaid or marketplace coverage or what steps to take to enroll.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) amend Policy H-290.955 by addition to read:
   <u>4. Our AMA encourages state Medicaid agencies to implement strategies to reduce inappropriate terminations from Medicaid/CHIP for procedural reasons, including</u>

automating renewal processes and following up with enrollees who have not responded to a renewal request, using multiple modalities, before terminating coverage.
5. Our AMA encourages states to provide continuity of care protections to patients transitioning from Medicaid or CHIP to a new health plan that does not include their treating physicians and other providers in network, and to recognize prior authorizations completed under the prior Medicaid/CHIP plan.
6. Our AMA encourages state Medicaid agencies to make Medicaid coverage status, including expiration of current coverage and information on pending renewals, accessible to physicians, clinics, and hospitals through the state's portal or by other readily accessible means. (Modify HOD Policy)

2. That our AMA reaffirm Policy H-165.855, which calls for adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans and supports allowing for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-165.823, which supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets certain standards related to consent, cost, ability to opt out, and other guardrails. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] Centers for Medicare & Medicaid Services. March 2023 Medicaid and CHIP Enrollment Trends Snapshot. Available at: https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/march-2023-medicaid-chip-enrollment-trend-snapshot.pdf
[2] *Ibid*.
[3] Buettgens Matthew and Green Andrew. The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage. Urban Institute and Robert Wood Johnson Foundation Research Report. December 2022. Available at: https://www.urban.org/sites/default/files/2022-12/The%20Impact%20of%20the%20COVID-19%20Public%20Health%20Emergency%20Expiration%20on%20All%20Types%20of%20Health%20Coverage_0.pdf
[4] Kaiser Family Foundation. 10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision. June 9, 2023. Available at: https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/
[5] U.S Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE). Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches, August 19, 2022. Available at: https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage_IB.pdf
[6] *Ibid*.
[7] Hanson, C, Hou, C, Percy A et al. Health Insurance for People Younger Than Age 65: Expiration of Temporary Policies Projected to Reshuffle Coverage, 2023-2033. *Health Affairs* Vol. 42, No. 6, June 2023.
[8] Centers for Medicare & Medicaid Services. Medicaid and CHIP Renewals: Returning to Regular Operations. Downloaded July 31, 2023. Available at: https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-data-reporting/index.html
[9] *Ibid*.

[10] *Ibid*.
[11] Kaiser Family Foundation. Medicaid Enrollment and Unwinding Tracker. Updated daily. Available at: https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-unwinding-tracker/
[12] Kaiser Family Foundation. Medicaid Enrollment and Unwinding Tracker. Updated daily. Available at: https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-unwinding-tracker/
[13] Ibid.
[14] Centers for Medicare & Medicaid Services. 2023 State Timelines for Initiating Unwinding-Related Renewals As of June 29, 2023Available at: https://www.medicaid.gov/resources-for-states/downloads/ant-2023-time-init-unwin-reltd-ren-06292023.pdf
[15] U.S. Department of Health and Human Services. Fact Sheet: Returning to Regular Medicaid Renewals: Monitoring, Oversight, and Requiring States to Meet Federal Requirements. July 2023. Available at: https://www.medicaid.gov/resources-for-states/downloads/renewals-for-monitoring-state-systems.pdf
[16] Kaiser Family Foundation. The Unwinding of Medicaid Continuous Enrollment: Knowledge and Experiences of Enrollees, May 24, 2023. Available at: https://www.kff.org/medicaid/poll-finding/the-unwinding-of-medicaid-continuous-enrollment-knowledge-and-experiences-of-enrollees/?utm_campaign=KFF-2023-Medicaid&utm_medium=email&_hsmi=2&_hsenc=p2ANqtz-_PkdkT3cI-XhADnQIFKJcM2zm-s33yNCZWhDAoOuc9Dy2pfo9i0M_usPll5HmuuQU0I5k8LLdKm5F6kkQq1pGf43D34g&utm_content=2&utm_source=hs_email
[17] U.S. Department of Health and Human Services. Letter to U.S. Governors from HHS Secretary Xavier Becerra on Medicaid Redeterminations, June 12, 2023. Available at: https://www.hhs.gov/about/news/2023/06/12/letter-us-governors-from-hhs-secretary-xavier-becerra-medicaid-redeterminations.html
[18] Centers for Medicare & Medicaid Services. Center for Consumer Information & Insurance Oversight. FAQ: Temporary Special Enrollment Period (SEP) for Consumers Losing Medicaid or the Children's Health Insurance Program (CHIP) Coverage Due to Unwinding of the Medicaid Continuous Enrollment Condition. January 27, 2023. Available at: https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf
[19] American Medical Association. Advocacy Update: Proposed fix to ACA family glitch follows AMA advocacy, April 15, 2022. Available at: https://www.ama-assn.org/health-care-advocacy/advocacy-update/april-15-2022-national-advocacy-update
[20] Hanson, C, Hou, C, Percy A et al. Health Insurance for People Younger Than Age 65: Expiration of Temporary Policies Projected to Reshuffle Coverage, 2023-2033. *Health Affairs* Vol. 42, No. 6, June 2023.
[21] Ku, L, Sharac, J, Shin, P, Rosenbaum, S and Jacobs F. Data Note: The Potential Effects of Medicaid Unwinding on Community Health Centers. George Washington University Geiger Gibson Program in Community Health. January 2023. Available at: https://geigergibson.publichealth.gwu.edu/potential-effect-medicaid-unwinding-community-health-centers#:~:text=The%20unwinding%20is%20estimated%20to,to%2018.5%20thousand%20staff%20members.
[22] Kaufman Hall. National Hospital Flash Report, August 2023. Available at: https://www.kaufmanhall.com/sites/default/files/2023-08/KH-NHFR_2023-08.pdf.

APPENDIX

Policies Recommended for Amendment and Reaffirmation

Preventing Coverage Losses After the Public Health Emergency Ends H-290.955
1. AMA encourages states to facilitate transitions, including automatic transitions, from health insurance coverage for which an individual is no longer eligible to alternate health insurance coverage for which the individual is eligible, and that auto-transitions meet the following standards:
a. Individuals must provide consent to the applicable state and/or federal entities to share information with the entity authorized to make coverage determinations. b. Individuals should only be auto-transitioned in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-transitioned.
d. Individuals should not be penalized if they are auto-transitioned into coverage for which they are not eligible. e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values. f. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and special enrollment periods. g. Auto-transitions should preserve existing medical home and patient-physician relationships whenever possible. h. Individuals auto-transitioned into a plan that does not include their physicians in-network should be able to receive transitional continuity of care from those physicians, consistent with Policy H-285.952.
2. Our AMA supports coordination between state agencies overseeing Medicaid, Affordable Care Act marketplaces, and workforce agencies that will help facilitate health insurance coverage transitions and maximize coverage.
3. Our AMA supports federal and state monitoring of Medicaid retention and disenrollment, successful transitions to quality affordable coverage, and uninsured rates. (CMS Rep. 3, A-22)

Medical Care for Patients with Low Incomes H-165.855
It is the policy of our AMA that: (1) states be allowed the option to provide coverage to their Medicaid beneficiaries who are nonelderly and nondisabled adults and children with the current Medicaid program or with premium tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, exclusively to allow patients and their families to purchase coverage through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP) with minimal or no cost-sharing obligations based on income. Children qualified for Medicaid must also receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program benefits and have no cost-sharing obligations. (2) in order to limit patient churn and assure continuity and coordination of care, there should be adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans. (3) to support the development of a safety net mechanism, allow for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care. (4) tax credit beneficiaries should be given a choice of coverage, and that a mechanism be developed to administer a process by which those who do not choose a health plan will be assigned a plan in their geographic area through auto-enrollment until the next enrollment opportunity. Patients who have been auto-enrolled should be permitted to change plans any time within 90 days of their original enrollment. (5) state public health or social service programs should cover, at least for a transitional period, those benefits that would otherwise be available under Medicaid, but are not medical benefits per se. (6) as the nonelderly and nondisabled

populations transition into needing chronic care, they should be eligible for sufficient additional subsidization based on health status to allow them to maintain their current coverage. (7) our AMA encourages the development of pilot projects or state demonstrations, including for children, incorporating the above recommendations. (8) our AMA should encourage states to support a Medicaid Physician Advisory Commission to evaluate and monitor access to care in the state Medicaid program and related pilot projects. (CMS Rep. 1, I-03; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation I-07; Modified: CMS Rep. 1, A-12; Reaffirmed in lieu of Res. 101, A-13; Reaffirmed: CMS Rep. 02, A-16; Reaffirmation: A-18; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21; Reaffirmed: CMS Rep. 3, A-22)

Options to Maximize Coverage under the AMA Proposal for Reform H-165.823

1. That our AMA advocate for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians.
2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards: a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition. b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits. c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice. d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option. e. The public option is financially self-sustaining and has uniform solvency requirements. f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans. g. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.
3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards: a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations. b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage. c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled. d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment. e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values. f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees. g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans. h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the

availability of premium tax credits and cost-sharing reductions and establishing a special enrollment period.
4. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status. (CMS Rep. 1, I-20Appended: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: Res. 122, A-22; Modified: Res. 813, I-22)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-I-23

Subject: Rural Hospital Payment Models

Presented by: Sheila Rege, MD Chair

Referred to: Reference Committee J

At the June 2023 Annual Meeting the House of Delegates adopted Policy D-465.996. The second resolve of the adopted policy asks that the American Medical Association (AMA) study alternative payment models for rural hospitals to examine their feasibility, and that the study include a discussion as to the feasibility of the patient-centered payment and standby capacity payments models. Consistent with Policy D-465.996, this report examines alternative payment models, including patient-centered payment and standby capacity payment models, that could assist in efforts to ensure that rural hospitals remain financially viable and able to provide care to rural patients.

BACKGROUND

Nearly one-fifth of the U.S. population, about 60 million people, live in rural areas. Individuals living in these areas are more likely to be sicker, older, and underinsured than their urban and suburban dwelling counterparts. They also have higher rates of smoking, hypertension, and obesity. These factors along with higher poverty rates, lead to health disparities for rural Americans. Additionally, rural populations are more likely to be beneficiaries of Medicare or Medicaid with nearly half of rural hospital revenue coming from these sources. A more in-depth look at the state of health care for rural populations can be found in CMS Report 09-A-21, Addressing Payment and Delivery in Rural Hospitals, and CMS Report 09-A-23, Federally Qualified Health Centers and Rural Health.

RURAL HOSPITALS

Rural hospitals are those that exist and serve communities outside metropolitan areas and make up about a quarter of all American hospitals.[1] These hospitals are geographically isolated, often making them one of the only, if not the only, source of health care in the community. These hospitals are a vital point of access to communities that are often older, sicker, and less insured than urban and suburban communities.

Rural hospitals are incredibly vulnerable not only to many of the issues facing health care generally but often face additional unique challenges like low patient volumes and higher fixed costs. As a result of lower patient volumes many rural hospitals face challenges in both reporting and being assessed by quality metrics. A full discussion of the complications faced by rural hospitals in relation to quality metrics can be found in CMS Report 09-A-21. Additionally, nearly a third of all rural hospitals in the U.S. are at risk of closing and a third of those hospitals are in jeopardy of immediate closure.[2] An estimated 136 rural hospitals closed completely between 2005 and 2021

with 19 closing in 2020 alone.[3] Nearly 100 additional facilities no longer provide inpatient services and have either converted to a Rural Emergency Hospital or provide limited outpatient services.[4]

These closures are often a result of payment rates that do not cover costs. Rural hospitals face a unique financial situation as many insurers do not pay them enough to cover the cost of providing services in low-population and rural communities.[5] Specifically, many private payers and Medicare Advantage plans pay rural hospitals less than the actual cost to deliver services.[6] While rural hospitals can sometimes also lose money when providing services to Medicaid beneficiaries, 19 states offset these losses with additional payments to hospitals via bolstered reimbursement rates.[7] Traditional Medicare, not Medicare Advantage, beneficiaries are the most financially beneficial patients for many rural hospitals. This is because Medicare explicitly pays more to cover the higher costs to deliver health services in these rural settings for hospitals classified as Critical Access Hospitals (CAHs). Of note, while all CAHs are rural hospitals, not all rural hospitals qualify as CAHs. For a hospital to qualify as a CAH it must go through a specific certification process and meet criteria related to its size, location, services provided, and average patient length of stay.[8] In addition to the payment shortfalls facing rural hospitals, they are also more susceptible to the workforce challenges that many hospitals and medical practices are facing.[2]

Another important factor impacting the financial viability of rural hospitals is the Affordable Care Act's (ACA) Medicaid expansion. Starting in 2014 states were able to opt into an expanded Medicaid coverage for nearly all adults with an income level up to 138 percent of the Federal Poverty Level along with enhanced federal matching for these extended populations. Currently, 40 states and the District of Columbia have implemented this expansion and are often referred to as "expansion states."[9] This is essential to understanding the full state of rural hospitals as research has demonstrated that rural hospitals fare financially better in expansion states compared to non-expansion states. This improvement is thought to stem from a lessening in uncompensated care as more patients are insured. Specifically, rural hospitals in Medicaid expansion states were shown to have increased operating margins and were less likely to face full or partial closures.[8] While many rural hospitals still struggle in expansion states, the situation is grimmer for the 34 percent of rural hospitals in non-expansion states.[8]

PATIENT-CENTERED PAYMENT MODEL

Research demonstrates that patient-centered payment and care models tend to yield positive impacts for patients and providers. Improved patient outcomes in these models include improved health and well-being.[10] Physicians and health care teams also report improved patient interactions, cost-effectiveness, and work environments. However, some studies have found patient drawbacks like an increase in personal and financial costs to patients.[7] Many of the studies done on this type of model focus on the broader patient-centered care models, not specifically on patient-centered payment models. Additionally, these studies are focused on outpatient instead of hospital inpatient settings. Accordingly, these studies need to be taken with some caution regarding their applicability to rural hospitals. A joint report from the AMA and the Center for Healthcare Quality and Payment Reform (CHQPR) has shown promise for this payment model but was not specific to rural health. Specifically, the report demonstrated that the patient-centered payment model yields higher-quality and lower-cost care through increased flexibility for physicians to deliver care and increases in physician payments.[11]

STANDBY CAPACITY PAYMENTS MODEL

Generally, standby capacity payments for hospitals would provide hospitals with advance payment for the populations of their respective communities regardless of how many health care services are

actually rendered.[9] Advocates of this type of payment system suggest that all health insurance plans, both public and private, should provide participating hospitals with a standby capacity payment for their community populations.[12] Though payment could hypothetically come from any payer, it seems most likely that the funding would, at least initially, come from local, state, and/or federal government entities to prevent critical rural hospitals from closing. For rural hospitals, standby payment would combat the issue of fixed costs that are often overwhelming for these hospitals. All hospitals are required to always maintain an emergency standby capability[13] to ensure that hospitals are ready if and/or when an emergency occurs. Larger hospitals are more likely to be able to incorporate this into their cost structure, but many rural hospitals are unable to cover the cost of emergency standby capability due to lower payments and smaller patient volumes. The struggle for many rural hospitals to absorb these costs means that standby capacity could be particularly advantageous. The amount of the standby capacity payment would be dependent on the population of the community, services provided by the hospital, and the hospital's operating costs. The AMA[5] and CHQPR[9] have supported standby payment for rural hospitals.

Much of the research on standby payment does not focus specifically on rural hospitals. The research does yield a number of distinct advantages to the patient and physician, such as an increase in quality of care, a decrease in costs, and the potential to aid in the mitigation of unsustainable cost trends. However, experts suggest that these payments alone would not be sufficient to address health care value generally or in rural hospitals particularly.[14] Experts suggest that standby payment models should be paired with incentives to improve care outcomes and that the Centers for Medicare & Medicaid Services (CMS) lead the payment reform. As low payment rates from Medicare Advantage plans are a key contributor to the problems facing rural hospitals the government would need to require that these plans provide more financially sustainable compensation.[12]

GLOBAL BUDGETS/PAYMENTS MODEL

Global budgets or global payments are similar to standby capacity payments in that they are a predictable and reliable payment to the hospital. However, this type of payment is constructed on fixed payments to hospitals or other providers that are based on the range of services that would be billed for individually in a traditional fee-for-service (FFS) arrangement during a specific time period, rather than the size of the community.[15] Generally, global payments are made at a predetermined point, which could be incremental or after a set of services are provided by a hospital. An important aspect of global payment systems is that they are made on behalf of a group of patients, like Medicaid beneficiaries, instead of individual patients. For global payments to be successful, contracts delineate specific standards and outcomes for the range of services included in the contract. Commonly, covered services are broad and include physician services, hospital services, diagnostic testing, prescription drugs, and may include expanded services like home health or hospice care.[12] The global payment system aims to improve patient outcomes and increase access to preventative services. It may include bonuses to physicians or hospitals if quality benchmarks are reached, which aims to promote high-value care.

The use of global payments or budgets has grown, as the model is used by some private payers as well as some Medicare Advantage plans and Medicaid managed care plans. A particularly relevant and promising implementation of this model was launched by the state of Pennsylvania with the support of CMS in 2019. The Pennsylvania Rural Health Model (PARHM) was created to allow rural hospitals in Pennsylvania to stay open and provide high-quality health care services that improve the health of the communities they serve.[16] PARHM was implemented as a CMS innovation model and is in an ongoing evaluation stage through 2024. As with many rural

communities, rural populations in Pennsylvania have poorer health outcomes than their urban counterparts.

The PARHM model is a potential answer to issues facing rural hospitals. In this model, payment is based on historical net patient revenue for both inpatient and outpatient services adjusted for factors like inflation and service line changes.[13] Participating hospitals are also able to access supports in identifying and implementing areas of transformation focused on prevention services, quality improvement, and community-based services, as well as advancing both community health goals and health equity. This model currently includes 18 rural hospitals, Medicare, Pennsylvania Medical Assistance (Medicaid), and five private payers; Geisinger Health Plan, Highmark Blue Cross Blue Shield, UPMC Health Plan, Gateway, and Aetna.[17]

Each participating PARHM hospital receives regular and consistent payments from participating payers based on the FFS portion of the budget. These consistent payments have shown promising results in the initial years of evaluation. Importantly, hospitals who participate have expressed strong commitment to the model and indicated that participation has allowed the hospitals to attain greater financial stability and remain open.[15] Although some participating commercial payers have expressed concern over the sustainability of this type of model, the model is continuing to be evaluated and will remain under a trial/evaluation period through 2024. Evaluators have indicated that future reports will assess the sustainability and impact of the model on health outcomes in the communities served. However, one main outcome is clear—rural hospitals at risk of closing are able to not only remain open but improve their financial stability.[15] In an era where many rural hospitals are closing or struggling to stay open, this is a potentially promising outcome to ensure that rural communities have access to health care services.

RELEVANT AMA POLICY

The AMA has extensive policy on both rural hospitals and rural health generally. Policy D-465.998 outlines the AMA's support to ensure that payments to rural hospitals from both public and private payers are adequate to cover services rendered. Additionally, this policy works to ensure that coordination of care and transparency are encouraged in rural hospitals. Finally, the policy encourages rural residents to select health insurance plans that pay rural hospitals equitably. Notably, this policy specifically calls for supporting the development of capacity payment models for rural hospitals.

In addition to the aforementioned policy, the AMA has multiple policies that outline the importance of economically supporting rural hospitals and advocating for their financial stability. Policy H-465.979 recognizes the importance of rural hospitals and supports organizations that are advocating for their sustainability. Policy H-465.990 addresses the concerning trend of rural hospital closures by encouraging legislation that reduces financial constraints on these hospitals. Policy H-420.971 supports eliminating the payment differentials that are seen between urban and rural medical care, and Policy H-240.970 advocates for reimbursement to rural hospitals for patients returning from tertiary care centers.

In addition to payment and reimbursement related policies, the AMA has policies that support reasonable designation and certification processes for rural hospitals. Policy D-465.999 focuses on encouraging CMS to support state development of rural health networks, oppose the elimination of CAH necessary provider designations, and to pursue steps to ensure that the federal government fully funds its obligations in the Medicare Rural Hospital Flexibility Program. Policy H-465.999 urges Health and Human Services to take a realistic approach to the

certification of rural hospitals and recommends that state licensing and certifying agencies surveil the process for issues with the certification and accreditation process.

The AMA also has a number of policies related to improving the health of rural Americans. Policy H-465.994 supports the development and implementation of programs that improve rural health, urges rural physicians to be involved in community health, and calls for the AMA to disseminate its efforts related to rural health improvement. Policies H-465.982 and H-465.997 focus on efforts to support and encourage the study and development of proposals to solve access issues in rural communities. Policy H-465.978 encourages the recognition of payment bias as a factor in rural health disparities and advocates for the resolution of these biases. Policy H-465.989 focuses on the monitoring and defense against adverse impacts of the Budget Reconciliation legislation along with AHA. Finally, Policy H-465.986 encourages the study and dissemination of results on the Rural Health Clinics Program and its certification and how to best incorporate mid-level practitioners with physician supervision.

DISCUSSION

The AMA is committed to improving the health of rural communities through maintaining and expanding access to care in those settings. AMA policy and advocacy have focused on ensuring that rural hospitals remain open and able to serve their communities. One potential method of ensuring the maintenance of rural hospitals is to focus on transforming payment models. Patient-centered payment, standby capacity payment, and global budgets/payment models all provide potential alternatives to the traditional FFS payment models that are generally used in American health care settings. In its study, the Council is encouraged that each of these models has some distinct advantages that indicate they could be leveraged to ease the burden many rural hospitals are facing.

In order to support rural hospitals with adequate payment to stay open and to encourage additional innovative strategies to address the payment issues facing rural hospitals, the Council recommends new policy that encourages the AMA to support efforts to create and implement proposals to transform the payment models utilized in rural hospitals. This policy would support such proposals from any entity including CMS and interested state medical associations.

Finally, the Council recommends that Policies H-465.978, Recognizing and Remedying Payment System Bias as a Factor in Rural Health Disparities, and D-465.998, Addressing Payment and Delivery in Rural Hospitals, be reaffirmed. Each of these policies works to both acknowledge and encourage action to remedy payment disparities and issues facing rural hospitals.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) support and encourage efforts to develop and implement proposals for improving payment models to rural hospitals. (New HOD Policy)

2. That our AMA reaffirm Policy H-465.978, which recognizes the payment bias toward rural hospitals as a factor in rural health disparities and encourages solutions to help solve this bias. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-465.998, which advocates for improvements to the payment and health care service delivery in rural hospitals. (Reaffirm HOD Policy)

4. That our AMA rescind Policy D-465.996 as having been accomplished with this report. (Rescind HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] Importance of Rural Hospitals. *Center for Healthcare Quality and Payment Reform.* 2021. https://ruralhospitals.chqpr.org/Importance.html
[2] Rural Hospitals at Risk of Closing. *Center for Healthcare Quality and Payment Reform*. 2023. https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf
[3] Rural Hospital Closures Threaten Access: Solutions to Preserve Care in Local Communities. *American Hospital Association.* 2022. https://www.aha.org/2022-09-07-rural-hospital-closures-threaten-access
[4] Rural Hospital Closures. *University of North Carolina: The Cecil G. Sheps Center for Health Services Research.* 2023. https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/
[5] Payment and Delivery in Rural Hospitals. *American Medical Association.* 2021. https://www.ama-assn.org/system/files/issue-brief-rural-hospital.pdf
[6] Rural Healthcare Payment and Reimbursement. *Rural Health Information.* 2022. https://www.ruralhealthinfo.org/topics/healthcare-payment
[7] Rural Hospitals and Medicaid Payment Policy. *Medicaid and CHIP Payment and Access Commission (MACPAC).* 2018. https://www.macpac.gov/publication/rural-hospitals-and-medicaid-payment-policy/
[8] Critical Access Hospitals. *Rural Health Information Hub.* 2021. https://www.ruralhealthinfo.org/topics/critical-access-hospitals
[9] Status of State Medicaid Expansion Decisions: Interactive Map. *Kaiser Family Foundation.* 2023. https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/
[10] Summer Meranius M, Holmström IK, Håkansson J, et al. Paradoxes of person-centred care: A discussion paper. Nurs Open. 2020;7(5):1321-1329. Published 2020 Jun 10. doi:10.1002/nop2.520
[11] A Guide to Physician-Focused Alternative Payment Models. *American Medical Association* and *Center for Healthcare Quality and Payment Reform.* 2021. https://pubmed.ncbi.nlm.nih.gov/32802352/
[12] A Better Way to Pay Rural Hospitals. Center for Healthcare Quality and Payment Reform. 2022. https://chqpr.org/downloads/Better_Way_to_Pay_Hospitals.pdf
[13] Fact Sheet: Site-neutral Payment Provisions. *American Hospital Association.* 2019. https://www.aha.org/system/files/media/file/2019/09/fact-sheet-site-neutral-0919.pdf
[14] The Potential of Global Payment: Insight from the Field. *The Commonwealth Fund.* 2010. https://www.commonwealthfund.org/publications/fund-reports/2010/feb/potential-global-payment-insights-field#:~:text=Global%20payment%20can%20address%20concerns,addressed%20by%20using%20this%20model.
[15] Payment Model Primer: Global Payments. *Center for Evidence-Based Policy.* 2022. https://centerforevidencebasedpolicy.org/CEbP_PaymentModelPrimer_GlobalPayments.pdf
[16] Pennsylvania Rural Health Model. *Center for Medicare and Medicaid Services.* 2023. https://innovation.cms.gov/innovation-models/pa-rural-health-model
[17] Pennsylvania Rural Health Model (PARHM) Evaluation of Performance Years 1-2 (2019-2020). Findings at a Glance. *CMS: Center for Medicare and Medicaid Innovation.* 2022. https://innovation.cms.gov/data-and-reports/2021/parhm-ar1-full-report

REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (I-23)
Sustainable Payment for Community Practices
(Resolution 108-A-23)
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the House of Delegates referred Resolution 108-A-23, which asked the American Medical Association (AMA) to assess the prevalence of insurance payments to small medical practices that are below Medicare rates and the impact of these payment levels on the ability of practices to provide care. The AMA was also asked to consider the impact on small and medium-sized practices of being excluded from population health management, outcome evidence-based care, and value-based purchasing arrangements, as well as to consider model legislation to address payment rates below the cost of practicing.

Despite the current trend toward larger practices, as of 2022, more than half of physicians still work in small private practices of ten or fewer physicians, a percentage that has fallen continuously since 2012. While small practices have some advantages that cannot be matched by larger practices, they are not necessarily well equipped to succeed in value-based purchasing given the financial investment and regulatory, technological, and analytic expertise necessary to enter these arrangements. However, small practices can collaborate to form alliances, which provide the scale needed to negotiate value-based contracts and to spread the risk across multiple practices. Such collaboration allows each practice access to the necessary technologies to draw actionable insights from data and regulatory and coding expertise to maximize revenue, while laying the groundwork for future savings.

Given their relative lack of market leverage, small practices are at a disadvantage when it comes to negotiating payment schedules. However, research shows that private insurance payment rates are, on average, higher than Medicare payment rates for the same medical services. This may benefit small practices, which have more private health insurance patients than Medicare patients and a higher percentage of private health insurance patients than larger practices. While AMA policy does not endorse a specific payment mechanism such as the Medicare Resource-Based Relative Value Scale (RBRVS), it does support use of RBRVS relative values as one option that could provide the basis for both public and private physician payment systems.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-I-23

Subject: Sustainable Payment for Community Practices (Resolution 108-A-23)

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee J

At the 2023 Annual Meeting, the House of Delegates referred Resolution 108, which was sponsored by the District of Columbia Delegation. Resolution 108-A-23 asked for the American Medical Association (AMA) to:

> "(1) study small medical practices to assess the prevalence of insurance payments to these practices that are below Medicare rates and to assess the effects of these payment levels on practices' ability to provide care, and report back by the 2024 Annual Meeting; (2) study and report back on remedies for such reimbursement rates for physician practices; (3) study the impact on small and medium-sized physician practices of being excluded from population health management, outcome evidence-based care, and value-based purchasing arrangements; and study and report back to the House of Delegates options for model legislation for states and municipalities seeking to correct reimbursement rates for medical practices that are below those required to meet fixed costs."

This report focuses on non-hospital owned small practices, which are typically not eligible for facility fees nor possess the market power inherent in larger, hospital-owned practices. We compare Medicare and private insurance payment rates, outline collaborative and negotiating resources available to small practices, highlight essential AMA policy and resources, and present new policy recommendations.

BACKGROUND

Despite the current trend toward larger practices, more than half of physicians (51.8 percent) still work in small private practices of ten or fewer physicians, a percentage that has fallen continuously from 61.4 percent in 2012.[1] Contributing factors to the shift include mergers and acquisitions, practice closures, physician job changes, and the different practice settings chosen by younger physicians compared to those of retiring physicians. The "cohort effect"[2] demonstrates that younger physicians appear to prefer larger practices for the more predictable income and work-life balance they can offer.[3] They also may be hesitant to assume the business and entrepreneurial responsibilities demanded by smaller practices.[4]

However, small practices have some advantages that cannot be matched by larger practices, most notably patients with lower rates of preventable readmissions than those in larger practices.[5] The autonomy of small practices and preservation of the traditional patient-physician relationship provide reassurance to patients that the physician is acting in their best interests. It is thought that

the patient-physician bond generates trust, which leads to better adherence to a treatment plan.[6] As physicians become patient-centered medical homes, their decisions can control downstream costs, highlighting the importance of trusted, engaged, and financially aligned physicians in value-based payment systems. Although the medical home model suggests that physicians in small practices are uniquely positioned to succeed in value-based purchasing arrangements, they are not necessarily well equipped to do so given the financial investment and regulatory, technological, and analytic expertise necessary to enter these arrangements. In addition to these inherent limitations of small practices, extrinsic factors can play a role in creating an uneven playing field, including the fact that independent primary care physicians often fill gaps in care in low-income, rural, and other underserved communities.[7]

Assessing the current level of sustainability for small community practices requires appreciating the limitations of governmental authority, understanding the relationship between Medicare and private insurance payment rates, acknowledging relevant AMA policy and advocacy, and exploring the resources available for small practices that want to engage more fully in an evolving value-based health care system.

FAIR LABOR STANDARDS ACT OF 1938

The Fair Labor Standards Act of 1938 (FLSA) protects workers against unfair employment practices. FLSA rules specify when workers are considered "on the clock" and when they should be paid overtime, along with a minimum wage. Employees are deemed either exempt or nonexempt under the FLSA.

Resolution 108-A-23 postulates that the FLSA confers governmental authority to establish minimum levels of payment for medical practices. However, Section 13(a)(1) of the FLSA provides an exemption from both minimum wage and overtime pay for employees employed as "bona fide executive, administrative, professional, and outside sales employees." Physicians are exempted from FLSA protection since they are considered "Learned Professionals," as their primary duty requires advanced knowledge, defined as work that is predominantly intellectual in character and that includes work requiring the consistent exercise of discretion and judgment, in a field of science or learning; and customarily acquired by a prolonged course of specialized intellectual instruction.[8] As such, the FLSA cannot provide protection for small medical practices regarding minimum levels of payment.

MEDICARE PHYSICIAN PAYMENT SCHEDULE

In 1992, the federal government established a standardized Medicare Physician Payment Schedule (MPPS) based on a resource-based relative value scale (RBRVS). Prior to that, the federal government paid physicians using a system of "customary, prevailing, and reasonable" (CPR) charges, which was based on the "usual, customary, and reasonable" system used by many private insurers. The Medicare CPR system allowed for wide variation in the amount paid for the same service, resulting in unfounded discrepancies in Medicare payment levels among geographic service areas and physician specialties.

In an RBRVS system, payments for services are determined by the standardized resource costs needed to provide them, which are then adjusted to account for differences in work, practice expense, and professional liability insurance costs across national geographic service areas. The MPPS publishes relative value units (RVUs) for each service, which are then converted to a payment amount using geographical practice cost indices and an annually-updated MPPS Conversion Factor (CF). The MPPS is required to make budget neutrality adjustments to ensure

payment rates for individual services do not result in changes to estimated Medicare spending. Since any MPPS changes cannot increase or decrease Medicare expenditures by more than $20 million in a year, the Centers for Medicare & Medicaid Services (CMS) typically maintains budget neutrality through annual adjustment of the MPPS CF.

The AMA/Specialty Society Relative Value Scale Update Committee (RUC) identifies the resources required to provide physician services, which CMS then considers in developing MPPS RVUs. The RUC represents the entire medical profession, with 22 of its 32 members appointed by major national medical specialty societies including those with a large percentage of physicians in patient care and those that account for high percentages of Medicare expenditures. While, historically, 90 percent or more of RUC recommendations have been accepted,[9] CMS makes all final Medicare payment decisions.

The RUC process allows the federal government to consider input from physicians about the medical services they perform in their daily patient care so that the government can adopt payment policies that reflect current medical practice. The RUC process produces a balanced system where physicians volunteer their highly technical and unique hands-on expertise regarding complex medical procedures, while the government retains oversight and final decision-making authority. Each step of the process is made accessible and transparent, as the RUC publishes meeting dates, meeting minutes, and vote totals for each service evaluated.

The transparency inherent in the RUC process results in an MPPS built on RVUs that accurately reflect the resources required to provide services. As such, 77 percent of public and private payers, including Medicaid programs, have adopted components of the MPPS to pay physicians.[10] Even in the current era of evolving models of physician payment, the MPPS, the coding principles on which it is built, and the code sets that foster standardized communication remain the most effective systems to ensure transparency, relativity, and representative fairness in physician service valuation.

PRIVATE INSURANCE PAYMENT SCHEDULES

For small community practices, payment schedules are typically negotiated between the payer and the practice as part of a network of preferred physicians. Practices agree to these payment schedules to permit inclusion in the network, since being in-network is generally more appealing to patients, allows access to in-network referrals, and reduces the chance of unexpectedly low payment to the practice.

When negotiating payment schedules, it is important that the practice is aware of its fixed and variable costs for a given service so that the long-term break-even point can be determined. The smaller the practice, the more important it is to negotiate with as much data and defined value proposition as possible, because a smaller practice has less leverage. Given that private insurance payment schedules are negotiated between two parties, they can vary by state, region, payer, specialty, and/or practice. Thus, it is likely that most small practices accept multiple different payment schedules from different payers.

A general measurement of a private insurance payment schedule is its relative payment rate compared to the MPPS, or “benchmarking” to Medicare. Payment schedules that are less than the MPPS are considered beneficial for the payer, whereas payment schedules that match or are greater than the MPPS are considered beneficial for the practice. The percentage of MPPS rates is one of the most widely accepted commercial payment benchmarks when evaluating physician payment level and comparing contracts in the health care industry. It can reflect the mix of services across

physicians and plans while removing impacts from billed charges that can vary widely across providers and regions.

Private insurance payments are variable across physician specialties. The Urban Institute conducted an analysis of FAIR Health professional claims from March 2019 to February 2020, comparing them to the MPPS for the same time period. The analysis included 17 physician specialties and approximately 20 services per specialty, which represented about 40 percent of total professional spending. The specialties considered "primary care" (i.e., family medicine, internal medicine, obstetrics/gynecology) had among the lowest commercial markups relative to Medicare prices, averaging approximately 110 percent of Medicare rates or less."[11] Since the majority of primary care offices are physician-owned and almost half of primary care physicians are full or partial owners of their practices,[12] it follows that lower relative payments to primary care physicians place small practices at an additional relative disadvantage. This is further supported by the 2022 AMA Physician Benchmark Study, which found that "primary care in private practice is typically provided in the solo or single specialty setting, with 30.9 percent of private practice physicians working in a solo or single specialty primary care practice."[13]

Areas where there is greater market concentration among physicians tend to have lower payment amounts from private insurance. The Health Care Cost Institute's Health Care Cost and Utilization Report found that there was substantial variation in private insurance payments across states, with average commercial prices ranging from 98 percent to 188 percent of Medicare rates. Seven states had payments that were, on average, higher than 150 percent of Medicare rates while eleven states had average payments within 10 percent of Medicare. The states with the highest private insurance payments relative to Medicare tended to be in the northwest of the country and along the Great Plains.[14]

MEDICARE VERSUS PRIVATE INSURANCE PAYMENT RATES

A 2020 Kaiser Family Foundation literature review discovered that private insurance paid 143 percent of Medicare rates for physician services, on average, ranging from 118 percent to 179 percent of Medicare rates across studies.[15] Estimates from a more recent Milliman white paper closely align, finding that 2022 commercial payment for professional medical services to be approximately 141 percent of Medicare fee-for-service rates.[16] A 2022 Congressional Budget Office report identified "rapid increases in the prices that commercial insurers pay for hospitals' and physicians' services,"[17] leading to further divergence between private and public insurance payment rates, a trend that has proven consistent over time. A 2003 Office of the Inspector General review determined that of 217 procedures, 119 were valued lower by Medicare than by private insurers[18] and a 2017 Health Care Cost Institute report found that commercial payments for the average professional service were 122 percent of what would have been paid under Medicare.[19] The 2022 AMA Physician Practice Benchmark Survey found that small practices of 1 to 15 physicians have a greater percentage of private health insurance patients than Medicare patients (45.9 percent vs 28.4 percent) and a higher percentage of private health insurance patients than larger practices (45.9 percent vs 40.9 percent).[20] Since research shows that private insurance payment rates are, on average, higher than Medicare payment rates for the same health services, this may benefit small practices.

While the Council was unable to identify a survey focused on small practice Medicare to private insurance rate ratios, anecdotal reports indicate that some small practices are seeing private insurers offer payment below 100 percent of Medicare, which may be further depressed when insurers utilize a prior year Medicare rate. A Washington, D.C. two-physician clinic reported receiving private insurance payment rates ranging from 16-43 percent lower than Medicare, despite

becoming a Patient-Centered Medical Home and entering into a local accountable care organization (ACO). Similarly, a solo endocrinologist who left a university-affiliated practice reported being disadvantaged by no longer being able to collect facility fees to generate higher billing, forcing him to opt out of all insurance plans due to inadequate payment.

SMALL PRACTICES AND VALUE-BASED PAYMENT SYSTEMS

Physicians have been moving to larger group practices in order to gain access to more resources to effectively implement value-based care and risk-based payment models.[21] In this era of consolidation, there is an expectation of progression from solo or small physician practices to groups and multispecialty practices and, finally, to fully integrated delivery systems that employ the physicians, own the hospitals, and use a single information system. In this limited view, the earlier forms of practice organization are assumed to be incapable of implementing the supporting systems needed for population health (e.g., registries, electronic medical records, care management, team-based care) and are therefore unable to compete in value-based payment systems. A 2011 report of the Massachusetts Attorney General concluded that while bearing financial risk through value-based payments encourages coordinated care, it also requires significant investment to develop the capacity to effectively manage risk, which is more difficult for most physicians who practice in small groups and have historically been paid less than larger practices.[22] The report also found that physicians who transitioned to larger groups received professional payment that was approximately 30 percent higher, which accelerated the number of physicians leaving small practices and joining larger groups.

However, small practices are able to compete if they join forces to create profitable economies of scale without forfeiting the advantages of being small.[23] When small practices collaborate, they form a network of peers to learn from and to glean deeper insights from population health models. Alliances can provide the scale needed to negotiate value-based contracts and to spread the risk across multiple practices, so that a handful of unavoidable hospitalizations does not destroy a single practice. Collaboration allows each practice access to the necessary technologies to draw actionable insights from data and regulatory and coding expertise to maximize revenue, while laying the groundwork for future savings.

Independent practice associations (IPAs), if structured in compliance with antitrust laws, allow contracting between independent physicians and payers and can succeed in value-based purchasing arrangements if they are able to achieve results equal to more highly capitalized and tightly structured large medical groups and hospital-owned practices. Traditionally, most IPAs have been networks of small practices organized for the purpose of negotiating fee-for-service contracts with health insurers. While small practices considering participating in an IPA should be aware of the potential risks, such as underfunded capitation revenue, IPAs can act as a platform for sharing resources and negotiating risk-bearing medical services agreements on behalf of participating practices. Many IPAs, especially those that are clinically integrated, have already converted to an ACO, or provide the infrastructure for their members to organize as one. Because many of these organizations have already operated as risk-bearing provider networks, IPAs are well positioned to take leading roles in developing ACOs or acting as sustaining member organizations. Even if the physician organization has operated in a fee-for-service environment, an IPA can bring expertise regarding contracting, analytics, and management. For example, the Greater Rochester IPA (GRIPA) has over 1,500 physician members who benefit from data analytics services to stratify and manage patients, as well as care management support, pharmacists, visiting home nurses, and diabetes educators. GRIPA has its own ACO, which distributed 83 percent of its 2020 shared savings to participants. ACOs can also benefit from participation by small practices. A 2022 study

found that small practices in ACOs controlled costs better than larger practices, thereby generating higher savings for ACOs.[24]

CMS structures several of its initiatives in an effort to support small practices in value-based participation, such as the Small, Underserved, and Rural Support initiative, which provides free, customized technical assistance to practices with 15 or fewer physicians. Small practices can contact selected organizations in their state to receive help with choosing quality measures, strategic planning, education and outreach, and health information technology optimization. CMS also includes several reporting flexibilities and rewards, specifically targeting solo and small practices under the Quality Payment Program's Merit-Based Incentive Payment System, most notably by varying submission methods and allowing special scoring consideration. The CMS ACO Investment Model built on the experience with the Advance Payment Model to test the use of pre-paid shared savings to encourage new ACOs to form in rural and underserved areas and to encourage current Medicare Shared Savings Program ACOs to transition to arrangements with greater financial risk. It resulted in more physicians in rural and underserved communities signing on to participate in ACOs. These new ACOs invested in better care coordination, and savings have been attributed to fewer unnecessary acute hospitalizations, fewer emergency department visits, and fewer days in skilled nursing facilities among beneficiaries. The ACO Investment Model generated $381.5 million in net Medicare savings between 2016 and 2018.[25] In June 2024, CMS will launch the Making Care Primary program to allow practices to build a value-based infrastructure by "improving care management and care coordination, equipping primary care clinicians with tools to form partnerships with health care specialists, and leveraging community-based connections to address patients' health needs as well as their health-related social needs such as housing and nutrition." The program will offer three progressive tracks to recognize participants' varying experience in value-based care, including one reserved for practices with no prior value-based care experience.

There has been a recent emergence of payer-sponsored arrangements, such as the one sponsored by Acuitas Health. It is a partnership between a nonprofit health plan and a large multispecialty group that offers a range of services to small practices, including billing and coding assistance, practice transformation consulting, and patient aggregation, thereby allowing practices to achieve the scale needed for value-based contracts. Through its work with Acuitas, the NYC Population Health Improvement Program was able to "answer important questions about what skills small practices need in order to succeed in the new environment and how small practices might work together to share the services necessary to develop those skills…(as well as) break new ground by presenting a financial model for the cost of shared services and probing the legal and regulatory issues raised by such arrangements."[26] Other private companies have created shared service infrastructures to allow small, independent practices to participate in APMs, offering low-cost shared resources in return for a portion of downstream savings.

RESOURCES FOR SMALL PRACTICES

Regardless of the payment rates, small practices can increase profit margins if they are able to keep their costs down. Group purchasing organizations (GPOs) and physician buying groups (PBGs) can offer independent practices a chance to access lower costs by using the power of many practices to benefit all. Some GPOs do not require purchases from a given supplier yet still offer leverage with other suppliers to grant small practices reduced rates. As most community-based practices offer vaccines, PBGs can play an important role in keeping costs down. Vaccines are one of the most costly and important investments a practice makes, and PBGs can offer practices lower contract pricing and rebates from the vaccine manufacturer. Practices can save five to 25 percent on the cost

of supplies by joining a GPO or PBG, most of which have no fee and often allow practices to join several organizations.[27]

Small practices typically sign "evergreen" contracts with payers, which continuously renew automatically until one party terminates the agreement. A payment schedule is part of the contract and will not be updated unless one party opens the contract for negotiation. In most cases, this must be the practice since it is not usually in the payer's best financial interest to negotiate a new contract. As such, practices need to be prepared to contact the payer multiple times in order to actually get a contract negotiated – and then come to the table with as much data and population health metrics (e.g., A1C numbers for patients with diabetes) as possible. A practice able to successfully manage complex patients will have costs within a relatively narrow range without many outliers, thereby increasing negotiating leverage. Small practices can also gain a negotiating advantage if they have extended office hours, are considered the "only show in town," provide specialized care for an underserved patient population, have obtained quality accreditation recognition (e.g., National Committee for Quality Assurance), or can share positive patient testimonials.

The AMA has several resources dedicated to support physicians in private practice, such as the AMA Private Practice Simple Solutions series, which are "free, open access rapid learning cycles designed to provide opportunities to implement actionable changes that can immediately increase efficiency in private practices." Session topics range from marketing to recruitment to reducing administrative burden. The AMA Practice Management Center developed the Evaluating and Negotiating Emerging Payment Options manual to assist members who are considering transitioning to risk-based payment, while the AMA Value Based Care Toolkit is being updated for 2023 to provide a step-by-step guide to designing, adopting, and optimizing the value-based care model. The 2016 adoption of AMA Policy D-160.926, which calls for the development of a guide to provide information to physicians in or considering solo and small practice on how they can align through Independent Practice Associations, Accountable Care Organizations, Physician Hospital Organizations, and other models to help them with the imminent movement to risk-based contracting and value-based care, resulted in the development of the Joining or Aligning with a Physician-Led Integrated Health System guide, which was updated in June 2020. The AMA also offers a Private Practice Group Membership Program to drive sustainability and accelerate innovation for members in private practice, as well as a Voluntary Best Practices to Advance Data Sharing Playbook to address the future of sustainable value-based payment.

AMA POLICY

The AMA's longstanding goal to promote the sustainability of solo, small, and primary care practices is reflected in numerous AMA policies, including those that:

- Call for the development of a guide to provide information to physicians in or considering solo and small practice on how they can align through IPAs, ACOs, Physician Hospital Organizations, and other models to help them with the imminent movement to risk-based contracting and value-based care (Policy D-160.926);
- Advocate in Congress to ensure adequate payment for services rendered by private practicing physicians, create and maintain a reference document establishing principles for entering into and sustaining a private practice, and issue a report in collaboration with the Private Practice Physicians Section at least every two years communicating efforts to support independent medical practices (Policy D-405.988);
- Support development of administrative mechanisms to assist primary care physicians in the logistics of their practices to help ensure professional satisfaction and practice

sustainability, support increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, and advocate for public and private payers to develop physician payment systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes (Policy H-200.949);

- Reinforce the freedom of physicians to choose their method of earning a living and the right of physicians to charge their patients their usual fee that is fair, irrespective of insurance/coverage arrangements between the patient and the insurers (Policy H-385.926);
- Support insurance payment rates that are established through meaningful negotiations and contracts (Policy H-165.838);
- Call for a formal, legal review of ongoing grievous behaviors of the health insurance industry (Policy D-385.949);
- Advocate for payment rates that are sufficient to cover the full cost of sustainable medical practice, continue to monitor health care delivery and physician payment reform activities, and provide resources to help physicians understand and participate in payment reform initiatives (Policy H-390.849); and
- Seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs to ensure payment rates cover the full cost of sustainable medical practice (D-390.946).

The AMA has policy that addresses the challenges presented by the evolving value-based health care system, such as those that:

- Provide guidance and support infrastructure that allows independent physicians to join with other physicians in clinically integrated networks independent of any hospital system, identify financially viable prospective payment models, and develop educational opportunities for physicians to learn and collaborate on best practices for such payment models for physician practice, including but not limited to independent private practice (Policy H-385.904);
- Support a pluralistic approach to third-party payment methodology, promoting flexibility in payment arrangements (Policy H-385.989);
- Reaffirm the AMA's support for a neutral public policy and fair market competition among alternative health care delivery and financing systems (Policy H-385.990); and
- Emphasize the AMA's dedication to seeking payment reform, supporting independent physicians in joining clinically integrated networks, and refining relative values for services based on valid and reliable data (Policy H-400.972).

AMA policy does not endorse a specific payment mechanism such as the MPPS RBRVS, but instead, states that use of RBRVS relative values is one option that could provide the basis for both public and private physician payment systems. Among the most relevant policies are those that:

- Oppose any type of national mandatory fee schedule (Policy H-385.986);
- Seek legislation and/or regulation to prevent insurance companies from utilizing a physician payment schedule below the updated Medicare professional fee schedule (Policy D-400.990);
- Advocate that annually updated and rigorously validated RBRVS relative values could provide a basis for non-Medicare physician payment schedules, ensure that any potential non-Medicare use of an RBRVS reflects the most current and accurate data and implementation methods, and identify the extent to which third party payers and other

public programs modify, adopt, and implement Medicare RBRVS payment policies (Policy D-400.999);

- Support a pluralistic approach to third-party payment methodology under fee-for-service, and do not support a preference for usual and customary or reasonable or any other specific payment methodology (Policy H-385.989); and
- Reinforce that there is no relationship between the Medicare fee schedule and Usual, Customary, and Reasonable Fees (Policy H-385.923).

Finally, AMA policies establish a minimum physician payment of 100 percent of the RBRVS Medicare allowable for the Children's Health Insurance Program and Medicaid (Policy H-290.976) as well as for TRICARE and any other publicly funded insurance plan (Policy H-385.921).

DISCUSSION

Research has found that small community practices are able to deliver more personalized patient care and have lower rates of preventable hospital admissions. They are able to detect potential conditions before they result in hospital admissions and accordingly play a vital role in keeping patients healthier. However, small community practices may be challenged in implementing the support systems needed for participation in population health management and value-based purchasing arrangements. Small physician-owned practices are typically not eligible to collect facility fees or utilize various addresses or facility types to generate higher billing for similar procedures depending on contracts and incentives, thereby creating a revenue differential with larger practices. There are resources available to help small practices succeed, most notably in underserved markets where average private professional service payments tend to be higher than those in more competitive physician markets.[28]

Resolution 108-A-23 presumes that small practices experience private insurance payment rates well below Medicare payment rates. However, research shows that private insurance payment rates are, on average, higher than Medicare payment rates for the same health care services.[29] While there are limitations in the available data due to inclusion of larger practices and hospital-employed physicians, variability in private insurance payment schedules means that most small practices accept multiple different payment schedules from different payers, making it difficult for them to respond to questions about payment rates with accuracy. Accordingly, a physician survey is not likely to illuminate payment variations in small practices between private insurance and Medicare payment rates.

AMA policy does not endorse a specific payment mechanism such as the MPPS RBRVS and opposes any type of mandatory payment schedule. However, it does support the use of RBRVS relative values as one option that could provide the basis for both public and private physician payment systems – independent of Medicare's conversion factor and inappropriate payment policies. Amending existing Policies H-290.976 and H-385.921, including revising their titles, will corroborate consistency across all payer types.

The Council believes that current policy supporting the RVU methodology as one option in a pluralistic payment system, remains the best position for the AMA. An RBRVS that is annually updated and rigorously validated could be a basis for non-Medicare physician payment schedules. It is important to reiterate that this policy pertains to the RBRVS relative values only. It does not apply to Medicare's conversion factor, balance billing limits, geographical practice cost indices, and inappropriate payment policies.

In addition to recognizing appropriate payment policies, the Council believes it is imperative that private payers update their payment schedule on an annual basis to reflect coding changes and revisions to relative values. Each year, new services are assigned relative values and existing codes receive revised relative values. Therefore, payers must continually update their fee schedule, so physicians are paid according to the most recent relative values and payment policies.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 108-A-23, and the remainder of the report be filed:

1. That our American Medical Association (AMA) amend Policy H-290.976[2] by addition and deletion, and modify the title by deletion, as follows:

Enhanced ~~SCHIP~~ Enrollment, Outreach, and ~~Reimbursement~~ Payment H-290.976

1. It is the policy of our AMA that prior to or concomitant with states' expansion of State Children's Health Insurance Programs (SCHIP) to adult coverage, our AMA urge all states to maximize their efforts at outreach and enrollment of SCHIP eligible children, using all available state and federal funds.

2. Our AMA affirms its commitment to advocating for reasonable SCHIP, ~~and~~ Medicaid, and private insurance payment ~~reimbursement~~ for its medical providers, defined as at minimum 100 percent of RBRVS Medicare allowable. (Modify Current HOD Policy)

2. That our AMA amend Policy H-385.921 by addition and deletion, and modify the title by deletion, as follows:

Health Care Access ~~for Medicaid Patients~~ H-385.921

It is AMA policy that to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, ~~and~~ any other publicly funded insurance plan, and private insurance must be at minimum 100 percent of the RBRVS Medicare allowable. (Modify Current HOD Policy)

3. That our AMA reaffirm Policy D-400.990, which seeks legislation and/or regulation to prevent insurance companies from utilizing a physician payment schedule below the updated Medicare professional fee schedule. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-385.986, which opposes any type of national mandatory fee schedule. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-200.949, which supports development of administrative mechanisms to assist primary care physicians in the logistics of their practices to help ensure professional satisfaction and practice sustainability, support increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, and advocate for public and private payers to develop physician payment systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy D-405.988, which calls for advocacy in Congress to ensure adequate payment for services rendered by private practicing physicians, creating and maintaining a reference document establishing principles for entering into and sustaining a

private practice, and issuing a report in collaboration with the Private Practice Physicians Section at least every two years to communicate efforts to support independent medical practices. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] Kane, Carol, American Medical Association Policy Research Perspectives, "Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022;" Available at: https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf
[2] Simply Psychology, "What Is A Cohort Effect? Definitions and Examples;" Available at: https://www.simplypsychology.org/cohort-effect-definition.html
[3] Dorsey ER, Jarjoura D, Rutecki GW. The influence of controllable lifestyle and sex on the specialty choices of graduating U.S. medical students, 1996-2003. Acad Med. 2005 Sep;80(9):791-6. doi: 10.1097/00001888-200509000-00002. PMID: 16123455. Available at: https://pubmed.ncbi.nlm.nih.gov/16123455/
[4] Lin KY. Physicians' perceptions of autonomy across practice types: Is autonomy in solo practice a myth? Soc Sci Med. 2014 Jan;100:21-9. doi: 10.1016/j.socscimed.2013.10.033. Epub 2013 Nov 5. PMID: 24444835; PMCID: PMC3898537. Available at: https://pubmed.ncbi.nlm.nih.gov/24444835/
[5] Casalino LP, Pesko MF, Ryan AM, Mendelsohn JL, Copeland KR, Ramsay PP, Sun X, Rittenhouse DR, Shortell SM. Small primary care physician practices have low rates of preventable hospital admissions. Health Aff (Millwood). 2014 Sep;33(9):1680-8. doi: 10.1377/hlthaff.2014.0434. Epub 2014 Aug 13. PMID: 25122562. Available at: https://pubmed.ncbi.nlm.nih.gov/25122562/
[6] Piette JD, Heisler M, Krein S, Kerr EA. The role of patient-physician trust in moderating medication nonadherence due to cost pressures. Arch Intern Med. 2005;165(15):1749–1755. Available at: https://pubmed.ncbi.nlm.nih.gov/16087823/
[7] Hostetter M, Klein S. The Commonwealth Fund Case Study, "How Independent Primary Care Clinicians Leverage Trust to Help Vulnerable Populations;" September 2020. Available at: https://www.commonwealthfund.org/publications/case-study/2020/sep/how-independent-primary-care-clinicians-leverage-trust-help
[8] United States, Department of Labor, "Fact Sheet #17D: Exemption for Professional Employees Under the Fair Labor Standards Act (FLSA);" Available at: https://www.dol.gov/agencies/whd/fact-sheets/17d-overtime-professional
[9] American Medical Association, "AMA/Specialty Society RVS Update Committee: An Overview of the RUC Process," 2023. Available at: https://amatoday.sharepoint.com/sites/teamwork/RUC/doc/ruc-update-booklet.pdf?csf=1&e=jvcBH9&cid=63350f70-c0a0-4e39-adfb-5715cde71f57
[10] American Academy of Pediatrics, "2022 RBRVS: What Is It And How Does It Affect Pediatrics," 2022. Available at: https://downloads.aap.org/AAP/PDF/2022%20RBRVS.pdf
[11] McMorrow, S, et al., The Urban Institute, "Commercial Health Insurance Markups over Medicare Prices for Physician Services Vary Widely by Specialty," October 2021. Available at: https://www.urban.org/sites/default/files/publication/104945/commercial-health-insurance-markups-over-medicare-prices-for-physician-services-vary-widely-by-specialty.pdf
[12] Robert Graham Center, "Primary Care in the United States: A Chartbook of Facts and Statistics," February 2021. Available at: https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/PrimaryCareChartbook2021.pdf
[13] Kane, Carol, American Medical Association Policy Research Perspectives, "Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022;" Available at: https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf
[14] Johnson, B, et al., Health Care Cost Institute, "Comparing Commercial and Medicare Professional Service Prices," August 2020. Available at: https://healthcostinstitute.org/all-hcci-reports/comparing-commercial-and-medicare-professional-service-prices
[15] Lopez, E, et al., Kaiser Family Foundation, "How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature;" Available at: https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/

[16] McBeth, A, et al., Milliman white paper, "Commercial Reimbursement Benchmarking," November 2022. Available at: https://www.milliman.com/en/insight/commercial-reimbursement-benchmarking#2
[17] Congressional Budget Office, "The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services," January 2022. Available at: https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf
[18] Office of Inspector General, "Comparing Medicare Physician Payments to Private Payers," January 2003. Available at: https://oig.hhs.gov/oei/reports/oei-06-00-00570.pdf
[19] Johnson, B, et al., Health Care Cost Institute, "Comparing Commercial and Medicare Professional Service Prices," August 2020. Available at: https://healthcostinstitute.org/all-hcci-reports/comparing-commercial-and-medicare-professional-service-prices
[20] Rama, Apoorva, American Medical Association, 2022 AMA Physician Practice Benchmark Survey, July 2023. Available at: https://www.ama-assn.org/about/research/physician-practice-benchmark-survey#:~:text=2022%20Benchmark%20Survey,-Recent%20Changes%20in&text=There%20has%20been%20a%20redistribution,from%2012.2%25%20to%2018.3%25
[21] Muhlestein DB, Smith NJ. Physician Consolidation: Rapid Movement From Small To Large Group Practices, Health Affairs, September 2016. Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0130
[22] Coakley, Martha, Office of the Massachusetts Attorney General, Examination of Health Care Cost Trends and Cost Drivers, June 2011. Available at: https://www.mass.gov/doc/2011-examination-of-health-care-cost-trends-and-cost-drivers-with-appendix/download
[23] Liaw WR, Jetty A, Petterson SM, Peterson LE, Bazemore AW. Solo and Small Practices: A Vital, Diverse Part of Primary Care. Ann Fam Med. 2016 Jan-Feb;14(1):8-15. doi: 10.1370/afm.1839. PMID: 26755778; PMCID: PMC4709150. Available at: https://pubmed.ncbi.nlm.nih.gov/26755778/
[24] Gibbons, JB, et al., The American Journal of Managed Care, "Small Practice Participation and Performance in Medicare Accountable Care Organizations," Vol 8, Issue 3, March 2022; Available at: https://www.ajmc.com/view/small-practice-participation-and-performance-in-medicare-accountable-care-organizations
[25] Jacobs, D, et al, New England Journal of Medicine, "Expanding Accountable Care's Reach among Medicare Beneficiaries," July 14, 2022. Available at: https://www.nejm.org/doi/full/10.1056/NEJMp2202991
[26] New York City Health Department, "The PHIP Small Practice Project Final Report," June 2018. Available at: https://www.nyc.gov/assets/doh/downloads/pdf/public/phip-report2018.pdf
[27] Kaplan, DA, Medical Economics Journal, "Group purchasing: Save money by aligning with other physicians," Vol 95, Issue 21, November 2018; Available at: https://www.medicaleconomics.com/view/group-purchasing-save-money-aligning-other-physicians
[28] Baker LC, Bundorf MK, Royalty AB, Levin Z. Physician Practice Competition and Prices Paid by Private Insurers for Office Visits. JAMA. 2014;312(16):1653–1662. doi:10.1001/jama.2014.10921. Available at: https://jamanetwork.com/journals/jama/fullarticle/1917436
[29] Lopez, E, et al., Kaiser Family Foundation, "How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature;" Available at: https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 801
(I-23)

Introduced by: Medical Student Section

Subject: Improving Pharmaceutical Access and Affordability

Referred to: Reference Committee J

Whereas, the US spends nearly $600 billion on pharmaceuticals annually, with prices rising at an average of 10% and some exceeding 500%, doubling the increases seen in comparable countries after adjusting for rebates and discounts[1-2]; and

Whereas, over 3 million Americans use biologics, which comprise 40% of US drug spending with annual costs of $10,000 to $40,000 per patient and in some cases, $500,000[3-7]; and

Whereas, medication cost is a major barrier for 13 million Americans and often leads patients using biologics to switch to less expensive alternative treatments[7-12]; and

Whereas, the lack of biosimilar penetration in US markets due to preferential patent exclusivity for originator biologics further exacerbates the problem of medication costs[13-14]; and

Whereas, direct member reimbursement policies in some private insurance plans require patients to pay full medication costs out-of-pocket upfront and then submit a claim for reimbursement later, with biologics often requiring initial payments over $20,000[15-19;] and

Whereas, patients with direct member reimbursement plans are considered to have comprehensive coverage for medication costs due to eventual reimbursement and are ineligible for many patient assistance and discount programs for initial out-of-pocket payments[20-23]; and

Whereas, patient assistance programs often have yearly maximums and still exclude patients on publicly funded insurance[20-23]; therefore be it

RESOLVED, that our American Medical Association supports lowering out-of-pocket maximums in insurance plans including but not limited to ERISA plans, other forms of employer-sponsored insurance, plans offered on the ACA marketplace, TRICARE, and any other public or private payers (New HOD Policy); and be it further

RESOLVED, that our AMA oppose Direct Member Reimbursement plans, where patients pay the full retail costs of a prescription drug that they may then be reimbursed for, due to their potential to expose patients to significant out-of-pocket costs. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 09/11/2023

REFERENCES

1. Tichy EM, Hoffman JM, Suda KJ, et al. National trends in prescription drug expenditures and projections for 2022. Am J Health Syst Pharm. 2022;79(14):1158-1172. doi:10.1093/ajhp/zxac102
2. Bosworth A. Price increases for prescription drugs, 2016-2022. ASPE. https://aspe.hhs.gov/reports/prescription-drug-price-increases#:~:text=There%20were%201%2C216%20products%20whose,more%20than%20%2420%2C000%20or%20500%25. Published September 30, 2022. Accessed March 8, 2023.
3. Zhai M, Sarpatwari A, Kesselheim, AS. Why Are Biosimilars Not Living Up to Their Promise in the US? AMA J Ethics. 2019;21(8):E668-678. doi: 10.1001/amajethics.2019.668
4. Keller GS, Park AM. Introduction: An Overview. Facial Plast Surg Clin North Am. 2018;26(4):403-405. doi:10.1016/j.fsc.2018.06.001
5. Keller GS, Park AM. Introduction: An Overview. Facial Plast Surg Clin North Am. 2018;26(4):403-405. doi:10.1016/j.fsc.2018.06.001
6. Chen BK, Yang YT, Bennett CL. Why Biologics and Biosimilars Remain So Expensive: Despite Two Wins for Biosimilars, the Supreme Court's Recent Rulings do not Solve Fundamental Barriers to Competition. *Drugs*. 2018;78(17):1777-1781. doi:10.1007/s40265-018-1009-0
7. Morgan SG, Lee A. Cost-related non-adherence to prescribed medicines among older adults: a cross-sectional analysis of a survey in 11 developed countries. *BMJ Open*. 2017;7(1):e014287. doi:10.1136/bmjopen-2016-014287
8. Karpman M, Blavin F, McMorrow S, O'Brien C. In the Years before the COVID-19 Pandemic, Nearly 13 Million Adults Delayed or Did Not Get Needed Prescription Drugs because of Costs.; 2021. Accessed April 9, 2023. https://www.urban.org/sites/default/files/publication/105184/millio1.pdf
9. Osborn CY, Kripalani S, Goggins KM, Wallston KA. Financial strain is associated with medication nonadherence and worse self-rated health among cardiovascular patients. J Health Care Poor Underserved. 2017;28(1):499-513. doi:10.1353/hpu.2017.0036
10. Braverman G, Bridges SL, Moreland LW. Tapering biologic dmards in rheumatoid arthritis. Current Opinion in Pharmacology. 2022;67:102308. doi:10.1016/j.coph.2022.102308
11. Silver J, Bogart M, Molfino NA, et al. Factors leading to discontinuation of biologic therapy in patients with severe asthma. *J Asthma*. 2022;59(9):1839-1849. doi:10.1080/02770903.2021.1971700
12. Steve Tsang CC, Browning J, Todor L, Dougherty S, Hohmeier KC, Sam Li M, Borja-Hart N, Hines LE, Wang J. Factors associated with medication nonadherence among Medicare low-income subsidy beneficiaries with diabetes, hypertension, and/or heart failure. J Manag Care Spec Pharm. 2021 Aug;27(8):971-981. doi: 10.18553/jmcp.2021.27.8.971. PMID: 34337985.
13. Cross RK, Stewart AL, Edgerton CC, Shah B, Welz JA, Kay J. Implementation Strategies of Biosimilars in Healthcare Systems: The Path Forward. American Health & Drug Benefits. 2022;15(2):45-53. https://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=157435150&site=eds-live. Accessed April 10, 2023.
14. Socal M, Ballreich J, Chyr L, Anderson G. Biosimilar Medications - Savings Opportunities for Large Employers.; 2020. https://www.eric.org/wp-content/uploads/2020/03/JHU-Savings-Opportunities-for-Large-Employers.pdf Accessed April 8, 2023.
15. Humana. 2023 Direct Member Reimbursement Policy. Published November 10, 2022. https://docushare-web.apps.external.pioneer.humana.com/Marketing/docushare-app?file=3523546. Accessed April 9, 2023.
16. Direct Member Reimbursement (DMR) Frequently Asked Questions. https://www.modahealth.com/pdfs/oebb/oebb_dmr_faq.pdf. Accessed April 9, 2023.
17. Center for Medicaid and Medicare Services. How Medicare Covers Self-Administered Drugs Given in Outpatient Hospital Settings. *Medicare*, https://www.medicare.gov/Pubs/pdf/11333-Outpatient-Self-Administered-Drugs.pdf, Revised June 2020, Accessed August 28, 2022.
18. STELARA® (ustekinumab). STELARA® (ustekinumab). Published May 14, 2019. https://www.stelarainfo.com/crohns-disease/cost-support-and-more. Accessed April 8, 2023.
19. Yazdany J, Dudley RA, Chen R, Lin GA, Tseng CW. Coverage for high-cost specialty drugs for rheumatoid arthritis in Medicare Part D. *Arthritis Rheumatol*. 2015;67(6):1474-1480. doi:10.1002/art.39079
20. Stelara Savings Program. https://www.stelarawithme.com/sites/www.stelarawithme.com/files/stelara-savings-program-overview.pdf. Published May 2022. Accessed April 7, 2023.
21. Janssen Biotech. Stelara® (USTEKINUMAB) cost support. STELARA® (ustekinumab).https://www.janssencarepath.com/patient/stelara/cost-support. Accessed April 7, 2023.
22. Paying for remicade® - Cost Support. Janssen CarePath. https://www.janssencarepath.com/patient/remicade/cost-support. Published August 19, 2022. Accessed August 31, 2022.
23. Find out if you may be eligible. Find Out If You May Be Eligible | Johnson & Johnson Patient Assistance Foundation, Inc. https://www.jjpaf.org/eligibility/. Accessed August 31, 2022.

RELEVANT AMA POLICY

H-110.987 Pharmaceutical Costs

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.

4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation.
[CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21; Reaffirmed in lieu of: Res. 810, I-22]

H-110.998 Cost of New Prescription Drugs
Our AMA urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs. [Res. 112, I-89; Reaffirmed: Res. 520, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed in lieu of Res. 229, I-14]

H-120.975 Certifying Indigent Patients for Pharmaceutical Manufacturers' Free Drug Programs
Our AMA: (1) supports Pharmaceutical Research and Manufacturers of America (PhRMA) programs for indigent patients and the development of a universal application process, eligibility criteria and form for all prescription drug patient-assistance programs to facilitate enrollment of patients and physicians; (2) encourages PhRMA to provide information to physicians and hospital medical staffs about member programs that provide pharmaceuticals to indigent patients; (3) urges drug companies to develop user-friendly and culturally sensitive uniform centralized policies and procedures for certifying indigent patients for free or discounted medications; and (4) opposes the practice of charging patients to apply for or gain access to pharmaceutical assistance programs. [Sub. Res. 105, I-92; Sub. Res. 507, A-96; Appended: Sub. Res. 513, I-97; Reaffirmation I-98; Reaffirmation I-00; Reaffirmation A-01; Amended: Res. 513, A-02; Reaffirmed and Appended: Sub. Res. 705, I-03; Reaffimed and Modified: BOT Rep. 13, A-04; Reaffirmation I-04; Modified: CSAPH Rep. 1, A-14]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 802
(I-23)

Introduced by: Medical Student Section

Subject: Improving Nonprofit Hospital Charity Care Policies

Referred to: Reference Committee J

Whereas, nonprofit hospitals comprise over half of all US hospitals nationwide and receive a total in $28 billion in federal tax exemptions[1-2]; and

Whereas, nonprofit hospitals must fulfill community benefit requirements, including charity care, but they spend half as much on charity care as public and for-profit hospitals[3-5]; and

Whereas, nonprofit hospitals decide their own criteria for charity care eligibility, and only 10 states require that these are communicated to patients[6-8]; and

Whereas, the New York Times reported that a large nonprofit hospital system trained administrative employees to intentionally avoid screening patients for charity care eligibility or provide financial assistance information when asking patients for payment[1]; and

Whereas, in 2019, nonprofit hospitals billed patients who qualified for charity care for nearly $3 billion, and a study found that nonprofits comprised 70% of hospitals suing patients for medical debt, despite the IRS banning “extraordinary collections actions” by nonprofits[9-10]; and

Whereas, although nonprofit hospitals are supposed to widely publicize their charity care policies and notify and screen community members, they charge patients who meet eligibility criteria in over 50% of cases[8-9,11]; and

Whereas, health economists propose that increasing nonprofit hospital transparency by disclosing charity-care-to-expense and -benefit ratios would increase compliance with charity care and community benefit obligations[5]; therefore be it

RESOLVED, that our American Medical Association advocate for legislation and regulations that require nonprofit hospitals to notify and screen all patients for financial assistance according to their own eligibility criteria prior to billing (Directive to Take Action); and be it further

RESOLVED, that our AMA support efforts to establish regulatory standards for nonprofit hospital financial assistance eligibility (New HOD Policy); and be it further

RESOLVED, that our AMA encourages the Centers for Medicare and Medicaid Services (CMS) to publish the charity-care-to-expense ratio and the charity-care-to-benefit ratio for hospitals listed in Medicare Cost Reports to improve transparency and compliance of charitable care and community benefit activities. (New HOD Policy)

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

Received: 09/11/2023

REFERENCES

1. Jessica Silver-Greenberg KT. They Were Entitled to Free Care. Hospitals Hounded Them to Pay. *The New York Times*. Sept. 24, 2022. https://www.nytimes.com/2022/09/24/business/nonprofit-hospitals-poor-patients.html?searchResultPosition=1
2. Jamie Godwin ZL and Scott Hulver. The Estimated Value of Tax Exemption for Nonprofit Hospitals Was About $28 Billion in 2020. *Kaise Family Foundation*. Mar 14 , 2023. https://www.kff.org/health-costs/issue-brief/the-estimated-value-of-tax-exemption-for-nonprofit-hospitals-was-about-28-billion-in-2020/
3. Charitable Hospitals - General Requirements for Tax-Exemption Under Section 501(c)(3). *IRS*. Jul 15, 2022. https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3
4. James J. Nonprofit Hospitals' Community Benefit Requirements. *Health Affairs*. February 25, 2016; doi:10.1377/hpb20160225.954803
5. Ge Bai HZ, Matthew D. Eisenberg, Daniel Polsky, Gerard F. Anderson. Analysis Suggests Government And Nonprofit Hospitals' Charity Care Is Not Aligned With Their Favorable Tax Treatment *Health Affairs*. April 2021;40(4)https://doi.org/10.1377/hlthaff.2020.01627
6. Andrea Bopp Stark JB. An Ounce of Prevention: A Review of Hospital Financial Assistance Policies in the States. *National Consumer Law Center* November 2021. https://www.nclc.org/wp-content/uploads/2022/09/Rpt_Ounce_of_Prevention.pdf
7. State Community Benefit Requirements and Tax Exemptions for Nonprofit Hospitals. *The Hilltop Institue UMBC*. https://hilltopinstitute.org/our-work/hospital-community-benefit/hcbp-state-comparison/
8. Levey NN. Hundreds of Hospitals Sue Patients or Threaten Their Credit, a KHN Investigation Finds. Does Yours? *Kaiser Health News*. December 21, 2022.
9. Rau J. Patients Eligible For Charity Care Instead Get Big Bills. *Kaiser Health News*. October 14, 2019. https://khn.org/news/patients-eligible-for-charity-care-instead-get-big-bills/
10. Giuseppe RJ, Paturzo FH, Chen Dun, et al. Trends in Hospital Lawsuits Filed Against Patients for Unpaid Bills Following Published Research About This Activity. *JAMA Netw Open*. 2021;4(8). doi:doi:10.1001/jamanetworkopen.2021.21926
11. Financial Assistance Policy and Emergency Medical Care Policy – Section 501(r)(4). *IRS*. Jul 15, 2022. https://www.irs.gov/charities-non-profits/financial-assistance-policy-and-emergency-medical-care-policy-section-501r4

RELEVANT AMA POLICY

H-160.923 Offsetting the Costs of Providing Uncompensated Care

Our AMA: (1) supports the transitional redistribution of disproportionate share hospital (DSH) payments for use in subsidizing private health insurance coverage for the uninsured;(2) supports the use of innovative federal- or state-based projects that are not budget neutral for the purpose of supporting physicians that treat large numbers of uninsured patients, as well as EMTALA-directed care; and (3) encourages public and private sector researchers to utilize data collection methodologies that accurately reflect the amount of uncompensated care (including both bad debt and charity care) provided by physicians. [CMS Rep. 8, A-05; Reaffirmation A-07; Modified: CMS Rep. 01, A-17]

H-155.958 Appropriate Hospital Charges

Our AMA encourages hospitals to adopt, implement, monitor and publicize policies on patient discounts, charity care, and fair billing and collection practices, and make access to those programs readily available to eligible patients. [CMS Rep. 4, A-09; Reaffirmed in lieu of: Res. 213, I-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 803
(I-23)

Introduced by: Medical Student Section

Subject: Improving Medicaid and CHIP Access and Affordability

Referred to: Reference Committee J

Whereas, states may implement premiums and cost-sharing, including copays, coinsurance, deductibles, and other charges, for Medicaid and CHIP patients, which limits enrollment efforts, removes coverage from patients who cannot afford costs, and raises rates of uninsured patients, uncompensated care, and expensive emergency care[1-5]; and

Whereas, 8 states use CMS Section 1115 waivers to charge Medicaid premiums, 26 states charge CHIP premiums, and 21 states use other cost-sharing in CHIP[6-7]; and

Whereas, the RAND Health Insurance Experiment found that increased cost-sharing reduces use of both necessary and unnecessary services at similar rates and worsens health for patients from the most low-income households and patients with the most severe illness[8]; and

Whereas, in Indiana, 13,600 patients lost Medicaid, 46,200 patients lost eligibility, and 289,000 patients were restricted benefits due to inability to pay in 2015 and 2016[6,9-11;] and

Whereas, in Arkansas, only 14% of Medicaid patients paid at least one premium in 2015, and in Michigan, only 47% of those owing premiums paid at least one from 2014 to 2021[12–13]; and

Whereas, in Indiana and Wisconsin, inability to pay locks patients out of Medicaid for 6 months, while in Montana patients are locked out until all premium debt is paid[6]; and

Whereas, in Wisconsin, even an increase of up to $10 in monthly Medicaid premiums resulted in a 12% decrease in probability of remaining enrolled[14]; and

Whereas, in Alabama, CHIP premium and copay increases decreased renewal by 8%, especially among Black children, low-income children, and children with chronic illness[15]; and

Whereas, Medicaid copays affect preventive and chronic care, reducing vaccination rates and increasing rates of uncontrolled hypertension[16-17]; and

Whereas, state collections from premiums and cost-sharing are extremely limited and do not significantly finance care, comprising less than 0.02% of Michigan's Medicaid budget[6,13]; and

Whereas, state premiums and cost-sharing may even increase administrative costs, with Arkansas premiums increasing costs by nearly 30% compared to standard Medicaid[12]; and

Whereas, with the end of the COVID public health emergency, states that previously could not disenroll patients from Medicaid due to unaffordable costs may now reimpose those measures, leading to even greater expected coverage losses[1]; therefore be it

RESOLVED, that our American Medical Association oppose premiums, copayments, and other cost-sharing methods for Medicaid and the Children's Health Insurance Program, including Section 1115 waiver applications that would allow states to charge premiums or copayments to Medicaid beneficiaries (New HOD Policy); and be it further

RESOLVED, that our AMA amend policy H-290.982 "Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured" by deletion as follows;

> Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982
> AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;
> (2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.
> (3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;
> (4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;
> (5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;
> (6) urges states to administer their Medicaid and SCHIP programs through a single state agency;
> (7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;
> (8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health

insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;

(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;

(~~10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;~~ (Modify Current HOD Policy)

and be it further

RESOLVED, that our AMA encourage the Centers for Medicare & Medicaid Services to amend existing Section 1115 waivers to disallow states the ability to charge premiums to Medicaid beneficiaries. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 09/19/2023

REFERENCES

1. Samantha Artiga PU, Julia Zur. The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings. *Kaiser Family Foundation* Jun 01, 2017. https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings
2. Cost Sharing. *Medicaidgov*. https://www.medicaid.gov/medicaid/cost-sharing/index.html
3. Genevieve Kenney JH, Fredric Blavin. Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003. *Inquiry* 2003;43(Winter 2006/2007):345-361.
4. Stephen Zuckerman DMM, Emily Shelton Pape. Missouri's 2005 Medicaid Cuts: How Did They Affect Enrollees And Providers? *Health Affairs*. 2009;28doi:https://doi.org/10.1377/hlthaff.28.2.w335
5. Subramanian S. Impact of Medicaid copayments on patients with cancer: lessons for Medicaid expansion under health reform. *Med Care*. 2011;49(9):842-7. doi:doi: 10.1097/MLR.0b013e31821b34db
6. Madeline Guth MA, Elizabeth Hinton. Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers. *Kaiser Family Foundation*. Sep 09, 2021. https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers
7. Premiums, Enrollment Fees, and Cost-Sharing Requirements for Children. *Kaiser Family Foundation*. 2020. https://www.kff.org/medicaid/state-indicator/premiums-enrollment-fees-and-cost-sharing-requirements-for-children/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
8. 40 Years of the RAND Health Insurance Experiment. *RAND Corporation*. https://www.rand.org/health-care/projects/HIE-40.html
9. Federal Evaluation of Montana Health and Economic Livelihood Partnership (HELP): Draft Interim Evaluation Report. *Social & Scientific Systems*. July 22, 2019. https://www.medicaid.gov/medicaid/downloads/mt-fed-eval-draft-interim-eval-rpt.pdf
10. Iowa Wellness Plan. *Medicaidgov*. https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81706
11. Robin Rudowitz MBM, Elizabeth Hinton. Digging Into the Data: What Can We Learn from the State Evaluation of Healthy Indiana (HIP 2.0) Premiums. *Kaiser Family Foundation*. Mar 08, 2018. https://www.kff.org/medicaid/issue-brief/digging-into-the-data-what-can-we-learn-from-the-state-evaluation-of-healthy-indiana-hip-2-0-premiums
12. Arkansas Health Care Independent Program ('Private Option') Section 1115 Demonstration Waiver Final Report *Arkansas Center for Health Improvement* June 30, 2018. https://humanservices.arkansas.gov/wp-content/uploads/Final-Report-with-Appendices.pdf
13. MI Health Account Executive Summary Report. *Maximus* August 2022. https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder2/Folder83/Folder1/Folder183/MIHA_Monthly_Exec_Summary_Report.pdf?rev=cb3e2e9645ee41e6a7ca3f53947fa557
14. Dague L. The effect of Medicaid premiums on enrollment: a regression discontinuity approach. *J Health Econ*. May 17, 2014;(37):1-12. doi:10.1016/j.jhealeco.2014.05.001
15. Michael A. Morrisey JB, Bisakha Sen, David Becker, Meredith L. Kilgore, Cathy Caldwell, Nir Menachemi. The Effects of Premium Changes on ALL Kids, Alabama's CHIP Program. *Medicare Medicaid Res Rev*. 2012;2(3)doi:10.5600/mmrr.002.03.a01

16. Deliana Kostova JF. Chronic Health Outcomes and Prescription Drug Copayments in Medicaid. *Med Care*. May 2017;55(5):520-527. doi:10.1097/MLR.0000000000000700
17. Charles Stoecker AMS, Megan C. Lindley. The Cost of Cost-Sharing: The Impact of Medicaid Benefit Design on Influenza Vaccination Uptake. *Vaccines (Basel)*. Mar 6 2017;5(1):8. doi:10.3390/vaccines5010008

RELEVANT AMA POLICY

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

H-290.965 Affordable Care Act Medicaid Expansion
1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.
2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries.
4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.
5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.
6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.
7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.
8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.
9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.
10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.
11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.
12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.
13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits.
[CMS Rep. 02, A-16; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 807, I-18; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed: Res. 122, A-22]

H-290.960 Oppose Medicaid Eligibility Lockout
Our AMA will oppose ‘lock-out’ provisions that exclude Medicaid eligible persons for lengthy periods, and support provisions that permit them to reapply immediately for redetermination. [Res. 103, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 804
(I-23)

Introduced by: AMDA – The Society for Post-Acute and Long-Term Care Medicine

Subject: Required Clinical Qualifications in Determining Medical Diagnoses and Medical Necessity

Referred to: Reference Committee J

Whereas, governmental regulatory bodies and commercial payors audit and survey the clinical practice of medicine routinely and regularly to authorize payments made for medical care and services provided to patients in all care settings, including verifying and validating the accuracy of medical diagnoses made and used in determining medical necessity of such care and services, under the nomenclature of Utilization Management (UM), Medicare/Medicaid audits and regulatory surveys; and

Whereas, the survey and audit teams determining the accuracy of medical diagnoses and medical necessity are often clinicians who are not licensed, trained or qualified in making such diagnoses or determining medical necessity - which are the prerogative and privilege of trained and licensed Physicians, Nurse Practitioners, Physician Assistants and Clinical Psychologists; and

Whereas, the use of clinicians who are not trained, licensed and qualified to diagnose medical conditions or determine medical necessity in UM, audit and survey processes creates unnecessary hurdles to safe, timely, and equitable practice of clinical medicine and can create unnecessary additional physician work and contribute to burnout of healthcare professionals; therefore be it

RESOLVED, that our American Medical Association advocate for a change to existing public and private processes including Utilization Management, Prior Authorization, Medicare and Medicaid audits, Medicare and State Public Health surveys of clinical care settings, to only allow clinicians with adequate and commensurate training, scope of practice, and licensure to determine accuracy of medical diagnoses and assess medical necessity. (Directive to Take Action)

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

Received: 9/26/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 805
(I-23)

Introduced by: Michigan

Subject: Medication Reconciliation Education

Referred to: Reference Committee J

Whereas, increasingly medical documentation is housed in electronic health records (EHR); and

Whereas, the lack of interoperability between dissimilar EHRs remains problematic related to the sharing of information throughout the continuum of care; and

Whereas, skilled nursing facilities (SNF) and other patient care settings and primary providers in these facilities often do not have access to the same EHR as acute care facilities, primary care physicians, and specialty physicians within their geographic domain; and

Whereas, many older patients have complex care needs that may result in transitions for care with documentation for their health care in multiple care settings with dissimilar EHRs; and

Whereas, the medication list within one EHR may not be accurate in any care setting due to these transitions and dissimilar EHRs; and

Whereas, the “source of truth” for the medication list may be fragmented and difficult to determine, especially if the patient has a degree of cognitive impairment; and

Whereas, medication errors have been shown to result in severe illness, hospitalization, and death for 1.5 million patients annually in the United States with an estimated cost of $77 billion (with the majority of health care dollars spent on patients over the age of 65; and

Whereas, careful medication reconciliation utilizing all relevant EHR resources and patient input in each care setting and at each visit is imperative to ascertain and maintain accuracy of the medication list; and

Whereas, many physicians rely on other health care professionals, such as licensed pharmacists, to perform medication reconciliation, although thorough reconciliation including diagnostic indications for each medication and consideration of overlapping side effects may exceed their scope of practice; therefore be it

RESOLVED, that our American Medical Association work with Centers for Medicare and Medicaid Services and other appropriate organizations to study current medication-reconciliation practices across transitions of care with dissimilar electronic health records to evaluate the impact on patient safety and quality of care, and to determine the potential need for additional training to reduce medical errors and ensure patient safety and quality of care (Directive to Take Action); and be it further

RESOLVED, that our American Medical Association work with other appropriate organizations to determine whether education for physicians-in-training is sufficient to attain the medication

reconciliation core competencies necessary to reduce medical errors and ensure patient safety and quality of care and provide recommendations for action as applicable. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 9/26/23

REFERENCES
1. Hughes RB, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr, Chapter 38: Medication Reconciliation, p. 7.
2. Institute of Medicine, Committee on Identifying and Preventing Medication Errors, Preventing Medication Errors. National Academies Press; 2007:124-25.
3. Grissinger MC, et al. "The Role of Managed Care Pharmacy in Reducing Medication Errors." Journal of Managed Care Pharmacy 9, no. 1 (2003):62-65.

RELEVANT AMA POLICY

Pharmacy Review of First Dose Medication D-120.965
1. Our AMA supports medication reconciliation as a means to improve patient safety.
2. It is AMA policy that (a) systems be established to support physicians in medication reconciliation, and (b) medication reconciliation requirements should be at a level appropriate for a particular episode of care and setting. [BOT Action in response to referred for decision Res. 808, I-06; Reaffirmation A-10; Reaffirmation A-15]

Hospital Discharge Communications H-160.902
1. Our AMA encourages the initiation of the discharge planning process, whenever possible, at the time patients are admitted for inpatient or observation services and, for surgical patients, prior to hospitalization.
2. Our AMA encourages the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlight salient patient information, such as the discharging physician's narrative and recommendations for ongoing care.
3. Our AMA encourages hospital engagement of patients and their families/caregivers in the discharge process, using the following guidelines:
    a. Information from patients and families/caregivers is solicited during discharge planning, so that discharge plans are tailored to each patient's needs, goals of care and treatment preferences.
    b. Patient language proficiency, literacy levels, cognitive abilities and communication impairments (e.g., hearing loss) are assessed during discharge planning. Particular attention is paid to the abilities and limitations of patients and their families/caregivers.
    c. Specific discharge instructions are provided to patients and families or others responsible for providing continuing care both verbally and in writing. Instructions are provided to patients in layman's terms, and whenever possible, using the patient's preferred language.
    d. Key discharge instructions are highlighted for patients to maximize compliance with the most critical orders.
    e. Understanding of discharge instructions and post-discharge care, including warning signs and symptoms to look for and when to seek follow-up care, is confirmed with patients and their families/caregiver(s) prior to discharge from the hospital.
4. Our AMA supports making hospital discharge instructions available to patients in both printed and electronic form, and specifically via online portals accessible to patients and their designated caregivers.
5. Our AMA supports implementation of medication reconciliation as part of the hospital discharge process. The following strategies are suggested to optimize medication reconciliation and help ensure that patients take medications correctly after they are discharged:
    a. All discharge medications, including prescribed and over-the-counter medications, should be reconciled with medications taken pre-hospitalization.

b. An accurate list of medications, including those to be discontinued as well as medications to be taken after hospital discharge, and the dosage and duration of each drug, should be communicated to patients.
c. Medication instructions should be communicated to patients and their families/caregivers verbally and in writing.
d. For patients with complex medication schedules, the involvement of physician-led multidisciplinary teams in medication reconciliation including, where feasible, pharmacists should be encouraged.

6. Our AMA encourages patient follow-up in the early time period after discharge as part of the hospital discharge process, particularly for medically complex patients who are at high-risk of re-hospitalization.
7. Our AMA encourages hospitals to review early readmissions and modify their discharge processes accordingly. [CMS Rep. 07, I-16]

Reducing Polypharmacy as a Significant Contributor to Senior Morbidity D-120.928
1. Our AMA will work with other organizations e.g., AARP, other medical specialty societies, PhRMA, and pharmacists to educate patients about the significant effects of all medications and most supplements, and to encourage physicians to teach patients to bring all medications and supplements or accurate, updated lists including current dosage to each encounter.
2. Our AMA along with other appropriate organizations encourages physicians and ancillary staff if available to initiate discussions with patients on improving their medical care through the use of only the minimal number of medications (including prescribed or over-the-counter, including vitamins and supplements) needed to optimize their health.
3. Our AMA will work with other stakeholders and EHR vendors to address the continuing problem of inaccuracies in medication reconciliation and propagation of such inaccuracies in electronic health records.
4. Our AMA will work with other stakeholders and EHR vendors to include non-prescription medicines and supplements in medication lists and compatibility screens. [Res. 515, A-22]

Continuity of Care for Patients Discharged from Hospital Settings H-125.974
Our AMA:
(1) will advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge;
(2) supports medication reconciliation processes that include confirmation that prescribed discharge medications will be covered by a patient's health plan and resolution of potential coverage and/or prior authorization (PA) issues prior to hospital discharge;
(3) supports strategies that address coverage barriers and facilitate patient access to prescribed discharge medications, such as hospital bedside medication delivery services and the provision of transitional supplies of discharge medications to patients;
(4) will advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors;
(5) will advocate to the ONC to include proven and established real-time pharmacy benefit criteria within its certification program;
(6) will advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTPB) within their products do so without disruption to EHR usability and minimal to no cost to physicians and hospitals, providing financial support if necessary; and
(7) supports alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools. [CMS Rep. 2, A-21; Modified: CMS Rep. 2, I-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 806
(I-23)

Introduced by: Michigan

Subject: Evidence-Based Anti-Obesity Medication as a Covered Benefit

Referred to: Reference Committee J

Whereas, obesity is a complex, multifactorial, common, serious, relapsing, and costly chronic disease that serves as a major risk factor for developing conditions such as heart disease, stroke, type 2 diabetes, renal disease, non-alcoholic steatohepatitis, and certain types of cancer; and

Whereas, health care costs are 34 percent higher for people with obesity, with the total cost of obesity in the U.S. being $1.7 trillion; and

Whereas, weight bias negatively impacts those affected financially, mentally, socially, and physically; and

Whereas, the National Health and Nutrition Examination Survey data shows that from 1999–2000 through 2017–March 2020, U.S. obesity prevalence increased from 30.5% to 41.9%. During the same time, the prevalence of severe obesity increased from 4.7% to 9.2%; and

Whereas, health care coverage for obesity and weight management is inadequate and insufficient, and varies significantly by each health plan, with millions of Americans being denied access to evidence-based treatments to help them address this disease and the numerous comorbidities that accompany obesity; for example, a majority of state employee health plans fail to cover FDA-approved obesity drugs and 27 state health exchanges exclude coverage for metabolic and bariatric surgery; and

Whereas, people who are affected by obesity deserve access to affordable, individualized medical coverage for science-based treatments in the same way as other chronic diseases are managed; therefore be it

RESOLVED, that our American Medical Association amend Policy H-150.953, “Obesity as a Major Public Health Problem,” by addition as follows:

9. Urge national payors to ensure coverage parity for FDA-approved anti-obesity medications without exclusions or additional carve-outs. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 9/27/23

RELEVANT AMA POLICY

Obesity as a Major Public Health Problem H-150.953
Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions;
(2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs;
(3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians;
(4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight;
(5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity;
(6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain;
(7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and
(8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.
[CSA Rep. 6, A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 3, A-13; Reaffirmation: A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 807
(I-23)

Introduced by: Young Physicians Section

Subject: Any Willing Provider

Referred to: Reference Committee J

Whereas, access to quality healthcare is a fundamental right for all Americans; and

Whereas, the ability of physicians to establish and maintain a successful practice is critical to the provision of quality healthcare; and

Whereas, many insurance companies limit access to their networks for new physicians, thereby limiting a physician's ability to establish a practice and provide care to patients; and

Whereas, a few states have adopted "Any Willing Provider" laws, which allow physicians to contract with insurance companies to participate as in-network providers without discrimination; and

Whereas, the American Medical Association believes that access to quality healthcare should not be restricted by insurance company practices that limit the ability of physicians to establish a successful practice; therefore be it

RESOLVED, that our American Medical Association shall develop and advocate for model "Any Willing Provider" legislation nationwide, enabling all physicians to build successful practices and deliver quality patient care (Directive to Take Action); and be it further

RESOLVED, that our AMA shall lobby for federal regulations or legislation mandating insurers to implement "Any Willing Provider" policies as a prerequisite for participating in federally-supported programs (Directive to Take Action); and be it further

RESOLVED, that our AMA will work with state and national organizations, including insurance companies, to promote and support the adoption of "Any Willing Provider" laws, and will monitor the implementation of these laws to ensure that they are having a positive impact on access to quality healthcare. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 9/26/23

RELEVANT AMA POLICY

Any Willing Provider Provisions and Laws H-285.984
Our AMA: (1) acknowledges that health care plans or networks may develop and use criteria to determine the number, geographic distribution, and specialties of physicians needed;

(2) will advocate strongly that managed care organizations and third party payers be required to disclose to physicians applying to the plan the selection criteria used to select, retain, or exclude a physician from a managed care plan, including the criteria used to determine the number, geographic distribution, and specialties of physicians needed;

(3) will advocate strongly that those health care plans or networks that use criteria to determine the number, geographic distribution, and specialties of physicians needed be required to report to the public, on a regular basis, the impact that the use of such criteria has on the quality, access, cost, and choice of health care services provided to patients enrolled in such plans or networks;

(4) will advocate in those cases in which economic issues may be used for consideration of sanction or dismissal, the physician participating in the plan should have the right to receive profile information and education, in a due process manner, before action of any kind is taken;

(5) opposes any federal effort to preempt state "any willing provider" laws; and

(6) will continue to advocate its "Legislative Specifications for Federal Regulation of Managed Care Plans." [BOT Rep. I-93-25; Reaffirmed: Sub. Res. 110 and 702, A-94; Reaffirmed: CMS Rep. 3, I-97; Reaffirmed: Sub. Res. 704, A-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmation: A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 808
(I-23)

Introduced by: Young Physicians Section

Subject: Prosthodontic Coverage after Oncologic Reconstruction

Referred to: Reference Committee J

Whereas, head and neck cancer and trauma that requires resection often times leaves patients with incomplete or completely absent dentition; and

Whereas, prosthodontic reconstruction can broaden the opportunities for nutritional supplementation after treatment of head and neck cancers; and

Whereas, prosthodontic reconstruction allows for improved psychosocial outcomes after treatment of head and neck cancers; and

Whereas, prosthodontic reconstruction done at the time of orofacial reconstruction is more frequently covered by insurers while delayed prosthodontic reconstruction is significantly less likely to be covered; and

Whereas, same day reconstruction is not an option for all patients but does not negate the potential benefits for eventual prosthodontic reconstruction; and

Whereas, the American Medical Association has long standing policy advocating for coverage of dental implants for persons with congenital orofacial clefting; therefore be it

RESOLVED, that our American Medical Association with appropriate stakeholders to advocate: (a) that prosthodontic reconstruction (including dental implants) after orofacial reconstruction secondary to oncologic resection be covered by all insurers, (b) that such coverage, shall include treatment which, in the opinion of the treating physician is medically necessary to optimize the patient's appearance and function to their original form as much as possible, and (c) that such insurability be portable, i.e. not denied as a pre-existing condition if the patients insurance coverage changes before treatment has been initiated or completed. (Directive to Take Action)

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

Received: 9/26/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 809
(I-23)

Introduced by: New York

Subject: Outsourcing of Administrative and Clinical Work to Different Time Zones – An Issue of Equity, Diversity, and Inclusion

Referred to: Reference Committee J

Whereas, our American Medical Association (AMA) has previously affirmed its strategic plan to embed equity, diversity, and inclusion as its guiding principles; and

Whereas, many healthcare tasks are outsourced by health plans to lower-cost countries in vastly different time zones, including India, Pakistan, Philippines, among others; likewise, many revenue cycle management (RCM) duties, >70% are outsourced to the same countries by medical practices, including hospitals and physician practices. Surveys suggest that 85-90% of calls are answered by insurance representatives in non-US time zones, and

Whereas, studies have shown that night shift work has adverse health effects; and

Whereas, provider outsourced RCM staff and health plan outsourced staff work in the same time zone, separated from the US by around 12 hours. Both provider RCM outsourced staff and health plan outsourced staff work night shifts during US business hours while mostly interacting with each other; and

Whereas, common sense suggests that it would be advantageous for outsourced staff to work in their local time zone as much as possible, and that would be the preferred option for most; and

Whereas, outsourced workers in low-cost outsourced countries are relatively under-privileged; therefore it be

RESOLVED, that our American Medical Association advocate that health plans that outsource their customer service facing operations to foreign countries in time zones separated by more than 4 hours from the US should implement 16 or 24-hour availability for their support services staffed by outsourced employees to allow local day shift work schedules for their own outsourced employees in different time zones and provider employees located in similar time zones (Directive to Take Action); and be it further

RESOLVED, that our AMA support national legislation that calls on health plans that outsource their customer service facing operations to foreign countries in time zones separated by more than 4 hours from the US to implement 16 or 24-hour availability for their support services staffed by outsourced employees to allow local day shift work schedules for their own outsourced employees in different time zones and provider employees located in similar time zones (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for fair treatment of outsourced employees in vastly different time zones by health plans. (Directive to Take Action)

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

Received: 9/26/23

RELEVANT AMA POLICY

Prior Authorization and Utilization Management Reform H-320.939
1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.
Policy Timeline: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21; Reaffirmation: A-22

Remuneration for Physician Services H-385.951
1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.
Policy Timeline: Sub. Res. 814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmation A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19; Reaffirmation: A-22

Plan for Continued Progress Toward Health Equity H-180.944
Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.
Policy Timeline: BOT Rep. 33, A-18; Reaffirmed: CMS Rep. 5, I-21

Prior Authorization Reform D-320.982
Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.
Policy Timeline: Res. 704, A-19; Reaffirmation: A-22

Light Pollution: Adverse Health Effects of Nighttime Lighting H-135.932
Our AMA:
1. Supports the need for developing and implementing technologies to reduce glare from vehicle headlamps and roadway lighting schemes, and developing lighting technologies at home and at work that minimize circadian disruption, while maintaining visual efficiency.
2. Recognizes that exposure to excessive light at night, including extended use of various electronic media, can disrupt sleep or exacerbate sleep disorders, especially in children and adolescents. This effect can be minimized by using dim red lighting in the nighttime bedroom environment.
3. Supports the need for further multidisciplinary research on the risks and benefits of occupational and environmental exposure to light-at-night.
4. That work environments operating in a 24/7 hour fashion have an employee fatigue risk management plan in place.
Policy Timeline: CSAPH Rep. 4, A-12; Reaffirmation: A-22; Reaffirmed: CSAPH Rep. 1, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 811
(I-23)

Introduced by: Medical Student Section

Subject: Expanding the Use of Medical Interpreters

Referred to: Reference Committee J

Whereas, over 25 million people in the US have limited English proficiency (LEP), and interpreter use for these patients is associated improved morbidity and mortality, provider communication, discharge education, and health literacy and fewer medical errors[1-8]; and

Whereas, a study of increased interpreter use showed decreased readmission rates with monthly hospital savings of $160,000, after accounting for interpreter costs[9]; and

Whereas, multiple analyses, including a systematic review, find that reminders by text and phone provided in a patient's preferred language can increase appointment attendance that reminders by text reminders by text or phone improve patient adherence and appointment attendance when delivered in the patient's preferred language[10-13]; and

Whereas, bilingual physicians are not officially certified and may still be required to use an interpreter for liability[14]; and

Whereas, in one study, 84% of bilingual medical students reported being asked to interpret for patients, of whom 53% reported feeling uncomfortable with interpretation[15]; and

Whereas, some institutions offer interpretation courses (with advanced skills beyond introductory language electives) for already bilingual trainees to increase comfort with interpretation, improve patient interactions, and even save costs[16-22]; therefore be it

RESOLVED, that our American Medical Association amend H-160.924, "Use of Language Interpreters in the Context of the Patient-Physician Relationship," by addition as follows:

> Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924
> 1. AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care; (b) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (c) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid Limited English Proficiency (LEP) patients' involvement in meaningful decisions about their care; <u>d) patients have expanded access to documentation and</u>

communications available in their preferred language, including appointment reminder calls/messages, post-appointment summaries, and electronic medical records, through access to trained interpreter and translator services; and (~~d~~e) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.

2. Our AMA recognizes the importance of using medical interpreters as a means of improving quality of care provided to patients with LEP including patients with sensory impairments.

3. Our AMA encourage hospital systems, clinics, residency programs, and medical schools to promote and incentivize opportunities for physicians, staff, and trainees to receive medical interpreter training and certification.

(Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 09/27/2023

REFERENCES

1. State Demographics Data | migrationpolicy.org. Accessed March 9, 2023. https://www.migrationpolicy.org/data/state-profiles/state/language/US#
2. Pippins JR, Alegría M, Haas JS. Association between language proficiency and the quality of primary care among a national sample of insured Latinos. Med Care. 2007 Nov;45(11):1020-5. doi: 10.1097/MLR.0b013e31814847be. PMID: 18049341; PMCID: PMC2836911.
3. Diamond, L, Izquierdo, K, Canfield, D et al. A Systematic Review of the Impact of Patient–Physician Non-English Language Concordance on Quality of Care and Outcomes. Journal of General Internal Medicine. 2019;34:1591–1606. https://doi.org/10.1007/s11606-019-04847-5.
4. Parker MM, Fernández A, Moffet HH, et al. Association of Patient-Physician Language Concordance and Glycemic Control for Limited-English Proficiency Latinos With Type 2 Diabetes. JAMA Intern Med. 2017;177(3):449. doi:10.1001/jamainternmed.2016.8648
5. Schwebel F, Larimer ME.. Using text message reminders in health care services: A narrative literature review. Internet Interventions. 2018;13:82-104. https://doi.org/10.1016/j.invent.2018.06.002.
6. Schiaffino MK, Nara A, Mao L. Language Services In Hospitals Vary By Ownership And Location. Health Aff (Millwood). 2016;35(8):1399-1403. doi:10.1377/hlthaff.2015.0955
7. Tan-McGrory A., Schwamm L.H., Kirwan C., et al. Addressing Virtual Care Disparities for Patients With Limited English Proficiency. American Journal of Managed Care. 2022;28(1):36-40. https://doi.org/10.37765/ajmc.2022.88814.
8. Lee, JS, Pérez-Stable, EJ, Gregorich, SE. et al. Increased Access to Professional Interpreters in the Hospital Improves Informed Consent for Patients with Limited English Proficiency. J GEN INTERN MED 2017;32(8):863–870. https://doi.org/10.1007/s11606-017-3983-4
9. Karliner LS, Pérez-Stable EJ, Gregorich SE. Convenient Access to Professional Interpreters in the Hospital Decreases Readmission Rates and Estimated Hospital Expenditures for Patients With Limited English Proficiency. Med Care. 2017;55(3):199-206. doi:10.1097/MLR.0000000000000643
10. Schwebel F, Larimer ME.. Using text message reminders in health care services: A narrative literature review. Internet Interventions. 2018;13:82-104. https://doi.org/10.1016/j.invent.2018.06.002.
11. Mehranbod C, Genter P, Serpas L, et al. Automated Reminders Improve Retinal Screening Rates in Low Income, Minority Patients with Diabetes and Correct the African American Disparity. Journal of Medical Systems. 2020;44(1):1-7. doi:10.1007/s10916-019-1510-3
12. Flower KB, Wurzelmann S, Rojas C, et al. Improving satisfaction and appointment attendance through navigation for spanish-speaking families. J Health Care Poor Underserved. 2020;31(2):810-826. doi: https://doi.org/10.1353/hpu.2020.0062.
13. NYC Health + Hospitals expands access to text message appointment reminders. NYC Health + Hospitals. https://www.nychealthandhospitals.org/pressrelease/nyc-health-hospitals-expands-access-to-text-message-appointment-reminders/. Published May 26, 2022. Accessed April 2, 2023.
14. Duma N, Velazquez AI, Franco I, et al. Dónde están? latinx/hispanic representation in the oncology workforce: present and future. JCO Oncol Pract. 2022;18(5):388-395. doi:10.1200/OP.22.00153
15. Vela MB, Fritz C, Press VG, Girotti J. Medical students' experiences and perspectives on interpreting for LEP patients at two US medical schools. J Racial Ethn Health Disparities. 2016;3(2):245-249. doi:10.1007/s40615-015-0134-7

16. Diaz JEL, Ekasumara N, Menon NR, et al. Interpreter training for medical students: pilot implementation and assessment in a student-run clinic. BMC Med Educ. 2016;16(1):256. doi:10.1186/s12909-016-0760-8
17. Hernandez RG, Tanaka K, McPeak K, Thompson DA. Resident Training Experiences Providing Spanish-Language Concordant Care: Implications for Growing Health Equity Efforts Within Graduate Medical Education. Clin Pediatr (Phila). 2022;61(4):352-361. doi:10.1177/00099228221074776
18. Himmelstein J, Wright WS, Wiederman MW. U.S. medical school curricula on working with medical interpreters and/or patients with limited English proficiency. Adv Med Educ Pract. 2018;9:729-733. doi:10.2147/AMEP.S176028
19. Cowden JD, Martinez FJ, Dickmeyer JJ, Bratcher D. Culture and language coaching for bilingual residents: the first 10 years of the CHiCoS model. Teach Learn Med. June 30, 2022:1-12. doi:10.1080/10401334.2022.2092113
20. Barr WB, Valdini A, Louis JS, Weida N, Marshall C. Sí, tu puedes: an integrated spanish language acquisition in residency utilizing personal instruction. J Grad Med Educ. 2018;10(3):343-344. doi:10.4300/JGME-D-17-00919.1
21. ASL Medical School Elective | Family Medicine | Michigan Medicine | University of Michigan. Accessed April 10, 2023. https://medicine.umich.edu/dept/family-medicine/programs/mdisability/education/asl-medical-school-elective
22. Pre-Clerkship Electives | Medical Education | Medical School | Brown University. Accessed April 10, 2023. https://education.med.brown.edu/md-curriculum/pre-clerkship/pre-clerkship-electives

RELEVANT AMA POLICY

H-295.870 Medical School Language Electives in Medical School Curriculum
Our AMA strongly encourages all Liaison Committee on Medical Education- and American Osteopathic Association-accredited US medical schools to offer medical second languages to their students as electives. [Res. 304, A-07; Reaffirmed: CME Rep. 01, A-17]

H-160.931 Health Literacy
Our AMA:
(1) recognizes that limited patient literacy is a barrier to effective medical diagnosis and treatment;
(2) encourages the development of literacy appropriate, culturally diverse health-related patient education materials for distribution in the outpatient and inpatient setting;
(3) will work with members of the Federation and other relevant medical and nonmedical organizations to make the health care community aware that approximately one fourth of the adult population has limited literacy and difficulty understanding both oral and written health care information;
(4) encourages the development of undergraduate, graduate, and continuing medical education programs that train physicians to communicate with patients who have limited literacy skills;
(5) encourages all third party payers to compensate physicians for formal patient education programs directed at individuals with limited literacy skills;
(6) encourages the US Department of Education to include questions regarding health status, health behaviors, and difficulties communicating with health care professionals in all future National Assessment of Adult Literacy studies;
(7) encourages the allocation of federal and private funds for research on health literacy;
(8) recommends all healthcare institutions adopt a health literacy policy with the primary goal of enhancing provider communication and educational approaches to the patient visit;
(9) recommends all healthcare and pharmaceutical institutions adopt the USP prescription standards and provide prescription instructions in the patient's preferred language when available and appropriate; and
(10) encourages the development of low-cost community- and health system resources, support state legislation and consider annual initiatives focused on improving health literacy. [CSA Rep. 1, A-98; Appended: Res. 415, I-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Appended: Res. 718, A-13; Reaffirmed: BOT Rep. 09, A-23]

H-385.917 Interpreter Services and Payment Responsibilities
Our AMA supports efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services. [CMS Rep. 5, A-11; Reaffirmed: CMS Rep. 1, A-21; Reaffirmed in lieu of: Res. 231, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 812
(I-23)

Introduced by: Medical Student Section

Subject: Indian Health Service Improvements

Referred to: Reference Committee J

Whereas, the Indian Health Service (IHS) serves 2.6 million American Indian and Alaska Native (AI/AN) patients in facilities operated by the federal government, tribes, and Urban Indian organizations (UIO)[1-2]; and

Whereas, unlike Medicaid, Medicare, and the VA, the IHS is not an insurance or entitlement program with an established benefits package[3-5]; and

Whereas, the IHS is a payer of last resort, thus their patients must exhaust all other public or private coverage for which they are eligible before receiving IHS payment, including the 36% of AI/AN adults under 65 who are on Medicaid[6-8]; and

Whereas, since 1976, all state Medicaid programs have been fully reimbursed at 100% Federal Medical Assistance Percentage (FMAP) for services at IHS/Tribal facilities[9-10]; and

Whereas, the 1976 100% FMAP legislation specifically excluded UIOs, even though 70% of AI/AN adults live in areas served by these facilities[8,10]; and

Whereas, in 2016, CMS expanded 100% FMAP to services from non-IHS/Tribal physicians if first requested by an IHS/Tribal physician with a care coordination agreement[10-11]; and

Whereas, the American Rescue Plan temporarily extended 100% FMAP to UIOs for 2 years, with the federal government saving 22 states an estimated $70 million[10,12]; and

Whereas, Congress is considering permanently extending 100% FMAP for UIOs, which is estimated to save states $547 million over 10 years[10]; and

Whereas, Washington State currently reinvests their $16 million in annual savings from 100% FMAP into into a tribally-driven health improvement fund[13-14]; and

Whereas, 100% FMAP expansion for UIOs will not negatively impact appropriations and services at Indian Health Service and Tribal Health Programs[13]; and

Whereas, pharmacoequity is also a serious concern for many Tribal leaders and advocates for AI/AN health[15]; and

Whereas, the IHS National Pharmacy and Therapeutics Committee (NPTC) sets the IHS National Core Formulary (NCF) for baseline pharmaceutical coverage at federal IHS facilities, but does not maintain parity with other federal health programs[16]; and

Whereas, the IHS NPTC added emergency contraception to the NCF 4 years after reports of complete lack availability at over half of all IHS facilities and 2 years after over-the-counter approval without age limits by the Food and Drug Administration[17-19]; and

Whereas, the IHS NPTC added testosterone and estradiol to the NCF 5 years after the release of consensus specialty clinical guidelines on gender-affirming medication[20-21]; and

Whereas, our American Medical Association supports "enforc[ing] the Medicare Part D Prescription Drug Program statutory requirement that all Part D plans include at least two drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients"; and

Whereas, in 1997, Congress created the IHS Special Diabetes Program for Indians (SDPI), an $150 million annual program funding diabetes prevention and treatment, which now comprises 301 community programs serving 780,000 adults and children in 35 states[22]; and

Whereas, in the 20 years since SDPI implementation, diabetes prevalence in AI/AN adults has consistently declined, diabetes-related mortality decreased 37%, diabetes-related hospitalizations decreased 84%, diabetic eye disease decreased 50%, and specifically diabetes-related kidney failure decreased 54% (the greatest reduction for any racial or ethnic group), which alone saved Medicare $520 million over 10 years[22-23]; and

Whereas, SDPI is subject to reauthorization every 2 years, affecting continuity of care during prolonged Congressional negotiations and exacerbating existing staffing issues because IHS is the only federal health program without advance appropriations[24]; and

Whereas, SDPI funds have stagnated at $150 million since 2004 without inflation-based adjustments, limiting program expansion, decreasing grant value, and forcing grantees and IHS programs to unsustainably absorb 20 years of inflationary cost increases[25-26]; and

Whereas, similar to SDPI, other IHS grants, such as the 5-year health professions grant Indians Into Medicine, are discretionary (not mandatory) and are also subject to repeated Congressional reauthorization, lack of funding increases, and struggles with inflation[27]; therefore be it

RESOLVED, that our American Medical Association advocate to permanently increase the Federal Medical Assistance Percentage (FMAP) to 100% for medical services which are received at or through an Urban Indian Organization that has a grant or contract with the Indian Health Service (IHS) (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage state and federal governments to reinvest Medicaid savings from 100% FMAP into tribally-driven health improvement programs (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for greater physician and federal oversight of the IHS National Core Formulary, ensuring that the pharmacy benefit for American Indian and Alaska Native patients represents the standard-of-care for prevalent diseases and medical conditions in this population (Directive to Take Action); and be it further

RESOLVED, that our AMA work with IHS and appropriate agencies and organizations to ensure that their National Core Formulary includes at least two standard-of-care drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients (Directive to Take Action); and be it further

RESOLVED, that our AMA support permanent reauthorization of the Special Diabetes Program for Indians (New HOD Policy); and be it further

RESOLVED, that our AMA support biannual inflationary increases for public health and health profession grants sponsored by IHS. (New HOD Policy)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 09/27/23

REFERENCES

1. Indian Health Service: Information on Third-Party Collections and Processes to Procure Supplies and Services. U.S. Government Accountability Office. Published online 2022. https://www.gao.gov/assets/gao-22-104742.pdf
2. Federal Register Volume 87, Issue 19 (January 28, 2022). Office of the Federal Register, National Archives and Records Administration. Published online 2022. https://www.govinfo.gov/app/details/FR-2022-01-28/2022-01789
3. Patient Resources. Indian Health Service. Accessed 2023. https://www.ihs.gov/forpatients/faq
4. Purchase/Referred Care (PRC): Requirements: Eligibility. Indian Health Services. Published online 2022. https://www.ihs.gov/prc/eligibility/requirements-eligibility
5. Indian Health Service (IHS) FY2022 Budget: Request and Funding History: In Brief. Congressional Research Service. Published online 2022. https://crsreports.congress.gov/product/pdf/R/R47004
6. Purchase/Referred Care (PRC). Indian Health Services. Published online 2022. https://www.ihs.gov/prc/
7. Requirements: Alternate Resources | Eligibility. Purchased/Referred Care (PRC). Accessed March 2023 https://www.ihs.gov/prc/eligibility/requirements-alternate-resources
8. Health Insurance Coverage and Access to Care for American Indians and Alaska Natives: Current Trends and Key Challenges. ASPE Office of the Assistant Secretary for Planning and Evaluation. Published online July 22, 2021. https://aspe.hhs.gov/sites/default/files/2021-07/aspe-aian-health-insurance-coverage-ib.pdf
9. 100% FMAP for LTSS — Educate Your State. Centers for Medicare and Medicaid Services. Published online November 15, 2022. https://www.cms.gov/outreach-and-education/american-indian-alaska-native/aian/ltss-ta-center/info/100-percent-fmap-educate-your-state#:~:text=CMS%20reimburses%20each%20state%20for,typically%20have%20a%20higher%20FMAP
10. Kalweit, Andrew, Chandos Culleen, and Isaiah O'Rear. Recent Trends in Third-Party Billing at Urban Indian Organizations: Impact of the American Rescue Plan Act and 100% FMAP Provisions. National Council for Urban Indian Health. Washington DC, 2022.
11. Urban Indian Organizations. Indian Health Service. https://www.ihs.gov/Urban/urban-indian-organizations
12. H.Res.1319 American Rescue Plan Act of 2021. US House. March 11, 2021. https://www.congress.gov/bill/117th-congress/house-bill/1319
13. Seattle Indian Health Board. Payment Parity for Indian Health Care Providers. Published online April 16, 2020. https://www.sihb.org/wp-content/uploads/SIHB-FMAP_FAQ_20200416_2.pdf
14. Lundberg, Laura, Sara Gentzler. Washington's Indian Health Improvement Act, explained. Washington State Wire. Published online June 5, 2019. https://washingtonstatewire.com/washington-state-passes-indian-health-improvement-bill
15. Calac A, Gasca L, Calac D. Reducing Health Disparities Through Achieving Pharmacoequity. JAMA. 2022;327(6):588-589. doi:10.1001/jama.2021.24516
16. Indian Health Service: About. National Pharmacy & Therapeutics Committee. Accessed March 2023. https://www.ihs.gov/nptc/about
17. Indian Health Services Releases Long-Awaited Update to Policy on Emergency Contraception. American Civil Liberties Union. Accessed March 2023. https://www.aclu.org/press-releases/indian-health-services-releases-long-awaited-update-policy-emergency-contraception
18. Indian Health Service: Chapter 15 - Emergency Contraception | Part 1. The Indian Health Manual (IHM). Published 2015. https://www.ihs.gov/IHM/pc/part-1/p1c15
19. Kingfisher P, The Native American Women's Health Education Resource Center. Indigenous Women' S Dialogue: Roundtable Report on the Accessibility of Plan B® as an over the Counter (OTC) within Indian Health Service.; 2012. http://www.nativeshop.org/images/stories/media/pdfs/Plan-B-Report.pdf
20. Indian Health Service. National Pharmacy and Therapeutics Committee Formulary Brief: Gender-Affirming Medications. Published February 2022. https://www.ihs.gov/sites/nptc/themes/responsive2017/display_objects/documents/guidance/NPTC-Formulary-Brief-Gender-Affirming-Medications.pdf
21. Wylie C Hembree, Peggy T Cohen-Kettenis, Louis Gooren, Sabine E Hannema, Walter J Meyer, M Hassan Murad, Stephen M Rosenthal, Joshua D Safer, Vin Tangpricha, Guy G T'Sjoen, Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, The Journal of Clinical Endocrinology & Metabolism, Volume 102, Issue 11, 1 November 2017, Pages 3869–3903, https://doi.org/10.1210/jc.2017-01658
22. Special Diabetes Program for Indians 2020 Report to Congress: Changing the Course of Diabetes: Charting Remarkable Progress [Internet]. Rockville (MD): Indian Health Service (US); 2020.

23. Bullock, A. et al. “Prevalence of diagnosed diabetes in American Indian and Alaska Native adults, 2006-2017.” BMJ open diabetes research & care vol. 8,1 (2020): e001218.
24. Advance Appropriations. National Indian Health Board. Accessed September 22, 2022. https://www.nihb.org/legislative/advance_appropriations.php
25. National Clinical Care Commission. Report to Congress on Leveraging Federal Programs to Prevent and Control Diabetes and Its Complications. Department of Health and Human Services. Published 2021. Accessed August 31, 2022. https://health.gov/sites/default/files/2022-01/NCCC%20Report%20to%20Congress.pdf
26. FY 2023 National Tribal Budget Formulation Workgroup. Indian Health Service. Published February 12, 2021. Accessed September 22, 2022. https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2023NationalTribalBudgetFormulationWorkSessionMaterials.pdf
27. National Indian Health Board. Increasing Funding for the Indians Into Medicine (INMED) Program. Resolution 22-05. Published 2022. Accessed August 31, 2022. https://www.nihb.org/docs/02252022/22-05%20NIHB%20Resolution%20on%20Increasing%20Funding%20for%20the%20Indians%20Into%20Medicine%20(INMED)%20Program.pdf

RELEVANT AMA POLICY

D-350.992 Medicaid Coverage for American Indian and Alaska Native Children
Our AMA will advocate for immediate changes in Medicaid regulations to allow American Indian/Alaska Native (AI/AN) children who are eligible for Medicaid in their home state to be automatically eligible for Medicaid in the state in which the Bureau of Indian Affairs boarding school is located. [BOT Action in response to referred for decision Res. 102, A-06; Reaffirmed: Res. 221, A-07; Reaffirmed: CMS Rep. 01, A-17]

H-350.948 Purchased and Referred Care Expansion
Our AMA will advocate for increased funding to the Indian Health Service Purchased/Referred Care Program and to the Urban Indian Health Program to enable the programs to fully meet the healthcare needs of American Indian/Alaska Native (AI/AN) patients. [Res. 209, A-23]

D-330.933 Restoring High Quality Care to the Medicare Part D Prescription Drug Program
Our AMA will:
a. work to eliminate prior authorizations under the Medicare Part D Prescription Drug Program which undermine a physician's best medical judgment;
b. work with the Centers for Medicare and Medicaid Services (CMS) to enforce the Medicare Part D Prescription Drug Program statutory requirement that all Part D plans include at least two drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients;
c. work with CMS to place reasonable copays in the Medicare Part D Prescription Drug Program;
d. work with other interested parties to simplify the CMS prior authorization process such that a diagnosis or reason written on the prescription should be accepted as documentation for non formulary request; and
e. work with CMS to develop a one-page form for physicians and patients to utilize in appealing a prescription coverage denial. [Res. 106, A-07; Reaffirmation A-08; Reaffirmation A-14]

D-350.987 Strong Opposition to Cuts in Federal Funding for the Indian Health Service
1. Our AMA will strongly advocate that all of the facilities that serve Native Americans under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers.
2. Our AMA will ask Congress to take all necessary action to immediately restore full and adequate funding to the Indian Health Service.
3. Our AMA adopts as new policy that the Indian Health Service not be treated more adversely than other health plans in the application of any across the board federal funding reduction.
4. In the event of federal inaction to restore full and adequate funding to the Indian Health Service, our AMA will consider the option of joining in legal action seeking to require the federal government to honor existing treaties, obligations, and previously established laws regarding funding of the Indian Health Service.
5. Our AMA will request that Congress: (A) amend the Indian Health Care Improvement Act to authorize Advanced Appropriations; (B) include our recommendation for the Indian Health Service (HIS) Advanced

Appropriations in the Budget Resolution; and (C) include in the enacted appropriations bill IHS Advanced Appropriations. [Res. 233, A-13; Appended: Res. 229, A-14]

H-440.844 Expansion of National Diabetes Prevention Program
Our AMA: (1) supports evidence-based, physician-prescribed diabetes prevention programs, (2) supports the expansion of the NDPP to more CDC-certified sites across the country; and (3) will support coverage of the NDPP by Medicare and all private insurers. [Sub. Res. 911, I-12; Reaffirmed: CSAPH Rep. 1, A-22]

H-350.976 Improving Health Care of American Indians
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations. [CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Reaffirmed: BOT Rep. 09, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 813
(I-23)

Introduced by: Medical Student Section

Subject: Strengthening Efforts Against Horizontal & Vertical Consolidation

Referred to: Reference Committee J

Whereas, despite robust evidence for the effects of both horizontal and vertical consolidation on patient outcomes, physician pay and work conditions, and market performance, FTC and DOJ are hesitant to try cases due to inadequate finances and a history of losses, including several in the early 2000s and recent cases only won after appeals requiring major funds[1-41]; and

Whereas, while healthcare merger activity rose 50% from 2010-2020, Federal Trade Commission (FTC) and Department of Justice (DOJ) budgets declined, and the amount of resources needed per antitrust lawsuit increased[37-40]; and

Whereas, nonprofit hospitals account for the majority of US hospitals but are immune from antitrust enforcement, despite also being impacted by the harms of consolidation[37-40]; and

Whereas, most vertical healthcare mergers are not reported because they fall beneath the $50 million threshold for mandatory reporting, even though they account for $30 to 40 billion in total value, making FTC and DOJ ineffective in preventing vertical consolidation[37-40]; and

Whereas, FTC and DOJ struggle in cases due to the extremely high evidentiary burdens placed on plaintiffs, such as proof that a merger will lead to “likely harm to competition,” which requires additional funds to effectively demonstrate and exacerbates budgetary concerns[37-41]; and

Whereas, while most healthcare mergers are challenged preemptively, FTC has previously challenged mergers retroactively, and given the inadequacies of existing enforcement, retroactive challenges will likely be necessary to restore effective markets[37-40]; therefore be it

RESOLVED, that our American Medical Association advocate to adequately resource competition policy authorities such as the Federal Trade Commission (FTC) and Department of Justice Antitrust Division to perform oversight of healthcare markets (Directive to Take Action); and be it further

RESOLVED, that our AMA oppose not-for-profit firm immunity from FTC competition policy enforcement in the healthcare sector, which represent the majority of U.S. hospitals (New HOD Policy); and be it further

RESOLVED, that our AMA support lowering the transaction value threshold for merger reporting in healthcare sectors to ensure that vertical acquisitions in healthcare do not evade antitrust scrutiny (New HOD Policy); and be it further

RESOLVED, that our AMA support healthcare-specific advocacy efforts which will strengthen antitrust enforcement in the healthcare sector through multiple mechanisms, including but not

limited to a) simplifying the evidentiary burden on plaintiffs and shifting the evidentiary burden to defendants and b) encouraging the FTC to leverage its authority to increase the frequency of challenges in consolidated healthcare markets. (New HOD Policy)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 09/27/2023

REFERENCES

1. Martin, Anne B., Micah Hartman, Benjamin Washington, Aaron Catlin, and the National Health Expenditures Team. 2019. “National Health Care Spending in 2017: Growth Slows to Post Great Recession Rates; Share of GDP Stabilizes.” Health Affairs 38 (1): 96–106.
2. Jean Tirole, 1988. "The Theory of Industrial Organization," MIT Press Books, The MIT Press, edition 1, volume 1, number
3. Fulton, Brent D. 2017. “Health Care Market Concentration Trends in the United States: Evidence and Policy Responses.”Health Affairs 36 (9): 1530–38.
4. Singh, Anu. 2019. “2018 Healthcare M&A in Review: A NewLandscape Takes Shape.” KaufmanHall, Chicago, IL.
5. American Hospital Association. 2018. “Trendwatch Chartbook 2018: Organizational Trends, Chart 2.9: Announced Hospital Mergers and Acquisitions, 2005–2017.” American Hospital Association, Chicago, IL
6. Cutler, David M., and Fiona Scott Morton. 2013. “Hospitals, Market Share, and Consolidation.” Journal of the American Medical Association 310 (18): 1964.
7. Capps, Cory S., David Dranove, and Christopher Ody. 2017. “Physician Practice Consolidation Driven by Small Acquisitions, So Antitrust Agencies Have Few Tools to Intervene.” Health Affairs 36 (9): 1556–63.
8. Muhlestein, David B., and Nathan J. Smith. 2016. “Physician Consolidation: Rapid Movement from Small to Large Group Practices.” Health Affairs 35 (9): 1638–42.
9. Capps, Cory S., and David Dranove. 2004. “Hospital Consolidation and Negotiated PPO Prices.” Health Affairs 23 (2): 175–81.
10. Cooper, Zack, Stuart V. Craig, Martin Gaynor, and John Van Reenen. 2019. “The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured.” Quarterly Journal of Economics 134 (1): 51–107.
11. Capps, Cory S., David Dranove, and Mark Satterthwaite. 2003. “Competition and Market Power in Option Demand Markets.” RAND Journal of Economics 34 (4): 737–63
12. Dafny, Leemore. 2009. “Estimation and Identification of Merger Effects: An Application to Hospital Mergers.” Journal of Law and Economics 52 (3): 523–50.
13. Gowrisankaran, Gautam, Aviv Nevo, and Robert Town. 2015. “Mergers When Prices Are Negotiated: Evidence from the Hospital Industry.” American Economic Review 105 (1): 172–203.
14. Haas-Wilson, Deborah, and Christopher Garmon. 2011. “Hospital Mergers and Competitive Effects: Two Retrospective Analyses.” International Journal of the Economics of Business 18 (1): 17–32.
15. Tenn, Steven. 2011. “The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction.” International Journal of the Economics of Business 18 (1): 65–82
16. Thompson, Aileen. 2011. “The Effect of Hospital Mergers on Inpatient Prices: A Case Study of the New Hanover-Cape Fear Transaction.” International Journal of the Economics of Business 18 (1): 91–101
17. Koch, Thomas, and Shawn W. Ulrick. 2017. “Price Effects of A Merger: Evidence from A Physicians’ Market.” Working Paper 333, Bureau of Economics, Federal Trade Commission, Washington, DC.
18. Anand, Priyanka. 2017. “Health Insurance Costs and Employee Compensation: Evidence from the National Compensation Survey.” Health Economics 26 (12): 1601–16
19. Baicker, Katherine and Amitabh Chandra. 2006. “The Labor Market Effects of Rising Health Insurance Premiums.” Journal of Labor Economics 24 (3): 609–34.
20. Cooper, Zack, Stephen Gibbons, Simon Jones, and Alistair McGuire. 2011. “Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms.” Economic Journal 121 (554): F228–F260.
21. Gaynor, Martin, Rodrigo Moreno-Serra, and Carol Propper. 2013.“Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service.” American Economic Journal: Economic Policy 5 (4): 134–66
22. Romano, Patrick, and David Balan. 2011. “A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare.” International Journal of the Economics of Business 18 (1): 45–64.
23. Cutler, David M., Robert S. Huckman, and Jonathan T. Kolstad. 2010. “Input Constraints and the Efficiency of Entry: Lessons from Cardiac Surgery.” American Economic Journal: Economic Policy 2 (1): 51–76.
24. Hayford, Tamara B. 2012. “The Impact of Hospital Mergers on Treatment Intensity and Health Outcomes.” Health Services Research 47 (3pt1): 1008–29.
25. Haas, Susan, Atul A. Gawande, and Mark E. Reynolds. 2018. “The Risks to Patient Safety from Health System Expansions.” Journal of the American Medical Association 319 (17): 1765–66.
26. Prager, Elena, and Matt Schmitt. 2019. “Employer Consolidation and Wages: Evidence from Hospitals.” Unpublished manuscript, Northwestern University, Chicago, IL.
27. Kane, Carol K. 2017. “Updated Data on Physician Practice Arrangements: Physician Ownership Drops Below 50 Percent.” Policy Research Perspectives, American Medical Association, Chicago, IL.
28. Baker, Lawrence, M. Kate Bundorf, and Daniel Kessler. 2014. Vertical integration: Hospital ownership of physician practices is associated with higher prices and spending. Health Affairs 33 (5): 756–63.
29. Capps, Cory S., David Dranove, and Christopher Ody. 2016. “The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending.” Unpublished manuscript, Northwestern University, Evanston, IL

30. Neprash, Hannah T., Michael E. Chernew, Andrew L. Hicks, Teresa Gibson, and Michael McWilliams. 2015. “Association of Financial Integration Between Physicians and Hospitals with Commercial Health Care Prices.” Journal of the American Medical Association Internal Medicine 175 (12): 1932–39.
31. Robinson, James C., and Kelly Miller. 2014. “Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California.” Journal of the American Medical Association 312 (6): 1663–69.
32. Brot-Goldberg, Zarek, and Mathijs de Vaan. 2018. “Intermediation and Vertical Integration in the Market for Surgeons.” Unpublished manuscript, University of California, Berkeley, CA.
33. Venkatesh, Shruthi. 2019. “The Impact of Hospital Acquisition on Physician Referrals.” Unpublished manuscript, Carnegie Mellon University, Pittsburgh, PA.
34. United States and the State of North Carolina v. The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas Healthcare System. 2019
35. People of the State of California Ex Rel. Xavier Becerra v. Sutter Health. (2018).
36. Abelson, Reed. 2019, October 16. “Sutter Health to Settle Antitrust Lawsuit.” New York Times.
37. Slaughter, Rebecca-Kelley. “Remarks of Commissioner Rebecca Kelly Slaughter As Prepared for Delivery: Antitrust and Health Care Providers Policies to Promote Competition and Protect Patients”. Federal Trade Commission. 2019.
38. Gaynor, Martin. 2020. “What to Do about Health-Care Markets? Policies to Make Health-Care Markets Work.” Brookings Institution.
39. Gaynor, Martin. “Statement before the U.S. Senate Subcommittee on Competition Policy, Antitrust, and Consumer Rights: Antitrust Applied: Hospital Consolidation Concerns and Solutions”. 2021.
40. Cooper, Zach and Gaynor, Martin. Addressing Hospital Concentration and Rising Consolidation in the United States. 1% Steps for Health Care Reform Project.
41. Cory Capps et al., The Continuing Saga of Hospital Merger Enforcement, 82 Antitrust Law Journal. 441, 485 (2019).

RELEVANT AMA POLICY

D-160.907 Health System Consolidation
1. Our American Medical Association will assess and report annually on nationwide health system and hospital consolidation, as well as payer consolidation, to assist policymakers and the federal government.
2. Our AMA annual report on nationwide hospital consolidation will be modeled after the “Competition in health insurance: A comprehensive study of U.S. Markets” in its comprehensiveness to include for example data an analyses as:
A) A review of the current level of hospital and/or health system consolidation at the level of all metropolitan statistical areas, state, and national markets;
B) A list of all mergers and acquisition transactions valued above a set threshold amount resulting in hospital and/or health system consolidation;
C) Analyses of how each transaction has changed or is expected to change the level of competition in the affected service and geographic markets;
D) Analyses of healthcare costs and prices have changes in affected markets after a large consolidation transaction has taken place.
3. Our AMA will report the initial findings of this study to the House of Delegates by Annual 2024.
4. Our AMA will report the findings of this study to its members and stakeholders, including policymakers and legislators, to inform future healthcare policy. [Res. 727, A-23]

D-160.908 Vertical Consolidation in Health Care – Markets or Monopolies
Our American Medical Association: (1) advocates against anticompetitive business practices that have the potential to adversely affect the physician patient relationship, to result in higher costs or decreased quality of care, or are not in the best interest of patients, the public and/or physicians; (2) supports efforts to increase transparency, review, and enforcement of laws with respect to vertical mergers that have the potential to negatively impact the health care industry; and (3) will work with all appropriate stakeholders to create model legislation to prohibit anticompetitive business practices within the health care sector. [Res. 723, A-23]

H-160.885 Impact of Integration and Consolidation on Patients and Physicians
Our AMA will:
1.Continue to monitor the impact of hospital-physician practice and hospital-hospital mergers and acquisitions on health care prices and spending, patient access to care, potential changes in patient quality outcomes, and physician wages and labor.
2.Continue to monitor how provider mix may change following mergers and acquisitions and how non-compete clauses may impact patients and physicians.

3.Support efforts to collect relevant information regarding hospital-physician practice and hospital-hospital mergers and acquisitions in states or regions that may fall below the Federal Trade Commission (FTC)/Department of Justice review threshold.
4.Encourage state and local medical associations, state specialty societies, and physicians to contact their state attorney general with concerns of anticompetitive behavior.
5.Encourage physicians to share their experiences with mergers and acquisitions, such as those between hospitals and/or those between hospitals and physician practices, with the FTC via their online submission form. [CMS Rep. 08, A-23]

D-215.984 Health System Consolidation
Our AMA will: (1) study nationwide health system and hospital consolidation in order to assist policymakers and the federal government in assessing healthcare consolidation for the benefit of patients and physicians who face an existential threat from healthcare consolidation; and (2) regularly review and report back on these issues to keep the House of Delegates apprised on relevant changes that may impact the practice of medicine, with the first report no later than the 2023 Annual Meeting. [Res. 702, A-22]

H-215.960 Hospital Consolidation
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 Rep. 07, A-19; Reaffirmation I-22]

D-383.980 Health Care Entity Consolidation
Our AMA will (1) study the potential effects of monopolistic activity by health care entities that may have a majority of market share in a region on the patient-doctor relationship; and (2) develop an action plan for legislative and regulatory advocacy to achieve more vigorous application of antitrust laws to protect physician practices which are confronted with potentially monopolistic activity by health care entities. [BOT Rep. 8, I-15]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 814
(I-23)

Introduced by: Senior Physicians Section

Subject: Providing Parity for Medicare Facility Fees

Referred to: Reference Committee J

Whereas, Payment rates for outpatient services provided in hospital facilities are higher than rates paid to physician offices that provide the same service; and

Whereas, Facility fees help hospitals to cover resources, such as staff, space, equipment and overhead; and

Whereas, This current site-of-service differential incentivizes payments based on the location of where a service is provided; and

Whereas, Many patients are unaware of Medicare payments paid to hospital outpatient settings or to private physicians; and

Whereas, Medicare, for example, pays $116 for a clinic visit to a doctor in an outpatient hospital clinic, and only $46 for the same level visit to an independent doctor[1]; and

Whereas, These payment cuts can ultimately effect where physicians choose to practice, and can contribute to physician shortages and payment disparities for those in rural and underserved areas; and

Whereas, Several states have recently passed laws that support site-neutral payment policies in some form that require reporting facility fee revenues in annual financial filings to the state[2]; and

Whereas, The financial viability of rural and underserved areas for office space procedures and care depends on the payment for healthcare services provided; therefore be it

RESOLVED, That our American Medical Association promote awareness that the 'site of service' payment differential does not reflect quality of care (Directive to Take Action); and be it further

RESOLVED, That our AMA seek legislative action or relief for independent physician practices, including rural and underserved practices, to be paid equally for office-based procedures whether or not they practice in offices, facilities or hospitals (Directive to Take Action); and be it further

RESOLVED, That our AMA amend policy D-330.902, The Site-of-Service Differential, by addition to read as follows:

Our AMA will produce a graphic report <u>yearly</u> illustrating the fiscal losses and inequities that practices without facility fees have endured for decades as a result of the site of service differential factoring in inflation. (Modify Current HOD Policy)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 09/27/23

REFERENCES

1. Carey, M. J. (2018). Facility fees: the farce everyone pays for. *Medical Economics*. August, 16.
2. Emerson, J. (2023, July 25) 14 recent state legislative actions supporting site-neutral payments. *Becker's Hospital Review*. Retrieved August 29 from https://www.beckershospitalreview.com/finance/14-recent-state-legislative-actions-supporting-site-neutral-payments.html

RELEVANT AMA POLICY

The Site-of-Service Differential D-330.902
1. Our AMA supports Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments.
2. Our AMA supports Medicare payments for the same service routinely and safely provided in multiple outpatient settings (e.g., physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting.
3. Our AMA will urge CMS to update the data used to calculate the practice expense component of the Medicare physician fee schedule by administering a physician practice survey (similar to the Physician Practice Information Survey administered in 2007-2008) every five years, and that this survey collect data to ensure that all physician practice costs are captured.
4. Our AMA encourages CMS to both: a) base disproportionate share hospital payments and uncompensated care payments to hospitals on actual uncompensated care data; and b) study the costs to independent physician practices of providing uncompensated care.
5. Our AMA will collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery.
6. Our AMA will produce a graphic report illustrating the fiscal losses and inequities that practices without facility fees have endured for decades as a result of the site of service differential factoring in inflation.
7. Our AMA will consider disseminating the resulting educational materials and graphics.
Citation: CMS Rep.04, I-18; Reaffirmed: BOT Action in response to referred for decision; Res.111, A-19; Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19; Appended: Res.826, I-22

Reimbursement for Office-Based Surgery Facility Fees H-385.916
Our AMA urges third party payers to include facility fee payments for procedures using more than local anesthesia in accredited office-based surgical facilities.
Citation: Res. 716, A-11; Reaffirmed: CMS Rep. 1, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 815
(I-23)

Introduced by: Senior Physicians Section

Subject: Long-Term Care and Support Services for Seniors

Referred to: Reference Committee J

Whereas, The current U.S. population is rapidly aging such that by 2030 those 65 years of age and above will total 73 million, accounting for approximately 20% of the population[1]; and

Whereas, The risk for disability increases with age and it is expected that at least half of the U.S. population will require long-term care and support services[2]; and

Whereas, Access to quality long-term care and support services can significantly improve the quality of life for older adults and people with disabilities[3]; and

Whereas, Long-term care insurance has become unaffordable or unobtainable increasing the likelihood of catastrophic financial consequences[4]; and

Whereas, Under Medicaid all states are required to provide institutional care, but home or community-based services are optional, left to the discretion of individual states; and

Whereas, The overall corporatization of medical care, has increased investment by venture capital firms in the long-term care marketplace, resulting in both increased costs and decreased quality[5]; and

Whereas, Optimizing long-term care and support services can reduce healthcare costs, improve patient outcomes, and alleviate caregiver burden; therefore be it

RESOLVED, That our American Medical Association advocate that private payors offer an affordable insurance product[s] to address long-term care needs (Directive to Take Action); and be it further

RESOLVED, That our AMA with other interested organizations, including the insurance industry, explore ways to ensure the viability of long-term care insurance by a mix of mandates and/or incentives that can be advocated for (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for equity in the financing of long-term care in order to assure affordable care of long-term care for all Americans (Directive To Take Action); and be it further

RESOLVED, That our AMA reaffirm Policy H-25.991, to continue to advocate for fiscal support for “aging in place” by promoting state and federal policy to expand home and community-based services (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA promote research regarding evidence-based interventions to assure the quality of long-term care for seniors both in the home and institutional settings. (Directive to Take Action)

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

Received: 09/27/23

REFERENCES

1. Federal Interagency Forum on Aging. (2004). Older Americans 2020-key indicators of well-being. Retrieved from: https://agingstats.gov/docs/LatestReport/OA20_508_10142020.pdf
2. *Ibid.*
3. Johnson, R. W., Favreault, M. M., Dey, J., Marton, W., & Anderson, L. (2021). Most Older Adults Are Likely to Need and Use Long-Term Services and Supports Issue Brief. *Washington, DC: ASPE, US Department of Health and Human Services*. Accessed June 2, 2023.
4. Arias, J. J. (2019). The last hope: how starting over could save private long-term care insurance. *Health Matrix*, 29, 127.
5. Borsa, A., Bejarano, G., Ellen, M., & Bruch, J. D. (2023). Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review. *bmj*, 382.

RELEVANT AMA POLICY

Promoting and Ensuring Safe, High Quality, and Affordable Elder Care Through Examining and Advocating for Better Regulation of and Alternatives to the Current, Growing For-Profit Long Term Care Options D-280.982
1. Our AMA will advocate for business models in long term care for the elderly which incentivize and promote the ethical use of resources to maximize care quality, staff and resident safety, and resident quality of life, and which hold patients' interests as paramount over maximizing profit.
2. Our AMA will, in collaboration with other stakeholders, including major payers, advocate for further research into alternatives to current options for long term care to promote the highest quality and value long term care services and supports (LTSS) models as well as functions and structures which best support these models for care.
Citation: Res. 023, A-22

Ensuring Medicare Coverage for Long Term Care D-280.985
Our AMA will work to identify additional mechanisms by which patients' out-of-pocket costs for skilled nursing facility care can be fairly covered.
Citation: Res. 706, A-18

Geriatric and Palliative Care Training For Physicians D-295.969
Our AMA: (1) encourages geriatrics and palliative care training for physicians caring for elderly and terminally ill patients in long-term care facilities; and 2) endorses the concept of affiliation between nursing home facilities for geriatric patients and residency/fellowship programs, where feasible, for the development of physicians' clinical experience in such facilities.
Citation: Res. 305, A-02, Reaffirmed: CCB/CLRPD Rep.4, A-12, Reaffirmed: BOT Rep.05, I-16, Modified: Citation: CME Rep. 01, A-20.

Alzheimer's Disease H-25.991
Our AMA:
(1) encourages physicians to make appropriate use of guidelines for clinical decision making in the diagnosis and treatment of Alzheimer's disease and other dementias;
(2) encourages physicians to make available information about community resources to facilitate appropriate and timely referral to supportive caregiver services;
(3) encourages studies to determine the comparative cost-effectiveness/cost-benefit of assisted in-home care versus nursing home care for patients with Alzheimer's disease and related disorders;
(4) encourages studies to determine how best to provide stable funding for the long-term care of patients with Alzheimer's disease and other dementing disorders;
(5) supports the use of evidence-based cost-effective technologies with prior consent of patients or

designated healthcare power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer's disease and other related dementias with the help of appropriate allied specialty organizations;
(6) supports increased awareness of the sex and gender differences in incidence and etiology of Alzheimer's disease and related dementias; and
(7) encourages increased enrollment in clinical trials of appropriate patients with Alzheimer's disease and related dementias, and their families, to better identify sex-differences in incidence and progression and to advance a treatment and cure of Alzheimer's disease and related dementias**.**
Citation: CSA Rep. 6, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Appended: Res. 503, A-16; Appended: Res. 915, I-16.

Senior Care H-25.993
Our AMA supports accelerating its ongoing efforts to work responsibly with Congress, senior citizen groups, and other interested parties to address the health care needs of seniors. These efforts should address but not be limited to: (1) multiple hospital admissions in a single calendar year; (2) long-term care; (3) hospice and home health care; and (4) pharmaceutical costs.
Citation: Sub Res. 181, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep.1, A-10; Reaffirmed: CSAPH Rep. 01, A-20.

Financing of Long-Term Services and Supports H-280.945
Our AMA supports:
(1) policies that standardize and simplify private LTCI to achieve increased coverage and improved affordability;
(2) adding transferable and portable LTCI coverage as part of workplace automatic enrollment with an opt-out provision potentially available to both current employees and retirees;
(3) allowing employer-based retirement savings to be used for LTCI premiums and LTSS expenses, including supporting penalty-free withdrawals from retirement savings accounts for purchase of private LTCI;
(4) innovations in LTCI product design, including the insurance of home and community-based services, and the marketing of long-term care products with health insurance, life insurance, and annuities;
(5) permitting Medigap plans to offer a limited LTSS benefit as an optional supplemental benefit or as separate insurance policy;
(6) Medicare Advantage plans offering LTSS in their benefit packages;
(7) permitting Medigap and Medicare Advantage plans to offer a respite care benefit as an optional benefit;
(8) a back-end public catastrophic long-term care insurance program;
(9) incentivizing states to expand the availability of and access to home and community-based services; and
(10) better integration of health and social services and supports, including the Program of All-Inclusive Care for the Elderly.
Citation: CMS Rep. 05, A-18; Reaffirmation: I-18; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep.4, I-21; Reaffirmed: Res. 705, A-23.

Policy Directions for the Financing of Long-Term Care H-280.991
The AMA believes that programs to finance long-term care should: (1) assure access to needed services when personal resources are inadequate to finance care; (2) protect personal autonomy and responsibility in the selection of LTC service providers; (3) prevent impoverishment of the individual or family in the face of extended or catastrophic service costs; (4) cover needed services in a timely, coordinated manner in the least restrictive setting appropriate to the health care needs of the individual; (5) coordinate benefits across different LTC financing program; (6) provide coverage for the medical components of long-term care through Medicaid for all individuals with income below 100 percent of the poverty level; (7) provide sliding scale subsidies for the purchase of LTC insurance coverage for individuals with income between 100-200 percent of the poverty level; (8) encourage private sector LTC coverage through an asset protection program; equivalent to the amount of private LTC coverage purchased; (9) create tax incentives to allow individuals to prospectively finance the cost of LTC coverage, encourage employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage, and allow tax-free withdrawals from IRAs and Employee Trusts for payment of LTC insurance premiums and

expenses; and (10) authorize a tax deduction or credit to encourage family care giving. Consumer information programs should be expanded to emphasize the need for prefunding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional medigap policies. State medical associations should be encouraged to seek appropriate legislation or regulation in their jurisdictions to: (a) provide an environment within their states that permit innovative LTC financing and delivery arrangements, and (b) assure that private LTC financing and delivery systems, once developed, provide the appropriate safeguards for the delivery of high quality care. The AMA continues to evaluate and support additional health system reform legislative initiatives that could increase states flexibility to design and implement long-term care delivery and financing programs. The AMA will also encourage and support the legislative and funding changes needed to enable more accurate and disaggregated collection and reporting of data on health care spending by type of service, so as to enable more informed decisions as to those social components of long-term care that should not be covered by public or private health care financing mechanisms.
Citation: BOT Rep.0, A-88; BOT Rep. X, I-88; Reaffirmed: CMS Rep. 3, A-94; BOT Rep. S,I-87; Reaffirmed: CMS Rep. 3-A-94; CMS Rep. 11, I-95; Reaffirmation A-04; Modified: CMS Rep. 6, I-05; Reaffirmed: BOT Rep. 32, A-09; Reaffirmation A-11; Reaffirmed: CMS Rep. 05, A-18; Appended: Res. 110, A-23.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 817
(I-23)

Introduced by: The American Academy of Pediatrics

Subject: Expanding AMA Payment Reform Work and Advocacy to Medicaid and other non-Medicare payment modules for Pediatric Healthcare and Specialty Populations

Referred to: Reference Committee J

Whereas, Current American Medical Association payment reform efforts are centered upon and prioritize Medicare payment reform; and

Whereas, Payment models that rely on shared savings, two-sided risk, and other financial incentives tied to reductions in total spending are based upon the premise that investment in delivery system reform can reduce unnecessary services and reduce health care expenditures while maintaining or improving quality of care and health outcomes within a short timeframe; and

Whereas, Children make up nearly one quarter of the US population but account for less than 10% of total health care expenditures[1]; and

Whereas, Children are excluded from most CMMI payment reform models which drive innovations in financing healthcare delivery; and

Whereas, Investments in child health reap long-term benefits beyond savings measured in the health care system, including in the child welfare, education, and juvenile justice systems, and such investments significantly lower long-term costs associated with prisons and adult chronic care[2], yet such return on investment is not recognized nor incentivized in short-term payment models; and

Whereas, Our AMA has decided to focus payment reform efforts on Medicare while holding off on efforts to improve and reform Medicaid payments as a strategic decision; and

Whereas, Our AMA's payment reform priorities may leave behind large populations of patients such as children or those in rural regions, and essential services such as mental and behavioral health, oral health, home care, and others; and

Whereas, Insufficient Medicaid fee-for-service and managed care payment rates can present tremendous barriers to care that result in a lack of patient access to care; and

Whereas, Medicaid is the largest insurer of patients across the country; therefore be it

RESOLVED, That our American Medical Association examine and report back on demonstration projects, carve outs, and adjustments for pediatric patients and services provided to pediatric patients within the payment reform arena (Directive to Take Action); and be it further

RESOLVED, That our AMA extend ongoing payment reform research, education, and advocacy to address the needs of specialties and patient populations not served by current CMMI models or other Medicare-focused payment reform efforts (Directive to Take Action); and be it further

RESOLVED, That our AMA support and work with medical specialty societies who are developing alternative payment models for pediatric healthcare (New HOD Policy); and be it further

RESOLVED, That our AMA consider improved Medicaid payment rates to be a priority given the critical impact these payment rates have on patient care and patient access to care. (New HOD Policy)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 9/27/23

REFERENCES

1. https://www.healthsystemtracker.org/chart-collection/health-expenditures-vary-across-population/#Proportion%20of%20individuals%20by%20health%20status,%202019
2. Flanagan P, Tigue PM, Perrin J. The Value Proposition for Pediatric Care. JAMA Pediatr. 2019;173(12):1125-1126. doi:10.1001/jamapediatrics.2019.3486

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 818
(I-23)

Introduced by: New England

Subject: Amendment to AMA Policy on Healthcare System Reform Proposals

Referred to: Reference Committee J

Whereas, almost 100 million Americans are either uninsured or underinsured, leading to worse health outcomes via inadequate access to necessary healthcare and adverse financial outcomes including bankruptcy[1-5]; and

Whereas, America's fragmented and disorganized health insurance system places too much power in the hands of for-profit insurers who are strongly incentivized to erect barriers to adequate healthcare, leading to the proliferation of "utilization management" methods like prior authorization that delay or deny necessary care and contribute to physician burnout[6-13]; and

Whereas, unified financing refers to any system of healthcare financing that provides uniform and universal access to healthcare coverage that is high quality and affordable, which can include single payer or multi-payer systems based on managed competition between private insurers[14-19], and does not necessarily mean "government run"; and

Whereas, our American Medical Association staunchly opposed the creation of Medicare, and was therefore not included in its creation, leading to the decades of poor reimbursement and other issues we have with it today; and

Whereas, ample evidence shows that single payer proposals, and other unified financing proposals based on other models, can be constructed that provide equitable, universal, and timely access to high quality care by simplifying our fragmented system and placing decision making power back in the hands of physicians and patients, but current oppositional AMA policy mandates opposition based on the label of single payer; therefore be it

RESOLVED, that our American Medical Association remove opposition to single-payer healthcare delivery systems from its policy, and instead evaluate all healthcare system reform proposals based on our stated principles as in AMA policy (Directive to Take Action); and be it further

RESOLVED, that our AMA support a national unified financing healthcare system that meets the principles of freedom of choice, freedom and sustainability of practice, and universal access to quality care for patients. (New HOD Policy)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 10/3/23

REFERENCES

1. https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey,
2. https://aspe.hhs.gov/sites/default/files/documents/15c1f9899b3f203887deba90e3005f5a/Uninsured-Q1-2022-Data-Point-HP-2022-23-08.pdf
3. http://medicine.tums.ac.ir/filegallery/2299016929/nezamoleslami%2031%20ordibehesht.pdf
4. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01150?casa_token=FqmCYfmNIN8AAAAA%3AdrF2Hngg6yz64J-23CgVo-JVMv-nMWWV_-GjcvzJu-2CEJCJNcSj-pXKsh4gJHUXjvgBOdgPYZM,
5. https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.13085
6. National Academies of Sciences, Engineering, and Medicine. 2019. Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being. Washington, DC: The National Academies Press. https://doi.org/10.17226/25521.
7. Colligan L, Sinsky C, Goeders L, Schmidt-Bowman M, Tutty M. Sources of physician satisfaction and dissatisfaction and review of administrative tasks in ambulatory practice: A qualitative analysis of physician and staff interviews. October 2016. Available at: ama-assn.org/go/psps.
(Taking Action Against Clinician Burnout.pdf, ps2-dartmouth-study-111016.pdf
8. https://www.ama-assn.org/press-center/press-releases/insurer-inaction-prior-authorization-reform-requires-federal-response
9. https://www.hhs.gov/guidance/document/medicare-parts-and-b-coverage-and-prior-authorization-0
10. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9745939/,
11. https://www.sciencedirect.com/science/article/pii/S0190962219307911?casa_token=71jQFkrVyQkAAAAA:VVE8KqX5qkKBcdP_A5I0yDAK9TCLL1WwTkk2d1o35WLTwznjzosQyf6sxe1qhOEn0rDEJeficw
12. https://onlinelibrary.wiley.com/doi/full/10.1002/acr.24062?casa_token=cTxc52YTlxoAAAAA%3Apkd-CjcQBHqF4neDDbvXdd51w8ziPP8txrTEP84jY31qDrHAfUgPkqOqB3AqKPQdcXNKtHI_juQ9Dg
13. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
14. https://www.chhs.ca.gov/wp-content/uploads/2022/04/Key-Design-Considerations_April-2022_Final-Report-for-Distribution.pdf
15. https://www.commonwealthfund.org/international-health-policy-center/countries
16. https://www.commonwealthfund.org/international-health-policy-center/countries/france
17. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4195085/
18. https://www.commonwealthfund.org/international-health-policy-center/countries/netherlands
19. https://www.commonwealthfund.org/international-health-policy-center/countries/germany

RELEVANT AMA POLICY

Evaluating Health System Reform Proposals H-165.888

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
H. True health reform is impossible without true tort reform.
2. Our AMA supports health care reform that meets the needs of all Americans including people with

injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.

3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.
Res. 118, I-91; Res. 102, I-92; BOT Rep. NN, I-92; BOT Rep. S, A-93; Reaffirmed: Res. 135, A-93; Reaffirmed: BOT Reps. 25 and 40, I-93; Reaffirmed in lieu of Res. 714, I-93, Res. 130, I-93, Res. 316, I-93, Sub. Res. 718, I-93; Reaffirmed: CMS Rep. 5, I-93; Res. 124, A-94; Reaffirmed by BOT Rep.1- I-94; CEJA Rep. 3, A-95; Reaffirmed: BOT Rep. 34, I-95; Reaffirmation A-00; Reaffirmation A-01; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep. 2, A-03; Reaffirmed and Modified: CMS Rep. 5, A-04; Reaffirmed with change in title: CEJA Rep. 2, A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation I-07; Reaffirmed in lieu of Res. 113, A-08; Reaffirmation A-09: Res. 101, A-09, Sub. Res. 110, A-09, Res. 123, A-09; Reaffirmed in lieu of Res. 120, A-12; Reaffirmation: A-17

Health System Reform Legislation H-165.838
1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy: a. Health insurance coverage for all Americans; b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps; c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials; d. Investments and incentives for quality improvement and prevention and wellness initiatives; e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care; f. Implementation of medical liability reforms to reduce the cost of defensive medicine; g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens
…
4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.

5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
…
12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.
…
Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 819
(I-23)

Introduced by: New York

Subject: Amend Virtual Credit Card Policy

Referred to: Reference Committee J

Whereas, our American Medical Association (AMA) has taken numerous steps to protect physicians from inappropriate delays and deductions from health insurance plans; and

Whereas, our AMA has previously adopted resolutions on Virtual Credit Card (VCC) Payments such as H-190.955, which calls for our AMA to educate its members about the use of virtual credit cards by third party payers, the costs of accepting virtual credit card payments from third party payers, the beneficiaries of the administrative fees paid by the physician practice inherent in accepting such payments, and the lower cost alternative of electronic funds transfer (EFT) via the Automated Clearing House; and

Whereas, an Interim Final Rule on EFT from the Centers for Medicare & Medicaid Services (CMS) allows payment by VCCs; and

Whereas, while CMS guidance states that health plans must comply with a physician's request to receive EFT instead of a VCC and that a physician cannot be forced to accept additional services with EFT, there is no specific prohibition on health plans or their vendors charging fees for EFTs; and

Whereas, Policy D-190.970[2] advocates that CMS resolve all complaints related to the non-compliant payment methods including opt-out VCCs, charging processing fees for electronic claims and other illegal EFT fees; therefore be it

RESOLVED, that our American Medical Association make no further statements regarding the "legality" of Virtual Credit Cards (VCCs) (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for legislation or regulation that would prohibit the use of VCCs for electronic health care payments (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate on behalf of physicians and plainly state that in no circumstance is it advisable or beneficial for medical practices to get paid by VCCs. (Directive to Take Action)

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

Received: 9/26/23

REFERENCES
Dyrda, Laura. "Private practice physicians drop to 26%." Becker's ASC Review, 20 April 2022, https://www.beckersasc.com/asc-transactions-and-valuation-issues/private-practice-physicians-drop-to-26.html

RELEVANT AMA POLICY

Virtual Credit Card Payments H-190.955
1. Our American Medical Association will educate its members about the use of virtual credit cards by third party payers, including the costs of accepting virtual credit card payments from third party payers, the beneficiaries of the administrative fees paid by the physician practice inherent in accepting such payments and the lower cost alternative of electronic funds transfer via the Automated Clearing House.
2. Our AMA will advocate for advance disclosure by third-party payers of transaction fees associated with virtual credit cards and any rebates or other incentives awarded to payers for utilizing virtual credit cards.
3. Our AMA supports transparency, fairness, and provider choice in payers' use of virtual credit card payments, including: advanced physician consent to acceptance of this form of payment; disclosure of transaction fees; clear information about how the provider can opt out of this payment method at any time; and prohibition of payer contracts requiring acceptance of virtual credit card payments for network inclusion.
Policy Timeline: Sub. Res. 704, A-15

Physician Credit Card Payments by Health Insurance Companies D-190.972
Our AMA will consider legislation on behalf of physicians that any credit card transaction/bank fees are paid by the insurer and not the health care provider.
Policy Timeline: Res. 225, I-14

CMS Administrative Requirements D-190.970
Our AMA will: (1) forcefully advocate that the Centers for Medicare and Medicaid Services (CMS) investigate all valid allegations of HIPAA Administrative simplification requirements thoroughly and offers transparency in its processes and decisions as required by the Administrative Procedure Act (APA); (2) forcefully advocate that the CMS resolve all complaints related to the non-compliant payment methods including opt-out virtual credit cards, charging processing fees for electronic claims and other illegal electronic funds transfer (EFT) fees; (3) communicate its strong disapproval of the failure by the CMS Office of Burden Reduction to effectively enforce the HIPAA administrative simplification requirements as required by the law and its failure to impose financial penalties for non-compliance by health plans; and (4) through legislation, regulation or other appropriate means, advocate for the prohibition of health insurers charging physicians and other providers to process claims and make payment.
Policy Timeline: Res. 229, I-21; Reaffirmation: A-22

Author's Priority Statement:
Virtual credit cards, debit, and other payment cards, as well as ERA/EFT fees, impose a significant hardship on the financial viability of independent physician practices. As a result, a recent survey shows that private practice physicians drop to 26%.

Physician practices have experienced consecutive years of decreasing reimbursement in the face of raging inflation and cannot afford to absorb the progressively increasing burden of such fees.

Private and independent medical practices are the most adaptable and provide a large proportion of low-cost care to the underinsured with high copays and high deductibles.

This is an urgent matter for physicians and patients whose access to treatment is limited or delayed by the loss of independent physician practices.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 820
(I-23)

Introduced by: Oregon

Subject: Affordability and Accessibility of Treatment of Overweight and Obesity

Referred to: Reference Committee J

Whereas, the prevalence of overweight and obesity in the United States is approaching 50% and together they account for at least $174 billion in annual excess health care spending; and

Whereas, obesity is a major contributor to serious chronic diseases such as diabetes, hypertension, and degenerative joint disease and thus a major contributor to poor health outcomes; and

Whereas, evidence-based medicine recognizes obesity as a chronic disease resulting from both genetic and environmental factors rather than from moral failure; and

Whereas, the best available evidence suggests that modifications of diet and exercise are unlikely to result in long-term benefits; and

Whereas, the treatment of obesity has progressed to the point where an individualized approach utilizing appropriate combinations of behavioral, surgical, and pharmacological interventions is considered the standard of care; and

Whereas, newer pharmacological treatments include medications that are very expensive and whose cost in the United States exceeds that in other countries; and

Whereas, currently, third-party payors, including Medicare, many state Medicaid programs, and many commercial insurance companies do not cover these and other established medications for weight loss consequently resulting in inequities in care and disparities in outcomes: therefore be it

RESOLVED, that our American Medical Association join in efforts to convince Congress to address the affordability and accessibility of prevention and evidence-based treatment of obesity across the United States as well as, urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to: 1. Revise their policies to ensure that prevention and evidence-based treatment of obesity is covered for patients who meet the appropriate medical criteria; and 2. Ensure that insurance policies in their states do not discriminate against potential evidence-based treatment of obese patients based on age, gender, race, ethnicity, socioeconomic status. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 10/10/23

REFERENCES

1. Christine Laine, Christina C. Wee. Overweight and Obesity: Current Clinical Challenges. Ann Intern Med. [Epub 14 March 2023]. Doi:10.7326/M23-0628.
2. Khrysta Baig, Stacie B. Dusetzina, David D. Kim, Ashley A. Leech. Medicare Part D Coverage of Antiobesity Medications – Challenges and Uncertainty Ahead. N Engl J Med 388;11. March 16, 2023
3. Obesity Clinical Guidance. https://www.aafp.org/family-physician/patient-care/clinical-recommendations/clinical-guidance-obesity.html. AAFP: Clinical Guidance: Obesity and Healthy Lifestyle: Clinical Guidance and Practice Resources. Date accessed: March 15, 2023. Date published: February 28, 2023.
4. About Overweight and Obesity. https://www.cdc.gov/obesity/about-obesity/index.html. Centers for Disease Control and Prevention. Date accessed: March 15, 2023. Date published: February 24, 2023.
5. Müller, T.D., Blüher, M., Tschöp, M.H. et al. Anti-obesity drug discovery: advances and challenges. Nat Rev Drug Discov 21, 201–223 (2022). https://doi.org/10.1038/s41573-021-00337-8.
6. Foster, D., Sanchez-Collins, S., & Cheskin, L. J. (2017). Multidisciplinary Team-Based Obesity Treatment in Patients With Diabetes: Current Practices and the State of the Science. Diabetes spectrum : a publication of the American Diabetes Association, 30(4), 244–249. https://doi.org/10.2337/ds17-0045.
7. Anti-obesity medications are set to skyrocket this year. But how will we afford them? https://www.usatoday.com/story/news/health/2023/02/19/anti-obesity-medications-cost/11069886002/. USA Today. Date accessed: March 15, 2023. Date published: February 20, 2023.

RELEVANT AMA POLICY

Addressing Adult and Pediatric Obesity D-440.954

1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.
2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).
3. Our AMA will work with interested national medical specialty societies and state medical associations to increase public insurance coverage of and payment for the full spectrum of evidence-based adult and pediatric obesity treatment.
4. Our AMA will: (a) work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment; and (b) work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.
5. Our AMA will leverage existing channels within AMA that could advance the following priorities:
· Promotion of awareness amongst practicing physicians and trainees that obesity is a treatable chronic disease along with evidence-based treatment options.
· Advocacy efforts at the state and federal level to impact the disease obesity.
· Health disparities, stigma and bias affecting people with obesity.
· Lack of insurance coverage for evidence-based treatments including intensive lifestyle intervention, anti-obesity pharmacotherapy and bariatric and metabolic surgery.
· Increasing obesity rates in children, adolescents and adults.
· Drivers of obesity including lack of healthful food choices, over-exposure to obesogenic foods and food marketing practices.
6. Our AMA will conduct a landscape assessment that includes national level obesity prevention and treatment initiatives, and medical education at all levels of training to identify gaps and opportunities where AMA could demonstrate increased impact.
7. Our AMA will convene an expert advisory panel once, and again if needed, to counsel AMA on how best to leverage its voice, influence and current resources to address the priorities listed in item 5. Above.

Reference Committee K

Report(s) of the Board of Trustees

02 Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies
05 AMA Public Health Strategy: The Mental Health Crisis
14 Funding for Physicians to Provide Safe Storage Devices to Patients with Unsecured Firearms in the Home

Report(s) of the Council on Science and Public Health

01 Drug Shortages: 2023 Update
02 Precision Medicine and Health Equity
03 HPV-Associated Cancer Prevention
04 Supporting and Funding Sobering Centers
05 Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room
06 Marketing Guardrails for the "Over-Medicalization" of Cannabis Use
07 Efficacy of Requirements for Metal Detection/Weapons Interdiction Systems in Health Care Facilities

Resolutions

901 Silicosis from Work with Engineered Stone
902 Post Market Research Trials
903 Supporting Emergency Anti-Seizure Interventions
904 Universal Return-to-Play Protocols
905 Support for Research on the Relationship Between Estrogen and Migraine
906 Online Content Promoting LGBTQ+ Inclusive Safe Sex Practices
909 High Risk HPV Subtypes in Minoritized Populations
910 Sickle Cell Disease Workforce
913 Public Health Impacts of Industrialized Farms
914 Adverse Childhood Experiences
915 Social Media Impact on Youth Mental Health
916 Elimination of Buprenorphine Dose Limits
917* Advocating for Education and Action Regarding the Health Hazards of PFAS Chemicals
918* Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals
919* Lithium Battery Safety
920* Antipsychotic Medication Use for Hospice Patients
921* Addressing Disparities and Lack of Research for Endometriosis
922* Prescription Drug Shortages and Pharmacy Inventories

***Not yet reviewed for consideration by the Resolution Committee**

REPORT 02 OF THE BOARD OF TRUSTEES (I-23)
Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies
(Reference Committee K)

EXECUTIVE SUMMARY

INTRODUCTION. At the 2022 Interim Meeting of the American Medical Association (AMA) House of Delegates, Resolution 901-I-22, "Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies" was referred. This resolution called on the AMA to: (1) oppose the use of forced or coercive labor practices for incarcerated populations, (2) support that any labor performed by incarcerated individuals or other captive populations should include adequate workplace safety and fairness standards similar to those outside of carceral institutions and (3) support their reintegration into the workforce after incarceration.

DISCUSSION. Our nation incarcerates more than 1.2 million people in state and federal prisons, and two out of three of these incarcerated people are also workers. Reports note that individuals who are incarcerated are required to work or face additional punishment such as solitary confinement, denial of opportunities to reduce their sentence, and loss of family visitation. U.S. law explicitly excludes workers who are incarcerated from the most universally recognized workplace protections. Workers who are incarcerated are not covered by minimum wage laws or overtime protection, are not afforded the right to unionize, and are denied workplace safety guarantees. A majority of incarcerated workers surveyed say that they received no formal job training, and many also say they worry about their safety while working. Incarcerated workers with minimal experience or training are often assigned hazardous work in unsafe conditions and without standard protective gear, leading to preventable injuries and deaths.

Further, at least 30 states explicitly include incarcerated workers as a labor resource in their emergency operations plans for disasters and emergencies. Incarcerated workers were especially vulnerable to exploitation during the COVID-19 pandemic. Workers in at least 40 states were forced to produce masks, and other personal protective equipment during early pandemic lockdowns as COVID-19 tore through prisons, even as they often lacked access to these protective tools themselves.

This report discusses the impact of excluding individuals who are incarcerated from health and safety protections, the types of labor performed by individuals who are incarcerated, benefits and harms of incarcerated labor, and examines the incentives behind incarcerated labor. The report also provides a historical look at the root of incarcerated labor.

CONCLUSION. Individuals who are incarcerated face various inequities while performing labor in correctional facilities. The recommendations address these inequities and provide actions that can be taken by the AMA, by Congress, state legislatures, and correctional facilities to ensure that individuals who are incarcerated are provided appropriate rights and protections during labor.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 02-I-23

Subject: Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies (Resolution 901-I-22)

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

Referred to: Reference Committee K

INTRODUCTION

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

BACKGROUND

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

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

HISTORY BEHIND INCARCERATED LABOR

Incarcerated labor has a long history in the United States and is rooted in racial oppression. The origins of incarcerated labor programs can be traced to the end of the Civil War and the passage of the 13th Amendment of the Constitution in 1865.[4] The 13th Amendment outlawed slavery and involuntary servitude, "except as a punishment for crime whereof the party shall have been duly convicted.[5]" What followed was a rise in practices designed to incarcerate and exploit Black people

and recently freed enslaved people.[6] One such practice was convict leasing. The system of convict leasing allowed correctional facilities to hire out or "lease" individuals who are incarcerated as laborers to private parties, such as railways, mines, or plantations.[6] Individuals who are incarcerated were not paid in this arrangement.[7]

The Convict Leasing System in the North and South

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

In the South, conditions for people who were incarcerated were just as brutal, with workers who were incarcerated forced to labor for up to 17 hours each day, building factories, laying railroads, and mining coal.[8,9] Under the convict leasing system, private employers could bid on and "lease" individuals who are incarcerated for days, months, or years to work on plantations and at coal mines, turpentine farms, sawmills, phosphate pits, railways, and brickyards.[10] These private employers had unregulated control over unpaid, predominantly Black workers and subjected them to brutal punishments such as whipping and branding and, in many cases, worked people who were incarcerated to death.[11] For example, in Mississippi, not a single leased convict lived long enough to serve a 10-year sentence.[11]

Black Codes

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

Shift From Convict Leasing System to Chain Gangs

By the 1890s, 35 states succumbed to rising union pressure to scale back incarcerated labor programs to reduce competition in the labor market. The result of this concession was the implementation of the "state-use system," in which the state became the only lawful purchaser of incarcerated labor and goods.[16] When Congress established the first federal correctional facilities in 1891, a similar system was adopted in which people who were incarcerated could be forced to work and produce certain commodities, provided that these workers were employed exclusively in the manufacture of such supplies for the government.[17] As state corrections systems expanded, the number of state-sponsored incarcerated labor programs expanded as well. Work crews, commonly known as chain gangs, were first established in the 1890s in Georgia and spread throughout the South as states began to phase out the convict lease system.[18] These chain gangs consisted of

individuals who are incarcerated, the vast majority of whom were Black men, who were forced to engage in unpaid labor in brutal conditions outside of the correctional facility, such as road construction, ditch digging, rock breaking, highway maintenance, and farming, under the supervision of correctional officers armed with shotguns and whips.[1,18] Chain gangs became more prevalent in the early 20th century as states gradually abolished the convict leasing system. By 1923 every state except for Rhode Island had used chain gangs to build and repair roads.[1,18]

Establishment of Work-Release Programs and Restitution Centers

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

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

In the 1970s, Congress and individual states increasingly allowed private entities and state governments to benefit from incarcerated labor.[1,12] For example, in 1972, Minnesota established America's first "restitution centers" in which low-level offenders were "paroled" out of jail only to be sent to a lower-security confinement facility where they were required to secure employment to pay off any victim restitution which they owed, or otherwise participate in community service.[22] Similar to work release programs, these restitution centers proved incredibly cost-effective and, in the years that immediately followed, were rapidly adopted by other states.[23]

"War on Drugs" to Present Day

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

available.[29] In the absence of formal statutes that regulate incarcerated labor, individuals who are incarcerated who refuse work also face threats from guards that they will be placed in solitary confinement, transferred to dangerous housing units, or lose some of their good-time credits.[30]

WORKPLACE SAFETY FOR INDIVIDUALS WHO ARE INCARCERATED

Occupational Health and Safety Administration (OSHA)

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

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

OSHA's Applicability to Individuals who are Incarcerated

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

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

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

Accreditation and Standards for Correctional Facilities

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

PRESENT DAY LOOK AT INCARCERATED LABOR

Types of Incarcerated Work

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

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

workers to provide a variety of services, such as data entry, repairing state-owned vehicles, and washing laundry for public hospitals and universities.[1]

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

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

Residential Reentry Centers (RRC)

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

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

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

Benefits of Incarcerated Labor

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

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

Harms of Incarcerated Labor

Despite some of the advantages of using incarcerated labor, there are also many drawbacks. One of the main concerns is that incarcerated labor may be exploitative.[1,58] Individuals who are incarcerated are often paid low wages and do not have the same protections as other workers. For example, individuals who are incarcerated are only paid $0.23–$1.15 per hour, and portions of these wages are often garnished to cover court fees or other incarceration-related expenses.[68] In comparison, the federal minimum wage is currently $7.25 per hour, and many states impose higher minimum-wage requirements.[69] Using incarcerated labor may also perpetuate the cycle of poverty

and incarceration.[1,58] Individuals who are incarcerated who work for low wages may struggle to support themselves and their families after they are released from correctional facilities, leading them to turn to crime again.[1] Forced labor can also displace educational benefits like GED programs, college programs, and skills training. Further, the use of incarcerated labor can also lead to human rights abuses. In some cases, individuals who are incarcerated have been forced to work in dangerous or unhealthy conditions, without proper safety equipment or training.[1]

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

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

Race and Gender Discrimination Play a Role in Job Assignments

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

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

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

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

SHOULD OSHA COVER INDIVIDUALS WHO ARE INCARCERATED?

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

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

This expansion in coverage could be achieved in part through administrative action as OSHA could issue new federal directives and interpretations that cover housework and make clear the

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

EXISTING AMA POLICY

AMA policy D-430.992 "Reducing the Burden of Incarceration on Public Health" support efforts to reduce the negative health impacts of incarceration, through implementation and incentivization of adequate funding and resources towards indigent defense systems; implementation of practices that promote access to stable employment and laws that ensure employment non-discrimination for workers with previous non-felony criminal records; and housing support for formerly incarcerated people, including programs that facilitate access to immediate housing after release from carceral settings. This policy also calls on the AMA to partner with public health organizations and other interested parties to urge Congress, the Department of Justice, the Department of Health and Human Services, and state officials and agencies to minimize the negative health effects of incarceration by supporting programs that facilitate employment at a living wage, and safe, affordable housing opportunities for formerly incarcerated individuals, as well as research into alternatives to incarceration.

CONCLUSION

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

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

accountability for the health and safety of those they incarcerate, affirming the inherent dignity, value, and humanity of workers who are incarcerated.

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

RECOMMENDATIONS

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

1. Our AMA acknowledges that systemic racism is a root of incarcerated labor policies and practices.
2. Our AMA supports:
   (a) Efforts to ensure that all work done by individuals who are incarcerated in correctional facilities is fully voluntary.
   (b) Eliminating policies that require forced labor or impose adverse consequences on incarcerated workers who are unable to carry out their assigned jobs due to illness, injury, disability, or other physical or mental limitations.
   (c) Eliminating policies that negatively impact good time, other reductions of sentence, parole eligibility, or otherwise extend a person's incarceration for refusal to work when they are unable to carry out their assigned jobs due to illness, injury, disability, or other physical or mental limitations.
   (d) The authority of correctional health care professionals to determine when an individual who is incarcerated is unable to carry out assigned work duties.
3. Our AMA encourages:
   (a) Congress and state legislatures to clarify the meaning of "employee" to explicitly include incarcerated workers within that definition to ensure they are afforded the same workplace health and safety protections as other workers.
   (b) Congress to enact protections for incarcerated workers considering their vulnerabilities as a captive labor force, including anti-retaliation protections for workers who are incarcerated who report unsafe working conditions to relevant authorities.
   (c) Congress to amend the Occupational Safety and Health Act to include correctional institutions operated by state and local governments as employers under the law.
   (d) The U.S. Department of Labor to issue a regulation granting the Occupational Safety and Health Administration jurisdiction over the labor conditions of all workers incarcerated in federal, state, and local correctional facilities.
4. Our AMA encourages:

(a) Comprehensive safety training that includes mandatory safety standards, injury and illness prevention, job-specific training on identified hazards, and proper use of personal protective equipment and safety equipment for incarcerated workers.
(b) That safety training is delivered by competent professionals who treat incarcerated workers with respect for their dignity and rights.
(c) That all incarcerated workers receive adequate personal protective equipment and safety equipment to minimize risks and exposure to hazards that cause workplace injuries and illnesses.
(d) Correctional facilities to ensure that complaints regarding unsafe conditions and abusive staff treatment are processed and addressed by correctional administrators in a timely fashion.

5. Our AMA acknowledges that investing in valuable work and education programs designed to enhance incarcerated individuals' prospects of securing employment and becoming self-sufficient upon release is essential for successful integration into society.
6. Our AMA strongly supports programs for individuals who are incarcerated that provides opportunities for advancement, certifications of completed training, certifications of work performance achievements, and employment-based recommendation letters from supervisors.

Fiscal Note: Minimal - less than $1,000

REFERENCES

[1] ACLU and The University of Chicago Law School. *Captive Labor Exploitation of Incarcerated Workers*. 2022. Available at https://www.aclu.org/news/human-rights/captive-labor-exploitation-of-incarcerated-workers.
[2] Katie Nixdorf & Kaitlyn Wang. *More than 20 States Are Using Prison Labor to Make Hand Sanitizer and Masks While the Coronavirus Spreads Through the Prison System*. Business Insider. Accessed July 20, 2021. Available at https://www.businessinsider.com/coronavirus-prison-labor-hand-sanitizer-masks-2020-4.
[3] Rachel Ellis. *Prison Labor in a Pandemic*, 19 Contexts: Soc. For the Pub. 66 (Dec. 14, 2020), https://journals.sagepub.com/doi/full/10.1177/1536504220977950.
[4] *United States Constitution*. Amend. XIII.
[5] United States Constitution. Amend. XIII. Sec. 1
[6] Michele Goodwin, *The Thirteenth Amendment: Modern Slavery, Capitalism, and Mass Incarceration*, 104 CORNELL L. REV. 899, 933–35, 945 (2019).
[7] Ashley Mott. *Fact Check: Southern States Used Convict Leasing to Force Black People into Unpaid Labor,* USA Today. Accessed July 20, 203. Available at https://www.usatoday.com/story/news/factcheck/2020/07/07/fact-check-convict-leasing-forced-black-people-into-unpaid-labor/5368307002/.
[8] Genevieve LeBaron. *Rethinking Prison Labor: Social Discipline and the State in Historical Perspective*, 15 J. of Lab. and Soc'y 327, 333 (2012).
[9] Christopher R. Adamson, *Punishment after Slavery: Southern State Penal Systems*, 1865-1890, 30 Soc. Probs. 555, 556 (1983).
[10] Andrea Armstrong, *Slavery Revisited in Penal Plantation Labor*, 35 Seattle U. L. Rev. 835, 877 (2012).
[11] Genevieve LeBaron, *Rethinking Prison Labor: Social Discipline and the State in Historical Perspective*, 15 J. of Lab. and Soc'y 327, 337 (2012).
[12] Heather Ann Thompson, *Rethinking Working-Class Struggle through the Lens of the Carceral State: Toward a Labor History of Inmates and Guards*, 8 Lab.: Stud. in Working-Class Hist. 15, 16 (2011)
[13] Wafa Junaid. *Forced Prison Labor: Punishment for a Crime?* 4 Northwestern U. L. Rev. 116, 1099-1136 (2022).
[14] Erin Blakemore, *Jim Crow Laws Created 'Slavery by Another Name*,' NAT'L GEOGRAPHIC (Feb. 5, 2020), https://www.nationalgeographic.com/history/ article/jim-crow-laws-created-slavery-another-name

[15] Nadra Kareem Nittle, *How the Black Codes Limited African American Progress After the Civil War*, HISTORY (Jan. 28, 2021), https://www.history.com/news/black-codes-reconstruction-slavery
[16] Stephen P. *Garvey, Freeing Prisoners' Labor*, 50 Stan. L. Rev. 339, 361-62 (1998).
[17] Three Prisons Act, ch. 529, sec. 2, 26 Stat. 839 (1891).
[18] Alex Lichtenstein, *Twice the Work of Free Labor: The Political Economy of Convict Labor in the New South* (New York: Verso, 1996).
[19] Stanley E. Grupp, Work Release in the United States, 54 J. Crim. L. and Criminology 267 (1963).
[20] Act of May 14, 1930, ch. 274 § 3, 46 Stat. 325 (1930).
[21] Ashurst-Sumners Act (Shipment in Interstate Commerce of Convict Made Goods), Pub. L. No. 74-215, 49 Stat. 494 (1935) (codified at 18 U.S.C. § 1761).
[22] Joe Hudson, *Contemporary Origins of Restorative Justice Programming: The Minnesota Restitution Center*, 76 Fed. Prob.: J. of Corr. Phil. and Prac. (2012), https://www.uscourts.gov/sites/default/files/76_2_9_0.pdf.
[23] Nevada in 1979 (1979 Nev. Stat. 743), California in 1984 (Cal. Penal Code § 6220), Mississippi in 1978 (Miss. Code § 99-37-19).
[24] Nkechi Taifa, *Race, Mass Incarceration, and the Disastrous War on Drugs*, Brennan Ctr. FOR JUST. (May 10, 2021), https://www.brennancenter.org/our-work/analysis-opinion/race-mass-incarceration-and-disastrous-war-drugs
[25] Betsy Pearl, *Ending the War on Drugs: By the Numbers*, Ctr. For Am. Progress, Accessed July 20, 2023), Available at https://www.americanprogress.org/issues/criminal-justice/reports/2018/06/27/452819/ ending-war-drugs-numbers/
[26] Lauren-Brooke Eisen, *COVID-19 Highlights the Need for Prison Labor Reform*, Brennan Ctr. For Just. (Apr. 17, 2020), https://www.brennancenter.org/our-work/analysis-opinion/covid-19-highlights-need-prison-labor-reform
[27] Christopher Zoukis, *Prison Work Programs: 'Cost-Effective Labor Pool' or 'Slave Labor of Yesterday'*?, PRISON LEGAL NEWS (Jan. 8, 2019), https://www.prisonlegalnews.org/news/2019/jan/8/ prison-work-programs-cost-effective-labor-pool-or-slave-labor-yesterday/
[28] Wendy Sawyer, *How Much Do Incarcerated People Earn in Each State*? Prison Policy Initiative (Apr. 10, 2017), https://www.prisonpolicy.org/blog/2017/04/10/wages/
[29] Tenn. Code Ann. § 41-2-123 (2021), S.D. Codified Laws § 24-11-28 (2021), Mont. Code Ann. § 53-30-132 (2021), Iowa Code § 904.701 (2021)
[30] The Indicator from Planet Money, *The Uncounted Workforce*, NPR, Accessed July 21, 2023. Available at https://www.npr.org/2020/06/29/884989263/the-uncounted-workforce.
[31] Palmer v. Amazon.com, Inc., -- F.Supp.3d ---, at *5 (E.D.N.Y. 2020)
[32] OSH Act of 1970. Sec 3
[33] Whirlpool Corp., 445 U.S at 13.
[34] Michael C. Duff et al., OSHA's Next 50 Years: Legislating a Private Right of Action to Empower Workers, Center For Progressive Reform 5 (July 2020), https://cpr assets.s3.amazonaws.com/documents/OSHA-Private-Right-of-Action-FINAL.pdf
[35] 29 U.S.C. § 652(5); see also Standard Interpretation: Federal OSHA has no jurisdiction over State, municipal, or volunteer fire departmetnts, Occupational Safety And Health Administration (Oct. 11, 2006), https://www.osha.gov/laws-regs/standardinterpretations/2006-10-11-1.
[36] 29 U.S.C. §§ 655
[37] 29 U.S.C. §§ 653(6)
[38] Kenneth Dau-Schmidt, *The Problem of "Misclassification," or How to Define Who is an "Employee" under Protective Legislation in the Information Age*, The Cambridge Handbook Of U.S. Labor Law For The Twenty-First Century 141-42.
[39] Occupational Safety and Health Administration, Dir. FAP 01-00-002 (1995), available at https://www.osha.gov/enforcement/directives/fap-01-00-002.
[40] Office of the Inspector General, *A Review of Federal Prison Industries' Electronic-Waste Recycling Program*, Dep. Of Justice (Oct. 2010), https://oig.justice.gov/reports/BOP/o1010_appendix.pdf
[41] *Bagola v. Kindt,* 131 F.3d 632, 635 (7th Cir. 1997)

[42] Memorandum from Jaylynn K. Fortney, Regional Solicitor to Davis Layne, RA/OSHA Re: Application of the Occupation Safety and Health Act to prisoners (May 15, 1996), https://www.osha.gov/laws-regs/standardinterpretations/1996-07-18.
[43] Occupational Safety and Health Administration, Standard Interpretation No. 1975 (Dec. 16, 1992), https://www.osha.gov/laws-regs/standardinterpretations/1992-12-16-1.
[44] OSHA, State Plans, https://www.osha.gov/stateplans/faq.
[45] OSHA, Establishment Search, https://www.osha.gov/pls/imis/establishment.search?p_logger=1&establishment=correctional&State=all&officetype=all&Office=all&sitezip=&p_case=all&p_violations_exist=all&startmonth=12&startday=09&startyear=2015&endmonth=12&endday=09&endyear=2020.
[46] Ariz. Gen. Stat. 23-615(B)(6), Wyoming Gen. Stat. 27-3-105(b)(xii)
[47] National Commission on Correctional Health Care. *About us*. Accessed February 17, 2023. Available at https://www.ncchc.org/about-us/.
[48] National Commission on Correctional Health Care. About us. Accessed February 17, 2023. Available at https://www.ncchc.org/about-us/.
[49] New York State Assembly, Public Hearing on Healthcare in New York Correctional Facilities (Oct. 30, 2017 at 74-75, Available at https://nystateassembly.granicus.com/DocumentViewer.php?file=nystateassembly_ddfafda03ce23b2164f9bfb016dd70f1.pdf&view=1.
[50]American Correctional Association, *History of Standards & Accreditation*, Accessed July 21, 2023. Available at https://www.aca.org/ACA_Prod_IMIS/ACA_Member/Standards___Accreditation/About_Us.
[51]American Correctional Association, *What are ACA's Standards*, Accessed July 21, 2023. Available at http://www.aca.org/ACA_Prod_IMIS/ACA_Member/Standards_and_Accreditation/StandardsInfo_Home.aspx?New_ContentCollectionOrganizerCommon=1#New_ContentCollectionOrganizerCommon.
[52] Letter from Elizabeth Warren to James A. Gondles Jr., Executive Director of ACA (May 31, 2019) at 2 available at https://www.warren.senate.gov/imo/media/doc/2019-05-30%20Letter%20to%20ACA%20on%20Accreditation.pdf.
[53] U.S. Dep't of Justice, Bureau of Justice Statistics, *Survey of Prison Inmates*, United States, 2016. Inter-university Consortium for Political and Social Research, (Sept. 2021), https://doi.org/10.3886/ICPSR37692.v4.
[54] Wis. Stat. § 303.0,1 Va. Code Ann. § 53.1-59
[55] Arkansas Division of Correction, Annual Report Fiscal Year 2020 (2021) at 21, https://doc.arkansas.gov/wp-content/uploads/2021/03/Division-of-Correction-FY20-Annual-Report-Board-of-Corrections-Approved-March-19-2021.pdf.
[56] U.S. Dep't of Justice, Office of Justice Programs, Bureau of Justice Assistance (BJS), *Prison Industry Enhancement Certification Program Brief* (2018). https://www.bja.gov/Publications/PIECPProgram-Brief_2018.pdf.
[57] Alfred C. Aman Jr. and Carol J. Greenhouse, *Prison Privatization and Inmate Labor in the Global Economy: Reframing the Debate Over Private Prisons*, 42 Fordham Urb. L. J. 355, 388 (2014).
[58] National Correctional Industries Association, Prison Industry Enhancement Certification Program (PIECP) Certification & Cost Accounting Center Listing: Statistics for the Quarter Ending September 30, 2021 (Baltimore, MD: NCIA, March 2022), https://www.nationalcia.org/_files/ugd/569cf7_0ab8d011f21b4127b18d15c77d104f45.pdf.
[59] Federal Bureau of Prisons. *Reentry Centers.* Accessed September 1, 2023. Available at https://www.bop.gov/about/facilities/residential_reentry_management_centers.jsp.
[60] Roxanne Daniel and Wendy Sawyer. Prison Policy Institute. *What you should know about halfway houses*. September 3, 2020. Available at https://www.prisonpolicy.org/blog/2020/09/03/halfway/.
[61] Minnesota Legislature. *Chapter 2920, Adult Community-Based Residential Correctional Facilities.* Available at https://www.revisor.mn.gov/rules/2920/.
[62] Lauren Sukin. The Century Foundation. *When Jail Is The Better Option: The Failure of Halfway Houses.* Accessed September 1, 2023. Available at https://tcf.org/content/commentary/when-jail-is-the-better-option-the-failure-of-halfway-houses/?agreed=1.

[63] Bureau of Justice Statistics. *Census of State and Federal Adult Correctional Facilities*. Accessed September 1, 2023. Available at https://bjs.ojp.gov/data-collection/census-state-and-federal-adult-correctional-facilities-ccf-formerly-csfacf.
[64] U.S. Department of Justice Office of the Inspector General. *Reentry Centers.* Accessed September 1, 2023. Available at https://oig.justice.gov/reports?keys=reentry+center&field_publication_date_value=&field_publication_date_value_1=&field_doj_component_target_id=All&field_report_type_target_id=All&field_location_country_code=All&sort_by=field_publication_date_value&sort_order=DESC&items_per_page=10.
[65] Prison Insight. *Do Companies Use Prison Labor? An Investigation into the Pros and Cons.* Accessed July 22,2023. Available at https://prisoninsight.com/do-companies-use-prison-labor-an-investigation-into-the-pros-and-cons/.
[66] The Prison Industry: Mapping Private Sector Players, Worth Rises (May 2020), https://worthrises.org/theprisonindustry2020 [https://perma.cc/VYU7-4ZB7
[67] Precise total sales for 2021 was $2,089,022,613. Telephone interview with Wil Heslop, interim executive director, National Correctional Industries Association (NCIA), Nov. 18, 2021,
[68] Katherine Stevenson, Profiting Off of Prison Labor, Bus. Rev. Berkeley (July 6, 2020), https://businessreview.berkeley.edu/profiting-off-of-prison-labor/
[69] Minimum Wage, U.S. DEP'T OF LAB., https://www.dol.gov/agencies/whd/minimum-wage.
[70] Spencer Woodman, *California Blames Incarcerated Workers for Unsafe Conditions and Amputations*, The Intercept (Dec. 28, 2016).
[71] Rebecca Woolington, Forest Grove Fire Crews Rescue Prison Inmate Injured in Tillamook State Forest, Oregonian (Oct. 12, 2011), https://www.oregonlive.com/forest-grove/2011/10/forest_grove_fire_crews_rescue.html. AP, Tree-Cutting Error May Have Caused Firefighter Death During Ferguson Fire, Associated Press (May 7, 2019), https://ktla.com/news/local-news/tree-cutting-error-mayhave-caused-firefighter-death-during-ferguson-fire-report/; Buckley v. Barbour County, Ala., 624 F. Supp. 2d (M.D. Ala. 2008); Buckley v. Barbour County, Ala., 2010 WL 1993066 (M.D. Ala. 2010).
[72] Dies Following Injury in Malibu Blaze, L.A. Times (Feb. 26, 2016), https://www.latimes.com/local/lanow/la-me-ln-female-inmatefirefighter-death-20160226-story.html; Abby Vesoulis, Inmates Fighting California Wildfires Are More Likely to Get Hurt, Records Show, Time (Nov. 16, 2018), https://time.com/5457637/inmate-firefighters-injuries-death/.
[73] Brian Edwards and Jacob Margolis, California's Firefighters Keep Getting Injured While Training, And Some Have Died, LAist (Sept. 21, 2021), https://laist.com/news/climate-environment/california-cal-firefighters-training-injuries-deaths.
[74] Michael Gibson-Light, The Prison as a Market: How Penal Labor Systems Reproduce Inequality, PhD diss., University of Arizona at 128 (2019) (on file with authors).
[75] Courtney A. Crittenden, Barbara A. Koons-Witt and Robert J. Kaminski, Being Assigned Work in Prison: Do Gender and Race Matter?, Feminist Criminology 1-23 (Sept. 2016), https://www.researchgate.net/publication/308104933_Being_Assigned_Work_in_Prison_Do_Gender_and_Race_Matter.
[76] Michael Gibson-Light, The Prison as a Market: How Penal Labor Systems Reproduce Inequality, PhD diss., University of Arizona at 123 (2019) (on file with authors).
[77] Leah Wang. Prison Policy Institute. *Unsupportive environments and limited policies: Pregnancy, postpartum, and birth during incarceration*. Accessed September 1, 2023. Available at https://www.prisonpolicy.org/blog/2021/08/19/pregnancy_studies/.
[78] Alirezaei S, Latifnejad Roudsari R. The Needs of Incarcerated Pregnant Women: A Systematic Review of Literature. Int J Community Based Nurs Midwifery. 2022 Jan;10(1):2-17. doi: 10.30476/IJCBNM.2021.89508.1613. PMID: 35005037; PMCID: PMC8724729.
[79] Aleks Kajstura and Wendy Sawyer. Prison Policy Institute. *Women's Mass Incarceration: The Whole Pie 2023.* Accessed September 1, 2023. Available at https://www.prisonpolicy.org/reports/pie2023women.html.
[80] The College of Labor and Employment Lawyers. *The Health and Safety of Incarcerated Workers: OSHA's Applicability in the Prison Context*. Accessed Jul 21, 2023. Available at https://www.theclel.org/wp-content/uploads/2021/10/ABA_OSHA_and_Incarcerated_Workers.pdf.
[81] Brunson v. Nichols, 975 F.3d 275, 276 (5th Cir. 2017)

[82] Colleen Dougherty, The Cruel and Unusual Irony of Prisoner Work Related Injuries in the United States, 10 U. Pa. J. Of Bus. And Employ. L. 483, 502-507 (2008).
[83] Alexander Volokh, The Modest Effect of Minneci v.Pollard on Inmate Litigants, 46 Akron L. Rev. 287, 299-311.
[84] Katherine Torres, Congress Pushes OSHA Coverage for Public Workers, EHS TODAY (May 24, 2007), https://www.ehstoday.com/standards/osha/article/21910936/congress-pushes-osha-coverage-for-public-workers; Protecting America's Workers Act: Modernizing OSHA Penalties: Hearing before the Subcomm. on Workforce Protections of the H. Comm. on Education and Labor, 111th Cong. 111-51 (2010)
[85] Prison Policy Initiative, Mass Incarceration: The Whole Pie 2022, by Wendy Sawyer and Peter Wagner (Mar. 14, 2022), https://www.prisonpolicy.org/reports/pie2022.html.
[86] U.S. Dep't of Justice, Bureau of Justice Statistics, Census of State and Federal Adult Correctional Facilities, 2019 – Statistical Tables (Nov. 2021) at 13, https://bjs.ojp.gov/content/pub/pdf/csfacf19st.pdf.
[87] Harvard International Review. The Shadow Workforce: Prison Labor and International Trade. Accessed July 21, 2023. Available at https://hir.harvard.edu/the-shadow-workforce-prison-labor-and-international-trade/.

REPORT 05 OF THE BOARD OF TRUSTEES (I-23)
AMA Public Health Strategy: The Mental Health Crisis
(Reference Committee K)

EXECUTIVE SUMMARY

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

This report provides detailed information about the AMA's many efforts to address the mental health crisis. The AMA's work includes numerous activities in the following areas:

1. Adoption of multiple related AMA policies;
2. Advocacy for legislative changes, resources and research (e.g., state, national, congressional, legislative, regulatory and private sector);
3. Formation of collaborative partnerships with Federation members and other medical and professional societies;
4. Development of educational and interactive tools and resources;
5. Publication of reports and research;
6. AMA-sponsored conferences, as well as AMA presence at external conferences; and
7. Creation of a recognition program for health systems to promote physician wellness.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 05-I-23

Subject: AMA Public Health Strategy: The Mental Health Crisis

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

Referred to: Reference Committee K

INTRODUCTION

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

BACKGROUND:

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

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

AMA POLICY

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

The AMA developed principles on mental health. They state:

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

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

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

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

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

a. reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public;
b. improving public awareness of effective treatment for mental illness;
c. ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents;
d. tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity;
e. facilitating entry into treatment by first-line contacts recognizing mental illness and making proper referrals and/or to addressing problems effectively themselves; and

f. reducing financial barriers to treatment (Policy H-345.981, "Access to Mental Health Services").

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

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

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

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

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

Moreover, the AMA supports:

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

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

The AMA will also: (1) utilize their existing communications channels to educate the physician community and the public on the new 9-8-8 National Suicide Prevention Lifeline program; (2) work with the Federation and other stakeholders to advocate for adequate federal and state funding for the 9-8-8 system including the development of model legislation; and (3) collaborate with the Substance Abuse and Mental Health Services Administration, the 9-8-8 partner community and

other interested stakeholders to strengthen suicide prevention and mental health crisis services that prioritize education and outreach to those populations at highest risk for suicide attempts, suicide completions and self-injurious behavior (Policy D-345.974, "Awareness Campaign for 988 National Suicide Prevention Lifeline").

The AMA also supports (1) mental health and faith community partnerships that foster improved education and understanding regarding culturally competent, medically accepted and scientifically proven methods of care for psychiatric and substance use disorders; (2) better understanding on the part of mental health providers of the role of faith in mental health and addiction recovery for some individuals; and (3) efforts of mental health providers to create respectful, collaborative relationships with local religious leaders to improve access to scientifically sound mental health services (Policy H-345.971, "Faith and Mental Health").

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

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

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

Moreover, the AMA:

a. recognizes youth and young adult suicide as a serious health concern in the U.S.;
b. encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter youth or young adult patients, addressing effective suicide prevention including screening tools, methods to identify risk factors and acuity, safety planning and appropriate follow-up care including treatment and linkages to appropriate counseling resources;
c. supports collaboration with federal agencies, relevant state and specialty medical societies, schools, public health agencies, community organizations and other stakeholders to enhance awareness of the increase in youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources and improve care for youth and young adults at risk of suicide;

d. encourages efforts to provide youth and young adults better and more equitable access to treatment and care for depression, substance use disorder and other disorders that contribute to suicide risk;
e. encourages continued research to better understand suicide risk and effective prevention efforts in youth and young adults, especially in higher risk sub-populations such as Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations and among youth and young adults with disabilities;
f. supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in youth and young adults;
g. supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools;
h. will publicly call attention to the escalating crisis in children and adolescent mental health in this country in the wake of the COVID-19 pandemic;
i. will advocate at the state and national level for policies to prioritize children's mental, emotional and behavioral health;
j. will advocate for a comprehensive system of care including prevention, management and crisis care to address mental and behavioral health needs for infants, children and adolescents; and
k. will advocate for a comprehensive approach to the child and adolescent mental and behavioral health crisis when such initiatives and opportunities are consistent with AMA policy (Policy H-60.937, "Youth and Young Adult Suicide in the United States").

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

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

Further, our AMA is in support of adequate attention and funds being directed towards culturally and linguistically competent mental health direct services for the diverse, multi-ethnic communities at greatest risk, and encourages greater cultural and linguistic-competent outreach to ethnic communities including partnerships with ethnic community organizations, health care advocates and respected media outlets (Policy H-345.974, "Culturally, Linguistically Competent Mental Health Care and Outreach for At-Risk Communities").

The AMA also supports: (1) strategies that emphasize de-stigmatization and enable timely and affordable access to mental health services for undergraduate and graduate students in order to improve the provision of care and increase its use by those in need; (2) colleges and universities in emphasizing to undergraduate and graduate students and parents the importance, availability and efficacy of mental health resources; and (3) collaborations of university mental health specialists and local public or private practices and/or health centers in order to provide a larger pool of resources, such that any student is able to access care in a timely and affordable manner (Policy H-345.970, "Improving Mental Health Services for Undergraduate and Graduate Students").

Our AMA advocates for:

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

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

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

DISCUSSION

Federal and State Advocacy

Congressional

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

In 2022, the AMA worked with pertinent national medical specialty societies to advocate for a number of measures to be included in a comprehensive mental health package as part of the

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

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

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

<u>Legislative</u>

In the past two years, the AMA Advocacy Resource Center (ARC) has advocated for and supported new laws in multiple states including Arizona, Delaware, Georgia, Illinois, Kentucky, Mississippi and Virginia. These laws help protect physicians who seek care for mental health

conditions. Provisions range from providing "safe-haven" protections that shield records from disclosure to provisions requiring state licensing boards to remove stigmatizing questions from medical licensure applications.[12]

Regulatory

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

Private Sector

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

National

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

Mental Health and Substance Use Disorder Parity

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

Statements

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

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

Acceleration of Behavioral Health Integration (BHI)

In 2020, the AMA partnered with the RAND Corporation to publish a study in the Annals of Internal Medicine summarizing the key motivators, facilitators and barriers to BHI from those physician practices with firsthand experience.[16] That same year, the AMA partnered with seven other Federation members, the American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Osteopathic Association and American Psychiatric Association, to create the BHI Collaborative which equips physicians and their practices with the necessary knowledge to overcome obstacles and sustain integrated care for their patients and families.[17] Additional research was conducted when the AMA partnered with Manatt Health to publish a report on the opportunities and limitations of incorporating technology to advance and enhance BHI adoption.[18]

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

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

The BHI Collaborative has yielded numerous free and open-source resources for physicians and others interested in integrated care. This includes the BHI Compendium, which provides an implementation framework to help guide practices through key steps and considerations of delivering effective and sustainable integrated behavioral health care, as well as educational and training opportunities through its Overcoming Obstacles series. This series provides actionable insights and real-world best practices including operational topics such as billing and coding, condition-specific topics such as suicidal ideation and patient population-specific topics such as pediatric and obstetric/gynecological care.[20,21] The Collaborative also offers, through its pilot BHI Immersion Program, free enhanced technical assistance on how to effectively implement BHI to a diverse cohort of 24 health care organizations from across the country.[22]

The AMA also developed six additional strategic behavioral health guides that provide physician practices with practical strategies, actionable steps and evidence-based resources on specific areas

of integrated care. Topics included guidance on pharmacological treatment, substance use/misuse disorder screening and treatment, suicide prevention and key CPT billing codes.[23]

Other Tools and Resources

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

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

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

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

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

Additionally, the JAMA Network includes JAMA Psychiatry- an international peer-reviewed journal for clinicians, scholars and researchers in the fields of psychiatry, mental health, behavioral science and allied fields. It has a journal impact factor of 25.8- among the highest of all psychiatry journals. The journal aims to inform and stimulate discussion around the nature, causes, treatment

and public health importance of mental illness, as well as promote equity and justice for those impacted.[35] Readers can also listen to podcasts where editors and authors discuss articles published in the journal.[36]

Reports, Conferences and Programs

Council on Medical Education Reports

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

AMA Substance Use and Pain Task Force Reports

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

AMA-Sponsored Conferences

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

Joy in Medicine™ Health System Recognition Program

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

Health Equity and Whole-Person Care

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

CONCLUSION

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

RECOMMENDATIONS

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

Fiscal Note: Minimal

REFERENCES

1. Lopes L, Kirzinger A, Sparks G, Stokes M, Brodie M. KFF/CNN Mental Health In America Survey. Kaiser Family Foundation; 2022. Accessed July 31, 2023. https://www.kff.org/other/report/kff-cnn-mental-health-in-america-survey/
2. Panchal N, Saunders H, Rudowitz R, Cox C. The Implications of COVID-19 for Mental Health and Substance Use. Kaiser Family Foundation; 2023. Accessed July 31, 2023. https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/
3. Kaiser Family Foundation. Adults Reporting Symptoms of Anxiety or Depressive Disorder During COVID-19 Pandemic. Kaiser Family Foundation; 2023. Accessed July 31, 2023. https://www.kff.org/other/state-indicator/adults-reporting-symptoms-of-anxiety-or-depressive-disorder-during-covid-19-pandemic/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
4. Murphy V. Youth Mental Health. HHS; 2021:1-53. Accessed July 31, 2023. https://www.hhs.gov/surgeongeneral/priorities/youth-mental-health/index.html
5. Goldner EM, Lusted A, Roerecke M, Rehm J, Fischer B. Prevalence of Axis-1 psychiatric (with focus on depression and anxiety) disorder and symptomatology among non-medical prescription opioid users in substance use treatment: systematic review and meta-analyses. Addictive Behaviors. 2014;39(3):520-531. https://pubmed.ncbi.nlm.nih.gov/24333033/
6. Substance Abuse and Mental Health Services Administration. 2021 National Survey of Drug Use and Health (NSDUH) Releases. SAMHSA. Published 2021. Accessed September 5, 2023. https://www.samhsa.gov/data/release/2021-national-survey-drug-use-and-health-nsduh-releases#annual-national-report
7. Crapanzano KA, Hammarlund R, Ahmad B, Hunsinger N, Kullar R. The Association Between Perceived Stigma and Substance Use Disorder Treatment Outcomes: A Review. Substance Abuse and Rehabilitation. 2019;10:1-12. https://pubmed.ncbi.nlm.nih.gov/30643480/
8. Adams JM, Volkow ND. Ethical Imperatives to Overcome Stigma Against People With Substance Use Disorders. AMA Journal of Ethics. 2020;22(8):702-708. https://journalofethics.ama-assn.org/article/ethical-imperatives-overcome-stigma-against-people-substance-use-disorders/2020-08
9. Weddle M, Kokotailo PK. Confidentiality and Consent in Adolescent Substance Abuse: An Update. AMA Journal of Ethics. 2005;7(3):239-243. https://journalofethics.ama-assn.org/article/confidentiality-and-consent-adolescent-substance-abuse-update/2005-03
10. McKenna J. Doctors' Burden: Medscape Physician Suicide Report 2023. Medscape; 3023. Accessed July 31, 2023. https://www.medscape.com/slideshow/2023-physician-suicide-report-6016243
11. Dyrbye LN, West CP, Sinsky CA, Goeders LE, Satele DV, Shanafelt TD. Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. Mayo Clinic Proceedings. 2017;92(10):1486-1493. https://www.mayoclinicproceedings.org/article/S0025-6196(17)30522-0/fulltext
12. AMA Advocacy Resource Center. ARC Issue Brief: Confidential Care to Support Physician Health and Wellness. American Medical Association; 2023:1-14. Accessed August 1, 2023. https://www.ama-assn.org/system/files/issue-brief-physician-health-wellness.pdf
13. Resneck J. Lack of access to evidence-based mental health care poses grave threat. American Medical Association. Published November 3, 2022. Accessed August 2, 2023. https://www.ama-assn.org/about/leadership/lack-access-evidence-based-mental-health-care-poses-grave-threat

14. Resneck J. Burnout is a Health Crisis for Doctors—and Patients. American Medical Association. Published March 9, 2023. Accessed August 2, 2023. https://www.ama-assn.org/about/leadership/burnout-health-crisis-doctors-and-patients
15. Robeznieks A. Key credentialing change has big upside for physician well-being. American Medical Association. Published February 28, 2023. Accessed August 1, 2023. https://www.ama-assn.org/practice-management/physician-health/key-credentialing-change-has-big-upside-physician-well-being
16. Malâtre-Lansac A, Engel CC, Xenakis L, et al. Factors Influencing Physician Practices' Adoption of Behavioral Health Integration in the United States. Annals of Internal Medicine. 2020;173(2):92-99. https://www.acpjournals.org/doi/10.7326/m20-0132
17. American Medical Association. Physician collaboration to accelerate behavioral health integration. American Medical Association. Published October 13, 2020. Accessed August 1, 2023. https://www.ama-assn.org/press-center/press-releases/physician-collaboration-accelerate-behavioral-health-integration
18. American Medical Association, Manatt Health. Accelerating and Enhancing Behavioral Health Integration Through Digitally Enabled Care: Opportunities and Challenges.; 2022. Accessed August 1, 2023. https://www.ama-assn.org/system/files/bhi-return-on-health-report.pdf
19. Harmon G, Giaimo J, Hoskins I, et al. Combating A Crisis By Integrating Mental Health Services And Primary Care. Health Affairs Forefront. Published online July 8, 2022. Accessed August 1, 2023. https://www.healthaffairs.org/content/forefront/combating-crisis-integrating-mental-health-services-and-primary-care
20. BHI Collaborative. Behavioral Health Integration Compendium. American Medical Association; 2021:1-32. Accessed August 1, 2023. https://www.ama-assn.org/system/files/bhi-compendium.pdf
21. American Medical Association. Behavioral health integration (BHI) Overcoming Obstacles Recorded Webinars. American Medical Association. Published June 27, 2023. Accessed August 1, 2023. https://www.ama-assn.org/delivering-care/public-health/behavioral-health-integration-bhi-overcoming-obstacles-recorded
22. American Medical Association. July 8, 2022 Advocacy Update. American Medical Association. Published July 8, 2022. Accessed August 1, 2023. https://www.ama-assn.org/health-care-advocacy/advocacy-update/july-8-2022-advocacy-update-other-news
23. American Medical Association. Strategic Behavioral Health Guides for Patient Care. American Medical Association. Published July 17, 2023. Accessed August 1, 2023. https://www.ama-assn.org/delivering-care/public-health/strategic-behavioral-health-guides-patient-care
24. American Medical Association. AMA STEPS Forward Innovation Academy. American Medical Association. Published May 25, 2023. Accessed August 1, 2023. https://www.ama-assn.org/practice-management/ama-steps-forward/ama-steps-forward-innovation-academy
25. Brooks E. Preventing Physician Suicide. AMA STEPS Forward. American Medical Association; 2016. Accessed August 1, 2023. https://edhub.ama-assn.org/steps-forward/module/2702599
26. Westphal R. Stress First Aid for Health Care Professionals. AMA STEPS Forward. American Medical Association; 2021. Accessed August 1, 2023. https://edhub.ama-assn.org/steps-forward/module/2779767
27. Shapiro J. Peer Support Programs for Physicians. AMA STEPS Forward. American Medical Association; 2020. Accessed August 1, 2023. https://edhub.ama-assn.org/steps-forward/module/2767766

28. Harding E. Project ECHO® (Extension for Community Healthcare Outcomes). AMA STEPS Forward. American Medical Association; 2016. Accessed August 1, 2023. https://edhub.ama-assn.org/steps-forward/module/2702692
29. American Medical Association. Organizational Well-Being Assessment. Published 2023. Accessed August 3, 2023. https://www.ama-assn.org/system/files/org-well-being-assessment.pdf
30. American Medical Association. Debunking Regulatory Myths. American Medical Association. Published 2023. Accessed August 3, 2023. https://www.ama-assn.org/practice-management/sustainability/debunking-regulatory-myths
31. American Medical Association. Licensing and Credentialing Bodies' Inquiry of Physician Mental Health. American Medical Association. Published December 28, 2022. Accessed August 3, 2023. https://www.ama-assn.org/practice-management/sustainability/licensing-and-credentialing-bodies-inquiry-physician-mental
32. Anderson E, Knight A, Rea M. Educator Well-Being in Academic Medicine. American Medical Association Accessed August 3, 2023. https://cloud.e.ama-assn.org/22-1665-Educator-Well-being-book
33. AMA Ed Hub™. Mental Health and Anxiety Disorders. AMA Ed Hub™. Published 2022. Accessed August 3, 2023. https://edhub.ama-assn.org/course/305
34. AMA Ed Hub™. Psychiatry and Behavioral Health. Psychiatry and Behavioral Health. Published 2023. Accessed August 3, 2023. https://edhub.ama-assn.org/collections/5871/psychiatry-and-behavioral-health
35. JAMA Psychiatry. JAMA Psychiatry Author Interviews. JAMA Network. Published 2023. Accessed August 3, 2023. https://jamanetwork.com/journals/jamapsychiatry/pages/jama-psychiatry-author-interviews
36. JAMA Psychiatry. For Authors: JAMA Psychiatry. JAMA Network. Published July 2023. Accessed August 3, 2023. https://jamanetwork.com/journals/jamapsychiatry/pages/for-authors
37. American Medical Association. Report 1 of the Council on Medical Education (I-16): Access to Confidential Health Services for Medical Students and Physicians. American Medical Association; 2016. Accessed August 3, 2023. https://councilreports.ama-assn.org/councilreports/downloadreport?uri=/councilreports/i16_cme_report_1.pdf
38. American Medical Association. Report 6 of the Council on Medical Education (A-18): Mental Health Disclosure on Physician Licensing Applications. American Medical Association; 2018. Accessed August 3, 2023. https://councilreports.ama-assn.org/councilreports/downloadreport?uri=/councilreports/a18_cme_06.pdf
39. American Medical Association. Report 6 of the Council on Medical Education (A-19): Study of Medical Student, Resident, and Physician Suicide. American Medical Association; 2019. Accessed August 3, 2023. https://councilreports.ama-assn.org/councilreports/downloadreport?uri=/councilreports/a19_cme_6.pdf
40. AMA Substance Use and Pain Care Task Force. AMA Substance Use and Pain Care Task Force. End the Epidemic. Published 2023. Accessed August 23, 2023. https://end-overdose-epidemic.org/task-force-recommendations/opioid-task-force/
41. American Medical Association. AMA Substance Use and Pain Care Task Force Recommendations. American Medical Association. Published 2022. Accessed August 23, 2023. https://www.ama-assn.org/delivering-care/overdose-epidemic/ama-substance-use-and-pain-care-task-force-recommendations
42. AMA Substance Use and Pain Care Task Force. Opioid Task Force 2019 Progress Report. American Medical Association; 2019. https://end-overdose-epidemic.org/wp-content/uploads/2020/05/AMA-Opioid-Task-Force-2019-Progress-Report-web-1.pdf

43. AMA Substance Use and Pain Care Task Force. 2022 Overdose Epidemic Report. American Medical Association; 2022. Accessed August 23, 2023. https://www.ama-assn.org/system/files/ama-overdose-epidemic-report.pdf
44. American Medical Association. American Conference on Physician Health 2023. American Medical Association. Published 2023. Accessed August 1, 2023. https://www.ama-assn.org/about/events/american-conference-physician-health-2023
45. American Medical Association. International Conference on Physician Health 2022. American Medical Association. Published 2022. Accessed August 1, 2023. https://www.ama-assn.org/about/events/international-conference-physician-health
46. American Medical Association. Joy in Medicine™ Health System Recognition Program. American Medical Association. Published May 3, 2023. Accessed August 3, 2023. https://www.ama-assn.org/practice-management/physician-health/joy-medicine-health-system-recognition-program
47. American Psychiatric Association. The 2022 Mental Health Services Conference. Published online 2022. Accessed August 1, 2023. https://www.psychiatry.org/getattachment/a45bf950-d466-40e8-9eb5-e7baeb5cfc9e/mhsc_program_2022.pdf

REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-I-23

Subject: Funding for Physicians to Provide Safe Storage Devices to Patients with Unsecured Firearms in the Home (Res. 923-I-22)

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

Referred to: Reference Committee K

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

BACKGROUND

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

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

In 2018, the AMA created a continuing medical education module to help physicians learn how to identify and counsel patients at high-risk of firearm injury and death. Case studies focus on patients at risk of suicide, victims of domestic violence, and parents of children with firearms in the home. The module is available for free on the AMA Ed Hub and is being revised to include updated data and scenarios. The updated module will be released in 2023. The module includes a handout that physicians can share with their patients on different firearm storage options, including average cost. The AMA is also developing an online tool that will be released in 2023 that contains state-specific information about legal topics related to firearms, such as laws governing physicians counseling patients about firearms, physicians' obligations to disclose confidential patient information, safe storage and child access prevention laws, laws governing the possession and transfer of firearms, and extreme risk protection orders.

Most recently, Policy D-145.992, "Further Action to Respond to the Gun Violence Public Health Crisis," adopted by the HOD at A-22, directed the AMA to "establish a task force to focus on gun violence prevention including gun-involved suicide." Following an initial meeting in February of 2023 of those Federation members who have been most highly engaged on the issue of firearm injury prevention, the AMA Board of Trustees approved the charter and membership of the task force in June of 2023. In addition, the AMA is actively participating in a coalition led by the American Academy of Pediatrics focused on maintaining and increasing federal funding for firearm violence research and looks forward to additional information regarding participating in a new coalition, the Healthcare Coalition for Firearm Injury Prevention, formed by the American College of Surgeons.

DISCUSSION

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

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

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

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

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

While safe storage of firearms in the home can lower the risk of injuries and deaths from firearms, and the AMA remains committed to educating physicians and counseling patients about existing initiatives and programs, the Board is concerned that there may be research gaps in existing knowledge about the most effective approaches to providing safe storage devices to patients. The Board also agrees with the issues and questions raised during Reference Committee and HOD floor debate about Resolution 923, specifically about complexity, cost, and concerns that, while well intentioned, the implementation could lead to increased physician liability in providing any such devices. The Board notes that while the AMA supports educating patients about the importance of children wearing bicycle helmets and using car seats, as a general practice, pediatricians do not provide bike helmets and car seats but rather ask parents if they have and use helmets and car seats. Moreover, in light of the availability of safe storage devices from existing police department, hospital, and local government programs that already are providing free gun locks, the Board concludes that the AMA should encourage existing and new programs to work with physician offices, hospitals, and other health care entities to provide safe storage devices at low or no cost.

Recommendation

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

> RESOLVED, That our AMA encourage health departments and local governments to partner with police departments, fire departments, and other public safety entities and organizations to make firearm safe storage devices accessible (available at low or no cost) in communities in

collaboration with schools, hospitals, clinics, physician offices, and through other interested stakeholders. (New HOD Policy)

Fiscal Note: Less than $500.

REPORT 1 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-23)
Drug Shortages: 2023 Update
(Reference Committee K)

EXECUTIVE SUMMARY

INTRODUCTION. American Medical Association (AMA) Policy H-100.956, "National Drug Shortages," directs the Council on Science and Public Health (CSAPH) to evaluate the drug shortage issue and report back at least annually to the House of Delegates (HOD) on progress made in addressing drug shortages in the United States. This report provides an update on continuing trends in national drug shortages and ongoing efforts to further evaluate and address this critical public health issue. Additionally, at the I-22 HOD meeting, Resolution 935, "Government Manufacturing of Generic Drugs to Address Market Failures," was referred to CSAPH for study. Due to the implications of government manufacturing efforts on alleviating drug shortages, the two reports have been combined.

DISCUSSION. Drug shortages remain an ongoing and complex public health concern in the United States and the AMA continues to monitor the situation and act when appropriate. Overall, new drug shortages are the highest they have been in a decade, including many instances of high-profile drug shortages with visibility in the public sphere, including amphetamine/dextroamphetamine salts (trade name Adderall or Mydayis), semaglutide (trade name Ozempic, Wegovy, or Rybelsus), and platinum-based chemotherapeutics such as cisplatin and carboplatin, amongst many others. This report examines three root causes for drug shortages: the evolving prescribing landscape, modern challenges of advertising and patient demand, and the economics and fragility of generic drug manufacturing. Potential solutions, including non-profit or government-owned generic drug manufacturing are explored.

CONCLUSION. Drug shortages continue to be a complicated, multi-factorial issue which directly impacts patient care in the United States. The AMA's policy regarding drug shortages is timely and comprehensive, and updates are proposed to align with the topics discussed. New policy is also recommended for non-profit and public generic drug manufacturing.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-I-23

Subject: Drug Shortages: 2023 Update

Presented by: David J. Welsh, MD, MBA, Chair

Referred to: Reference Committee K

American Medical Association (AMA) Policy H-100.956, "National Drug Shortages," directs the Council on Science and Public Health (CSAPH) to evaluate the drug shortage issue and report back at least annually to the House of Delegates (HOD) on progress made in addressing drug shortages in the United States. This report provides an update on continuing trends in national drug shortages and ongoing efforts to further evaluate and address this critical public health issue.

Additionally, Resolution 935-I-22, "Government Manufacturing of Generic Drugs to Address Market Failures", was referred to CSAPH for study. That resolution asked:

> that our American Medical Association support the formation of a non-profit government manufacturer of pharmaceuticals to produce small-market generic drugs.

Due to the implications of government manufacturing efforts on alleviating drug shortages, the two asks will be addressed in this report.

METHODS

English-language reports were selected from a PubMed and Google Scholar search from September 2020 to June 2023, using the text terms "drug shortages", "government drug manufacturing" and "non-profit drug manufacturing." Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of the U.S. Food and Drug Administration (FDA), National Academies of Sciences, Engineering, and Medicine (NASEM), U.S. Department of Health and Human Services (HHS), American Society of Health-System Pharmacists (ASHP), and Duke Margolis Center for Health Policy, and contemporary media reporting.

BACKGROUND

CSAPH has issued thirteen reports on drug shortages, with the most recent published at the November 2022 Interim meeting. The remainder of this report will provide an update on drug shortages since the 2022 report was developed, including specific comments on issues associated with government or non-profit manufacturing.

CURRENT TRENDS IN DRUG SHORTAGES

Drug shortages remain an ongoing and complex public health concern in the United States and the AMA continues to monitor the situation and act when appropriate. Overall, new drug shortages are the highest they have been in a decade, including many instances of high-profile drug shortages with visibility in the public sphere, including amphetamine/dextroamphetamine salts (trade name Adderall or Mydayis), semaglutide (trade name Ozempic, Wegovy, or Rybelsus), and platinum-based chemotherapeutics such as cisplatin and carboplatin, amongst many others.

The two primary data sources for information on drug shortages in the United States continue to be the Drug Shortage Program at the FDA and the Drug Shortage Resource Center maintained by ASHP in cooperation with the University of Utah Drug Information Service (see Box 1 for links to these resources). It should be noted that FDA resources also include guidance on drugs which have had their use dates extended while a known shortage is ongoing. Further, the ASHP shortages resources provides useful clinical mitigation strategies to minimize the impact of drug shortages, such as substitutions and alternative agents.

According to ASHP statistics (see Appendix 1), trends in drug shortages have gotten worse in the last year.[1] In the 2022 update of this report, the Council commented that while *new* drug shortages were decreasing year-after-year, the complexities of the supply chain were causing each individual shortage to last longer, which resulted in a net increase of shortages.[2] During the 2022 calendar year, however, there was a spike in new drug shortages, combined with the continuing problems of resolving ongoing shortages, resulting in the highest levels of drug shortages in the United States since 2014. For the first quarter of 2023, the five classes of drugs facing the largest number of shortages are: central nervous system therapies (52), antimicrobials (35), fluids/electrolytes (30), hormones (27), and chemotherapies (23).

In July 2023, ASHP conducted a survey of over 1000 of their members, with over 99 percent reporting challenges posed by drug shortages. Beyond the obvious disruptions to care, respondents also noted the increase in budget – both for purchasing alternative or scarce drugs and for the increasing cost of labor to manage the supply chain.[3] A link to their survey results has been included in Box 1 of this report. This highlights the disproportionate impact that drug shortages may have on smaller health facilities, such as solo practices or rural clinics, which may not have the staff or inventory to be able to rapidly adapt purchasing and procurement.

The Food and Drug Administration

The FDA continues to utilize a mobile app to provide up-to-date access to information about drugs in shortage as well as notifications about new and resolved drug shortages. This mobile app also gives physicians the ability to report a drug shortage. The FDA Drug Shortages webpage includes a current shortages list, a link to the mobile app, and additional information (Box 1).

The tenth annual report on drug shortages from the FDA to Congress published in early 2023 summarized the major actions the FDA took in calendar year 2022 related to drug shortages.[4] During the COVID-19 public health emergency, the FDA continued to closely monitor the medical product supply chain and as expected, the supply chain was impacted heavily, leading to supply disruptions or shortages of drug products in the United States. Appendix 2 includes a breakdown of the FDA's calendar year 2022 metrics, including the number of expedited reviews (204), expedited inspections (30), and prevented shortages (222). However, new challenges and complexities to shortages have emerged in the last year worth further evaluating for action.

CHALLENGES IN THE DRUG SUPPLY CHAIN

Drugs shortages are a multi-factorial problem, with seemingly small issues having large, cascading effects down the supply chain for years. In this year's survey of the drug shortages landscape, three key new challenges were identified: an evolving prescribing landscape, increased advertising for in-demand drugs, and the fragility of the drug manufacturing supply chain.

Challenge: An Evolving Prescribing Landscape

In our 2022 drug shortages report, the Council described the role of the Drug Enforcement Agency (DEA) and production quotas leading to drug shortages for medications such as opioids and mixed amphetamine salts (MAS). Since that report's publication, the shortage of MAS has continued and also received intense scrutiny from legislators and the media.[5,6] Used for the treatment of attention deficit hyperactivity disorder (ADHD), and colloquially referred to by its trade name Adderall, MAS has been classified as under shortage since August 2022.[7]

The root cause of MAS shortage is typically attributed to a surge in demand. Manufacturers are then unable to meet this new demand as supply has been capped due to their status as a Schedule II controlled substance under the Controlled Substances Act. Under this schedule, MAS are deemed to "have a high potential for abuse which may lead to severe psychological or physical dependence" and have significant restrictions on production, prescribing, and dispensing, including manufacturing quota allotments.[8]

Despite its status as a controlled substance, one study conducted in 2021, found that prescriptions for MAS increased by over 20 percent from 2019 to 2021 in patients aged 22-44. The increase was largely attributed to the expansion of telehealth services afforded during the COVID-19 pandemic, increasing access to these medications.[9] Prior to the 2020 COVID-19 public health emergency order, prescribing of MAS required an in-person visit and could not be performed via telehealth. Since the end of the public emergency order, the DEA has announced a temporary extension of prescribing policies until at least 2024.[10]

The DEA has not increased the aggregate production quota for amphetamine, indicating that "[a]ccording to DEA's data, manufacturers have not fully utilized the [aggregate production quota] for amphetamine in support of domestic manufacturing, reserve stocks, and export requirements for the past three calendar years 2020, 2021 and 2022."[11] In fact, in August 2023, the FDA and DEA issued a joint letter which called on manufacturers to increase production, stating "Based on DEA's internal analysis of inventory, manufacturing, and sales data submitted by manufacturers of amphetamine products, manufacturers only sold approximately 70 percent of their allotted quota for the year, and there were approximately 1 billion more doses that they could have produced but did not make or ship."[12] However, there were at least two manufacturers who have publicly indicated that they petitioned the DEA to have their amphetamine quota increased and it has contributed to their inability to meet demand or list their reason for shortage as "awaiting DEA quota review/approval".[7,13] Currently the market does not support incentivizing companies to meet their manufacturing allotment, even in cases of drug shortages, which can cause continued challenges.

Federal officials have raised concerns that expanded telehealth prescribing of MAS may lead to increased diversion and illicit use, although it is unclear what underlying data has been used to reach this conclusion.[14] While the appropriateness of telehealth in ADHD diagnosis and subsequent MAS prescriptions are beyond the scope of this report, it should be noted that studies suggest that

historically, ADHD has been under-diagnosed in vulnerable populations such as children of color and women.[15,16]

Challenge: Increased Advertising and PBM Formularies for In-Demand Drugs

Semaglutide, a glucagon-like peptide-1 (GLP-1) receptor agonist used to treat type 2 diabetes, exploded in popularity in 2021 after a formulation was FDA-approved for weight loss and long-term weight management.[17] Nine months later, it was listed as under shortage by the FDA due to increased demand.[18] Unlike many other drugs under shortage, semaglutide's increase in popularity can largely be attributed to a massive advertising presence, particularly through social media. For example, one report suggests that by November 2022, one hashtag (#Ozempic) was viewed over 273 million times on the social media platform TikTok.[19] By June 2023, merely seven months later, that number has increased to 1.2 billion views – all while the drug was actively experiencing shortage.[20] It should be noted, however, that in today's modern social media landscape, drugs can see a surge in public interest without direct advertising from the manufacturer, and instead may be driven by public discourse or celebrity influencers. Per AMA policy H-105.988, our AMA supports a ban on all direct-to-consumer pharmaceutical advertising.

Like MAS described above, it is outside the scope of this report to comment on the appropriateness of semaglutide advertising and prescriptions, including for formulations which have not been FDA-approved for weight loss. However, it can be generally said that when it comes to accessing drugs under shortage, stabilizing supply to current patients using a medication for the management of chronic disease should be prioritized over attracting new patients to compete for the same limited resource. In response, manufacturers, and some (but not all) telehealth prescribing platforms have halted advertising campaigns for semaglutide while the drug is in shortage.[21] It should be noted that approximately 47 percent of patients receiving insurance coverage for GLP-1 agonists did not receive coverage for a corresponding clinical visit, with direct-to-consumer telehealth platforms likely being the source for a portion of these prescriptions.[22] Additionally, some social media platforms have begun banning or suspending accounts for posting content related to GLP-1 agonists, however this change in policy appears to be ineffective and inconsistently enforced.[23]

An additional concern around GLP-1 agonist shortages is the role that pharmacy benefit managers' (PBMs) formularies play in accessing classes of medication. Under the 2023 National Preferred Formulary from a major PBM, two of the "preferred alternatives" for GLP-1 agonists are currently in shortage, while the two "excluded medications" are not.[24] If a medication is excluded from the formulary, it will not be reimbursed by insurance and patients are explicitly recommended by the PBM to "please ask your doctor to consider writing you a new prescription for one of the […] preferred alternatives," thus pushing patients towards a medication already in short supply and potentially leaving a patient without their medication for a chronic condition.

Challenge: The Fragility of the Drug Supply Chain

Platinum-based drugs such as cisplatin and carboplatin are first-line chemotherapies for many cancers, including lung cancer.[25] The National Cancer Institute estimates that approximately 20 percent of all cancer patients receive a platinum-based therapy during their treatment.[26] In February 2023, a cisplatin shortage was reported, followed by a carboplatin shortage in April 2023 which resulted in physicians having to ration life-saving treatments or deviate from clinical guidelines. Additionally, these shortages stifle medical innovation as they restrict access to clinical trials which either iterate on, or compare against, the standard of care.[27]

In response to this shortage, the FDA temporarily allowed the importation of a non-approved formulation of cisplatin from a Chinese manufacturer that does not have an English-language label and does not have the US National Drug Code, a linear barcode that allow for the product to be scanned and tracked.[28]

One of the key factors in the platin shortage is the economics of generic drug manufacturing. According to one study, the leading risk factor for a chemotherapy experiencing a shortage is the age of the drug.[29] This may seem counterintuitive – the longer a drug has been on the market, the better understanding we should have of expected demand, and have had more time to improve manufacturing yields. However, when considering the impact age has on profit margins, it begins to make more sense. Since cisplatin and carboplatin are available as generic medications, the profit incentives for their manufacturing dramatically decreases. Per the FDA's National Drug Code Directory, there are currently only 8 manufacturers of cisplatin and 6 for carboplatin.[30] The unit price of cisplatin and carboplatin are estimated to be $15 and $23 USD, respectively.[31]

Due to the limited number of manufacturers of generic drugs, any disruption to the marketplace can result in a multi-month-long shortage. In the case of platins, a single overseas cisplatin manufacturing site was shut down due to quality concerns revealed during an FDA inspection.[32] Shutting down this facility decreased the supply of cisplatin, resulting in a worldwide shortage, which then cascaded into a carboplatin shortage when there was a surge in demand from patients switching drugs.

In July 2023, a Pfizer plant in Rocky Mount, North Carolina, was struck by a tornado, destroying the facility.[33] The impact of this tragic event is still being fully evaluated and will likely be felt for years to come. It is estimated that 25 percent of all sterile injectables used by U.S. hospitals were manufactured at this single site and will likely result in shortages for over 64 formulations of 30 different drugs, including lidocaine, a drug that has been in shortage in some capacity since 2015.[34] The Food and Drug Administration estimates that this plant was the sole U.S. supplier for "less than 10" drugs, however additional details, such as what drugs and what formulations, are not available due to disclosure laws.[35] In a pre-emptive response to potential spikes in demand due to the fear of oncoming shortages, Pfizer transitioned many of their products to a strict allocation model rather than being readily available for purchase. In a letter to customers dated August 3rd, 2023, Pfizer additionally disclosed emergency ordering procedures for 12 medications.[36] A link to the Pfizer injectables product availability list, as well as additional resources for locating potential alternatives developed by the United States Pharmacopeia, have been included in Box 1.

However, the story of the Pfizer plant is unfortunately not an uncommon one. For example, in May 2022, a surge of COVID-19 infections led to the shutdown of a single Shanghai-based facility, resulting in a worldwide shortage of iodinated contrast agents.[37] In 2017, Hurricane Maria destroyed a facility producing sterile saline, resulting in a shortage.[38] The ongoing war in Ukraine also threatens the world's supply of helium gas, which is used for a wide variety of medical devices.[39]

POTENTIAL SOLUTIONS

As described above, drug shortages can be the result of a variety of factors, ranging from decades-long policy choices to severe weather. As such, proposed solutions for mitigating drug shortages primarily aim to make the drug supply chain more resilient and adaptable.

Solution: Increased Transparency

As outlined above with MAS and GLP-1 agonists, one of the persistent struggles with managing the drug supply chain is poor visibility into drug demand. In the case of MAS, a change in prescribing rules caused a surge of demand; in the case of GLP-1 agonists, a new off-label usage and subsequent marketing campaign caused prescriptions to spike. In both cases, shortages were primarily driven by supply not matching this newfound demand.

FDA leadership has been publicly discussing the role of the agency regarding drug shortages, including multiple calls for manufacturers to improve reporting of data.[40] Specifically, the FDA claims that less than half of all drug manufacturers are complying with reporting requirements that would provide the agency with information regarding the quantity of active pharmaceutical ingredients (API) and drugs being manufactured. They have also requested that the agency be granted additional authority to request manufacturers provide the FDA with information whenever they observe spikes in demand, so that the FDA can better predict when shortages may occur. This policy was originally proposed for inclusion in the Pandemic and All-Hazards Preparedness Act (PAHPA). PAHPA, which oversees HHS's emergency response activities, requires Congressional reauthorization every five years, and is considered "must-pass" legislation.[41] It is expected to be re-authorized in September 2023, which is after this report has been finalized, but before its presentation to the HOD at the Interim meeting. As of writing, PAHPA negotiations are still ongoing, and it is unclear if FDA's proposals regarding new drug shortage authorities will be included in the final legislative package. Other legislative measures are also being considered – for example, the House Energy & Commerce Committee chair released a request for information and subsequent discussion draft for legislation addressing root causes of drug shortages.[42] Additionally, the White House convened a new task force to develop proposals for improving drug shortages earlier this year, although a timeline has not been made public.[43]

Solution: Pre-Emptive Purchasing

In recent months, the strategy of pre-emptive purchasing, or stockpiling of critical drugs has been proposed. For example, in a recent publication from the Brookings Institute, they propose a "first-in, first-out" buffer inventory to be maintained at a national level by an entity such as HHS, which would hopefully prevent surges in demand from overcoming the supply.[44] Other proposals, such as one put forth by the Centers for Medicare & Medicaid Services, would incentivize hospital systems to maintain their own buffer supply.[45]

However, both models have flaws which may require further study or thoughtful guardrails. For a model in which a national entity maintains the buffer supply, there may be lessons to be learned from the pain points observed around sourcing and purchasing personal protective equipment (PPE) during the COVID-19 pandemic. Specifically, when the federal government entered the market to purchase PPE for the Strategic National Stockpile (SNS), they often found themselves bidding against the same state entities that would likely be the final recipient of those supplies if routed through the SNS.[46] If the model were to price state or local purchasers out of the market and instead force them to go through the national buffer supply, this risks again placing the health of the drug supply chain with a single source of failure, which could increase the national vulnerability to political disputes, mismanagement, or a catastrophic weather event.

Similarly, if the task were given to more local entities, such as at the hospital-level, the concern would be around which hospitals would have the ability to obtain and manage a buffer supply. For example, the initial purchasing of a buffer supply and the subsequent administrative and storage

could be too costly for all but the most profitable hospitals, and would put smaller clinics, particularly in rural settings, at a significant disadvantage.

Solution: Government, Public, or Non-Profit Manufacturing of Drugs

One of the suggested solutions for protecting the pharmaceutical supply chain against market-driven shortages, such as those seen with platins, is to have the manufacturing of essential medicines not be driven by profit incentives. Publicly owned production of medications in capitalist societies is not a new concept and has been implemented in countries such as Sweden (Apotek Produktion & Laboratorier), Poland (Polfa Tarchomin), India (Rajasthan Drugs and Pharmaceuticals), and Thailand (Government Pharmaceutical Organization). Even within the United States, California's Department of Health Services developed, conducted clinical trials, and has been manufacturing intravenous botulism immune globulin (BIG-IV, or BabyBIG), the only treatment for infant botulism, since 1988.[47] Under state law, California may only charge what is required to cover operational costs of BIG-IV manufacturing.

In 2020, California also passed legislation requiring the government, through the CalRx initiative, to partner or contract with manufacturers for the explicit purpose of creating competition and lowering prices in the generic drugs market. In March 2023, CalRx announced it would begin manufacturing insulin, with generic naloxone as a potential future target.[48] While the CalRx program was conceived to introduce competition into markets where limited manufacturers have led to generic drug prices that are arbitrarily and egregiously high, a similar approach could conceivably be taken to enter markets where low profit margins drive manufacturers away.

While not state-owned, a non-profit manufacturing model to address drug shortages has already been developed in the United States. In 2018, a group of philanthropic organizations partnered with medical systems (such as Advocate Aurora Health, Kaiser Permanente, and the U.S. Department of Veterans Affairs) to develop CivicaRx, a non-profit manufacturer of generic drugs.[49] The first drug made by CivicaRx was vancomycin, an antibiotic that has been under shortage for the past 8 years.[50] CivicaRx currently uses a supply partner model but has also initiated construction of domestic manufacturing facilities in Virgina.[51] Of note, some members of CivicaRx are religious affiliated hospitals, which may impact their future willingness to manufacture generic contraceptives, abortifacients, or other drugs opposed by their religious doctrine.

Programs such as CalRx and CivicaRx are too new to fully appreciate the impact that they will have on alleviating drug shortages, but the appeal is clear. Beyond simply the market and supply stabilization by removing profit incentives, having manufacturing facilities located within the United States and responsive to government agencies alleviates many of the major hurdles described by the FDA when combating drug shortages: low visibility into the supply chain, the difficulties of overseas inspections, and poor communication regarding changes in demand. It should also be noted that while the majority of public or non-profit manufacturing is centered on generic drugs, a similar approach could be used for other vulnerable links in the supply chain, such as APIs or fill-finish services.

ONGOING AMA ACTIVITIES

AMA staff continue to remain engaged in drug shortage activities. Staff are involved in a multi-stakeholder effort to remain current on policies, drug shortage and supply chain issues, and to develop group recommendations on the topics, many of which are already contained within AMA policy. The effort includes our AMA, the ASHP, the American Hospital Association (AHA), the

United States Pharmacopeia, the American Society of Anesthesiologists, and the American Society of Clinical Oncology.

Additional advocacy efforts were made since the publication of the 2022 drug shortages update, including communication with the DEA regarding shortages driven by telehealth prescriptions, and how enforcement activities should focus on outlier practices rather than blanket restrictions on telehealth care.[52]

CONCLUSION

In conclusion, drug shortages continue to be a persistent and worsening crisis that endangers patients. In this annual update on drug shortages, three case studies were discussed, investigating the roles of the DEA and production quotas, advertising, PBMs and formularies, and the fragility of the generic drug market particularly when it relies on a small number of overseas manufacturers. Finally, the topic of non-profit or state-owned manufacturing was investigated as a potential tool in alleviating drug shortages. The AMA's policy regarding drug shortages is timely and comprehensive, and updates are proposed to align with the topics discussed. New policy is also recommended for non-profit and public generic drug manufacturing.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution I-22-935, and that the remainder of the report be filed:

A. That Policy H-100.956, "National Drug Shortages," be amended by addition to read as follows:

1. Our AMA considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients.
2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.
4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.
5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations and pharmacy benefit managers on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.
6. Our AMA urges continued analysis of the root causes of drug shortages that includes consideration of federal actions, evaluation of manufacturer, Group Purchasing

Organization (GPO), pharmacy benefit managers, and distributor practices, contracting practices by market participants on competition, access to drugs, pricing, and analysis of economic drivers, and supports efforts by the Federal Trade Commission to oversee and regulate such forces.

7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market or caused to stop production due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.
8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.
9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.
10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.
11. Our AMA urges the FDA to require manufacturers and distributors to provide greater transparency regarding the pharmaceutical product supply chain, including production locations of drugs, any unpredicted changes in product demand, and provide more detailed information regarding the causes and anticipated duration of drug shortages.
12. Our AMA supports the collection and standardization of pharmaceutical supply chain data in order to determine the data indicators to identify potential supply chain issues, such as drug shortages.
13. Our AMA encourages global implementation of guidelines related to pharmaceutical product supply chains, quality systems, and management of product lifecycles, as well as expansion of global reporting requirements for indicators of drug shortages.
14. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing technologies such as continuous pharmaceutical manufacturing.
15. Our AMA supports the concept of creating a rating system to provide information about the quality management maturity, resiliency and redundancy, and shortage mitigation plans, of pharmaceutical manufacturing facilities to increase visibility and transparency and provide incentive to manufacturers. Additionally, our AMA encourages GPOs and purchasers to contractually require manufacturers to disclose their quality rating, when available, on product labeling.
16. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes.
17. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.
18. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.
19. Our AMA urges the Drug Enforcement Agency and other federal agencies to regularly communicate and consult with the FDA regarding regulatory actions which may impact the manufacturing, sourcing, and distribution of drugs and their ingredients.
20. Our AMA supports innovative approaches for diversifying the generic drug manufacturing base to move away from single-site manufacturing, increasing redundancy, and maintaining a minimum number of manufacturers for essential medicines.

21. Our AMA supports the public availability of FDA facility inspection reports to allow purchasers to better assess supply chain risk.
22. Our AMA opposes the practice of preferring drugs experiencing a shortage on approved pharmacy formularies when other, similarly effective drugs are available in adequate supply but otherwise excluded from formularies or coverage plans.
23. Our AMA shall continue to monitor proposed methodologies for and the implications of a buffer supply model for the purposes of reducing drug shortages and will report its findings as necessary. (Amend HOD Policy)

B. That the following policy be adopted:

Non-Profit or Public Manufacturing of Drugs to Address Generic Drug Shortages

Our AMA:
(1) supports activities which may lead to the stabilization of the generic drug market by non-profit or public entities. Stabilization of the market may include, but is not limited to, activities such as government-operated manufacturing of generic drugs, the manufacturing or purchasing of the required active pharmaceutical ingredients, or fill-finish. Non-profit or public entities should prioritize instances of generic drugs that are actively, at-risk of, or have a history of being, in shortage, and for which these activities would decrease reliance on a small number of manufacturers outside the United States.

(2) encourages government entities to stabilize the generic drug supply market by piloting innovative incentive models for private companies which do not create artificial shortages for the purposes of obtaining said incentives. (New HOD Policy)

CITED POLICIES

Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices H-105.988

1. To support a ban on direct-to-consumer advertising for prescription drugs and implantable medical devices.
2. That until such a ban is in place, our AMA opposes product-claim DTCA that does not satisfy the following guidelines:
(a) The advertisement should be indication-specific and enhance consumer education about the drug or implantable medical device, and the disease, disorder, or condition for which the drug or device is used.
(b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing.
(c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical device to distinguish such advertising from other advertising for non-prescription products.
(d) The advertisement should not encourage self-diagnosis and self-treatment, but should refer patients to their physicians for more information. A statement, such as "Your physician may recommend other appropriate treatments," is recommended.
(e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable.
(f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without distraction of content, and will help facilitate communication between physician and patient.
(g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition.
(h) In general, product-claim DTCA should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in DTCA, a disclaimer should be prominently displayed.
(i) The use of actual health care professionals, either practicing or retired, in DTCA to endorse a specific drug or implantable medical device product is discouraged but if utilized, the advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement.
(j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved.
(k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines.
3. That the FDA review and pre-approve all DTCA for prescription drugs or implantable medical device products before pharmaceutical and medical device manufacturers (sponsors) run the ads, both to ensure compliance with federal regulations and consistency with FDA-approved labeling for the drug or implantable medical device product.

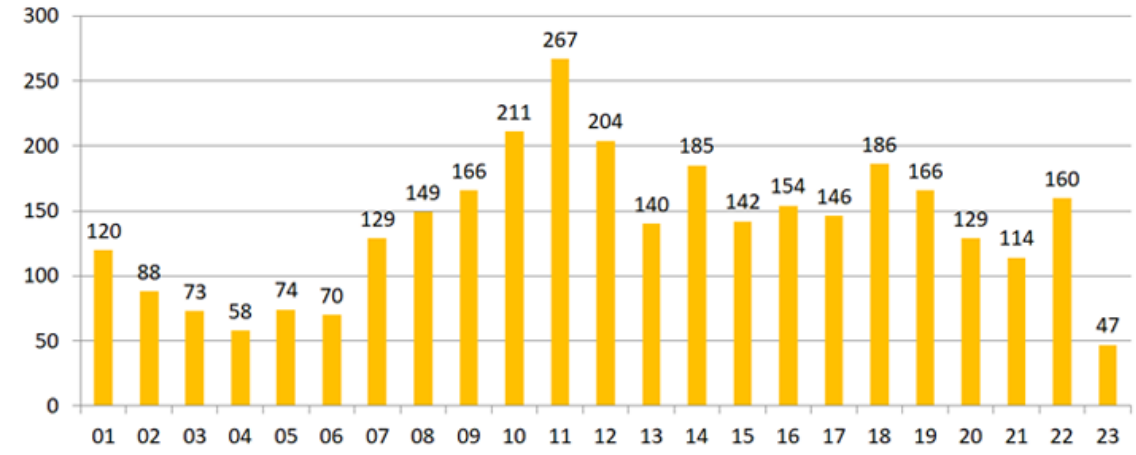
4. That the Congress provide sufficient funding to the FDA, either through direct appropriations or through prescription drug or implantable medical device user fees, to ensure effective regulation of DTCA.
5. That DTCA for newly approved prescription drug or implantable medical device products not be run until sufficient post-marketing experience has been obtained to determine product risks in the general population and until physicians have been appropriately educated about the drug or implantable medical device. The time interval for this moratorium on DTCA for newly approved drugs or implantable medical devices should be determined by the FDA, in negotiations with the drug or medical device product's sponsor, at the time of drug or implantable medical device approval. The length of the moratorium may vary from drug to drug and device to device depending on various factors, such as: the innovative nature of the drug or implantable medical device; the severity of the disease that the drug or implantable medical device is intended to treat; the availability of alternative therapies; and the intensity and timeliness of the education about the drug or implantable medical device for physicians who are most likely to prescribe it.
6. That our AMA opposes any manufacturer (drug or device sponsor) incentive programs for physician prescribing and pharmacist dispensing that are run concurrently with DTCA.
7. That our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries to conduct or fund research on the effect of DTCA, focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public.
8. That our AMA supports the concept that when companies engage in DTCA, they assume an increased responsibility for the informational content and an increased duty to warn consumers, and they may lose an element of protection normally accorded under the learned intermediary doctrine.
9. That our AMA encourages physicians to be familiar with the above AMA guidelines for product-claim DTCA and with the Council on Ethical and Judicial Affairs Ethical Opinion E-9.6.7 and to adhere to the ethical guidance provided in that Opinion.
10. That the Congress should request the Agency for Healthcare Research and Quality or other appropriate entity to perform periodic evidence-based reviews of DTCA in the United States to determine the impact of DTCA on health outcomes and the public health. If DTCA is found to have a negative impact on health outcomes and is detrimental to the public health, the Congress should consider enacting legislation to increase DTCA regulation or, if necessary, to prohibit DTCA in some or all media. In such legislation, every effort should be made to not violate protections on commercial speech, as provided by the First Amendment to the U.S. Constitution.
11. That our AMA supports eliminating the costs for DTCA of prescription drugs as a deductible business expense for tax purposes.
12. That our AMA continues to monitor DTCA, including new research findings, and work with the FDA and the pharmaceutical and medical device industries to make policy changes regarding DTCA, as necessary.
13. That our AMA supports "help-seeking" or "disease awareness" advertisements (i.e., advertisements that discuss a disease, disorder, or condition and advise consumers to see their physicians, but do not mention a drug or implantable medical device or other medical product and are not regulated by the FDA).
14. Our AMA will advocate to the applicable Federal agencies (including the Food and Drug Administration, the Federal Trade Commission, and the Federal Communications Commission) which regulate or influence direct-to-consumer advertising of prescription drugs that such advertising should be required to state the manufacturer’s suggested retail price of those drugs.

Box 1. Resources available to assist in mitigation of drug shortages.

1. ASHP Resource Center
2. ASHP list of current shortages
3. FDA Drug Shortages Page (includes current shortages list, extended use dates, mobile app, and additional information)
4. ASHP member survey on current drug shortages
5. Pfizer injectables availability report
6. USP resource on Pfizer Rocky Mount facility alternative products and market share data (note: may require providing name and email address to access)

APPENDIX 1

Figure 1. National Drug Shortages: New Shortages by Year: January 2001 to March 31, 2023

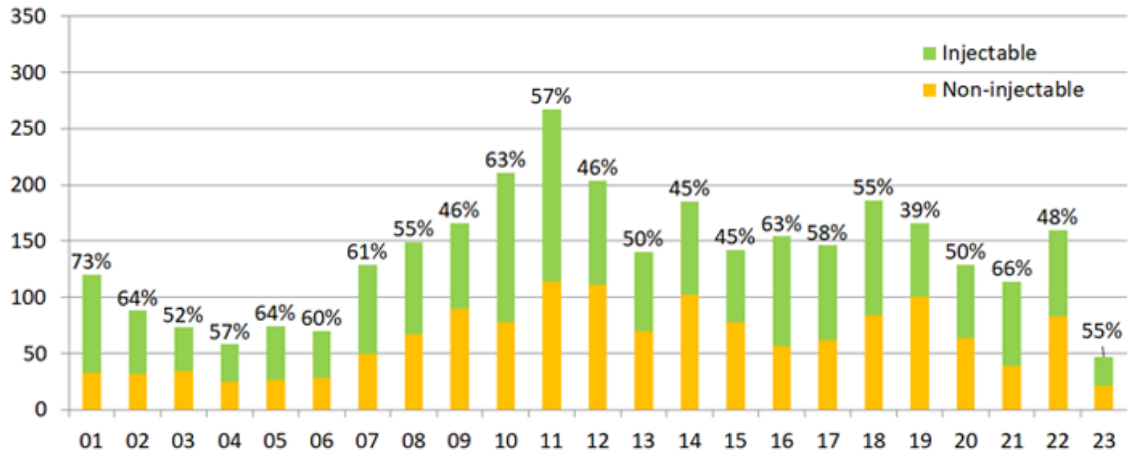


Note: Each column represents the number of new shortages identified during that year.

University of Utah Drug Information Service

Contact: Erin.Fox@hsc.utah.edu, @foxerinr for more information.

Figure 2. National Drug Shortages: New Shortages by Year
Percent Injectable: January 2001 to March 31, 2023, % Injectable

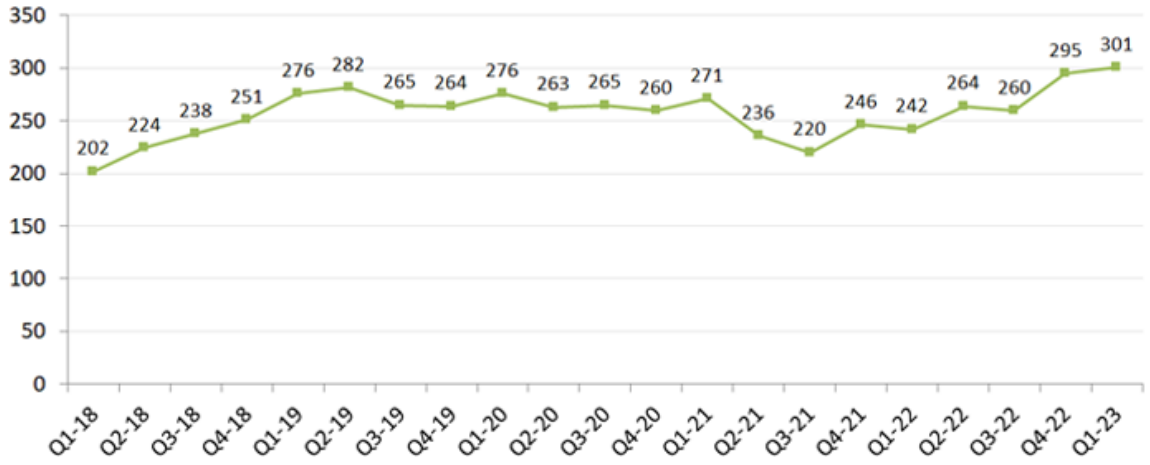


Note: Each column represents the number of new shortages identified during that year.

University of Utah Drug Information Service

Contact: Erin.Fox@hsc.utah.edu, @foxerinr for more information.

Figure 3. National Drug Shortages: Active Shortages by Quarter: 5 Year Trend

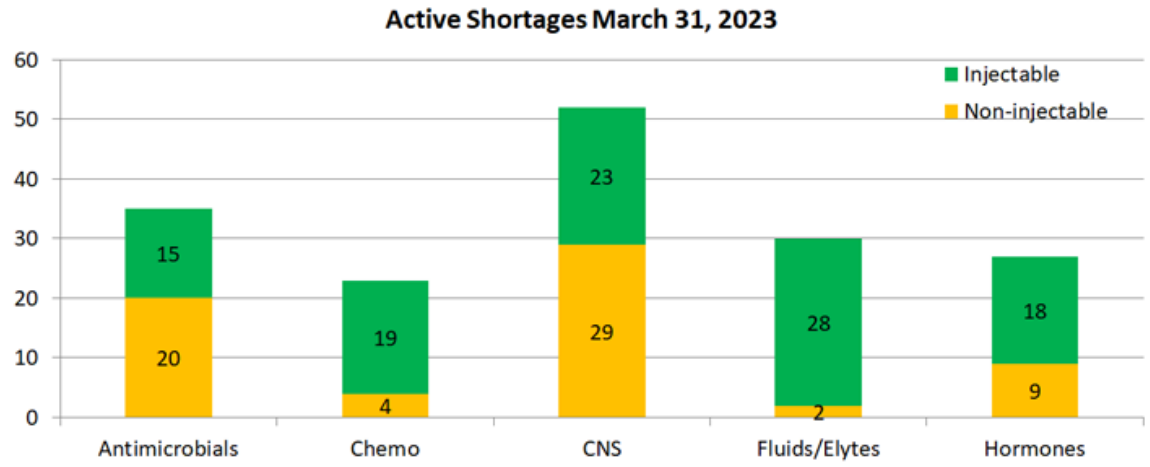


Note: Each point represents the number of active shortages at the end of each quarter.

University of Utah Drug Information Service

Contact: Erin.Fox@hsc.utah.edu, @foxerinr for more information.

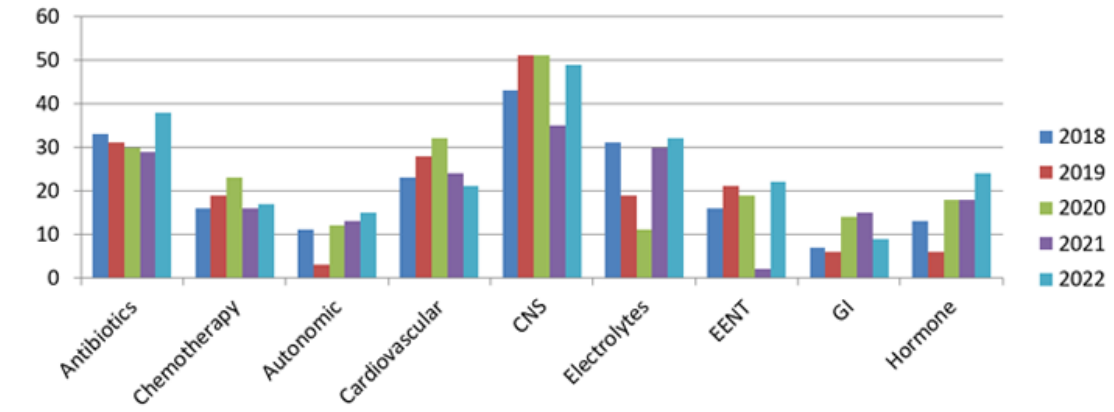
Figure 4. National Drug Shortages: Active Shortages Top 5 Drug Classes



University of Utah Drug Information Service

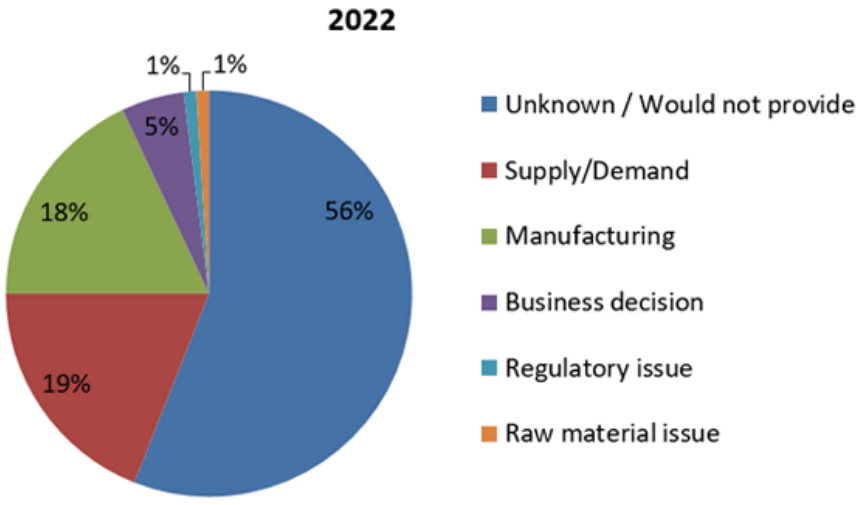
Contact: Erin.Fox@hsc.utah.edu, @foxerinr for more information.

Figure 5. National Drug Shortages: Common Drug Classes in Short Supply: 5 Year Trend



University of Utah Drug Information Service
Contact: Erin.Fox@hsc.utah.edu, @foxerinr for more information.

Figure 6. National Drug Shortages: Reasons for Shortages as Reported by Manufacturers During UUDIS Investigation — 2022



University of Utah Drug Information Service
Contact: Erin.Fox@hsc.utah.edu, @foxerinr for more information.

APPENDIX 2

Table 1. Breakdown of statistics from the Food and Drug Administration's Center for Drug Evaluation and Research (CDER) and Center for Biologics Evaluation and Research (CBER)

	CDER	CBER
NUMBER OF SHORTAGES		
New Shortages	48	1
Prevented Shortages	210	12
Ongoing Shortages	81	5
Notifications	1267	26
Number of Manufacturers Notifying	133	17
ACTIONS TAKEN TO MITIGATE SHORTAGES		
Regulatory Flexibility and Discretion	85	0
Expedited Reviews	193	11*
Expedited Inspections	30	0

* This number includes expedited reviews for six biologics license application (BLA)/BLA supplements and five lot-release submissions for CBER-regulated products.

REFERENCES

1. Drug Shortage Statistics. American Society of Health-System Pharmacists. https://www.ashp.org/drug-shortages/shortage-resources/drug-shortages-statistics. Published 2023. Accessed2023.
2. Council on Science and Public Health. Drug Shortages: 2022 Update. American Medical Association. https://www.ama-assn.org/system/files/i22-csaph-report-01.pdf. Published 2022. Accessed.
3. American Society of Health-System Pharmacists. Severity and Impact of Current Drug Shortages. https://www.ashp.org/-/media/assets/drug-shortages/docs/ASHP-2023-Drug-Shortages-Survey-Report.pdf. Published 2023. Accessed August 11, 2023.
4. U.S. Food and Drug Administration. Drug Shortages CY 2022. https://www.fda.gov/media/169302/download. Published 2023. Accessed July 7, 2023.
5. Office of Senator Ron Wyden. Wyden Sounds the Alarm on ADHD Drug Shortage. https://www.wyden.senate.gov/news/press-releases/wyden-sounds-the-alarm-on-adhd-drug-shortage. Published 2023. Accessed June 13, 2023.
6. Blum D. People With A.D.H.D. Claim Adderall Is 'Different' Now. What's Going On? *The New York Times.* March 9, 2023.
7. American Society of Health-System Pharmacists. Amphetamine Mixed Salts, Immediate-Release Tablets. https://www.ashp.org/drug-shortages/current-shortages/drug-shortage-detail.aspx?id=857&loginreturnUrl=SSOCheckOnly. Published 2023. Accessed June 13, 2023.
8. U.S. Department of Justice. List of Controlled Substances. https://www.deadiversion.usdoj.gov/schedules/. Published 2023. Accessed June 13, 2023.
9. Jain S. Sharp Uptick in Adderall Prescribing for Adults Ages 22-44 Amid COVID-19 Pandemic. *Trilliant Health.* June 19, 2022, 2023.
10. Facher L. DEA will delay telemedicine restrictions for buprenorphine, Adderall, and other drugs. *STAT News.* May 3, 2023, 2023.
11. Justice USDo. Established Aggregate Production Quotas for Schedule I and II Controlled Substances and Assessment of Annual Needs for the List I Chemicals Ephedrine, Pseudoephedrine, and Phenylpropanolamine for 2023. https://www.federalregister.gov/documents/2022/12/02/2022-26351/established-aggregate-production-quotas-for-schedule-i-and-ii-controlled-substances-and-assessment. Published 2022. Accessed June 13, 2023.
12. U.S. Food and Drug Administration, Drug Enforcement Administration. Joint Letter to the American Public. https://www.fda.gov/media/170736/download?attachment. Updated August 1, 2023. Accessed August 3, 2023.
13. Swetlitz I. Understanding Why Adderall Shortages Are Shrouded In Mystery. *Bloomberg.* February 28, 2023, 2023.
14. Beavins E. As Califf Points To Adderall Telehealth Kickbacks, FDA Adds Safety Warnings. *InsideHealthPolicy.* May 17, 2023, 2023.
15. Morgan PL, Staff J, Hillemeier MM, Farkas G, Maczuga S. Racial and Ethnic Disparities in ADHD Diagnosis From Kindergarten to Eighth Grade. *Pediatrics.* 2013;132(1):85-93.
16. Quinn PO, Madhoo M. A review of attention-deficit/hyperactivity disorder in women and girls: uncovering this hidden diagnosis. *Prim Care Companion CNS Disord.* 2014;16(3).
17. Administration USFaD. FDA Approves New Drug Treatment for Chronic Weight Management, First Since 2014. https://www.fda.gov/news-events/press-announcements/fda-approves-new-drug-treatment-chronic-weight-management-first-2014. Published 2021. Accessed June 13, 2023.
18. Administration USFaD. FDA Drug Shortages - Semaglutide Injection. https://www.accessdata.fda.gov/scripts/drugshortages/dsp_ActiveIngredientDetails.cfm?AI

=Semaglutide%20(WEGOVY%C2%AE)%20Injection&st=c. Published 2023. Accessed June 13, 2023.
19. Blum D. What Is Ozempic and Why Is It Getting So Much Attention? *The New York Times.* November 22, 2022, 2022.
20. TikTok. #Ozempic. https://www.tiktok.com/tag/ozempic?lang=en. Published 2023. Accessed June 13, 2023.
21. Chen E. Ro pauses advertising of weight loss drug Wegovy amid shortages. *STAT News.* June 12, 2023.
22. Palmer K. Where are patients getting their prescriptions for GLP-1 drugs like Wegovy and Ozempic? *STAT News.* August 10, 2023.
23. Muller M. TikTok Cracks Down on the Latest Diet Fad: Weight-Loss Drugs. *Bloomberg.* July 25, 2023.
24. ExpressScripts. 2023 Express Scripts National Preferred Formulary. https://emihealth.com/pdf/Prescription-Formulary-2023.pdf. Accessed June 13, 2023.
25. Bodor JN, Kasireddy V, Borghaei H. First-Line Therapies for Metastatic Lung Adenocarcinoma Without a Driver Mutation. *Journal of Oncology Practice.* 2018;14(9):529-535.
26. National Cancer Institute. The "Accidental" Cure—Platinum-based Treatment for Cancer: The Discovery of Cisplatin. https://www.cancer.gov/research/progress/discovery/cisplatin. Updated May 30, 2014. Accessed June 13, 2023.
27. Lee J. Cisplatin, carboplatin shortages raise questions about impact on clinical trials *Endpoint News.* August 18, 2023.
28. Qiu Pharmaceutical Company Limited. Temporary Importation of CISplatin Injection with non-U.S. Labeling to Address Drug Shortage https://www.fda.gov/media/168657/download. Updated May 24, 2023. Accessed June 13, 2023.
29. Parsons HM, Schmidt S, Karnad AB, et al. ReCAP: Association Between the Number of Suppliers for Critical Antineoplastics and Drug Shortages: Implications for Future Drug Shortages and Treatment. *Journal of Oncology Practice.* 2016;12(3):249-250.
30. Administration USFaD. National Drug Code Directory. https://www.accessdata.fda.gov/scripts/cder/ndc/index.cfm. Accessed June 13, 2023.
31. Reed T, Dreher A. Cancer drug shortages highlight supply chain vulnerabilities. *Axios.* June 14, 2023.
32. Administration USFaD. Inspection Record - Intas Pharmaceuticals Limited. https://www.fda.gov/media/164602/download. Updated December 2, 2022. Accessed June 13, 2023.
33. Erman M. Pfizer says supply of some drugs may be disrupted after NC tornado. *Reuters.* July 24, 2023.
34. Pharmacists ASoH-S. Lidocaine Injection. https://www.ashp.org/drug-shortages/current-shortages/drug-shortage-detail.aspx?id=88. Updated July 26, 2023. Accessed July 27, 2023.
35. Administration USFaD. FDA Provides Update Regarding Storm Damage at Pfizer Facility in North Carolina. https://www.fda.gov/news-events/press-announcements/fda-provides-update-regarding-storm-damage-pfizer-facility-north-carolina. Updated July 21, 2023. Accessed July 27, 2023.
36. Pfizer. Inventory Management Update for Pfizer Hospital Rocky Mount Products. https://cdn.pfizer.com/pfizercom/Pfizer_RM_Emergency_Order_Process.pdf. Published 2023. Accessed August 11, 2023.
37. Chuck E. Hospitals ration CT scans, other procedures over shortage of contrast dye. *NBC News.* May 18, 2022.

38. Mazer-Amirshahi M, Fox ER. Saline Shortages — Many Causes, No Simple Solution. *New England Journal of Medicine.* 2018;378(16):1472-1474.
39. Awan O. Why The Global Helium Shortage May Be The World's Next Medical Crisis. *Forbes.* November 10, 2022.
40. DeGroot L. Califf, ASHP: FDA Needs More Authority To Respond To Drug Shortages. *InsideHealthPolicy.* February 15, 2023.
41. Goldman M. Drug shortages become flashpoint in PAHPA draft. *Axios.* June 13, 2023, 2023.
42. Energy and Commerce Committee. Chair Rodgers Unveils Proposal to Address Root Cause of Drug Shortages Facing American Patients. https://energycommerce.house.gov/posts/chair-rodgers-unveils-proposal-to-address-root-cause-of-drug-shortages-facing-american-patients. Accessed August 11, 2023.
43. Silverman E. Pharmalittle: White House drug-shortage task force brainstorms fixes; U.S. pharma layoffs are ballooning. *STAT News.* August 4, 2023.
44. Wosińska M, Frank R. Federal policies to address persistent generic drug shortages. Brookings Institute. https://www.brookings.edu/articles/federal-policies-to-address-persistent-generic-drug-shortages/. Updated June 21, 2023. Accessed July 27, 2023.
45. Wanneh G. CMS Proposes Paying Hospitals Extra To Set Up 'Buffer Stock' Of Essential Drugs. *InsideHealthPolicy.* July 14, 2023.
46. Soergel A. States Competing in 'Global Jungle' for PPE. *U.S. News.* April 7, 2020.
47. Arnon SS. Creation and Development of the Public Service Orphan Drug Human Botulism Immune Globulin. *Pediatrics.* 2007;119(4):785-789.
48. Bowman E. California enters a contract to make its own affordable insulin. *NPR.* March 19, 2023.
49. CivicaRx. Civica's Health System Partners Represent 1/3 of All U.S. Hospital Beds. https://civicarx.org/our-members/. Accessed June 13, 2023.
50. CivicaRx. Patients Are Now Being Treated with a Civica Rx Medication https://civicarx.org/wp-content/uploads/2020/02/Civica-Rx-First-Deliveries.pdf. Updated October 2, 2019. Accessed June 13, 2023.
51. King R. Civica Rx to build drug manufacturing facility to make sterile injectables. *Fierce Healthcare.* January 25, 2021.
52. American Medical Association. Docket No. DEA-407, Telemedicine Prescribing of Controlled Substances When the Practitioner and the Patient Have Not Had a Prior In-Person Medical Evaluation. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfrd.zip%2F2023-3-31-Letter-to-Milgram-re-Telemedicine-Prescribing-of-Controlled-Substances-v4.pdf. Updated March 31, 2023. Accessed June 13, 2023.

REPORT 2 OF THE COUNCIL OF SCIENCE AND PUBLIC HEALTH (I-23)
Precision Medicine and Health Equity
(Reference Committee K)

EXECUTIVE SUMMARY

INTRODUCTION. In continuance of the American Medical Association's (AMA) commitment to health equity, the Council on Science and Public Health has initiated this report, based on in-depth interviews conducted by the AMA and its Health, Science and Ethics team, on precision medicine and its intersections with health equity. Precision medicine, for the purposes of this report, will refer to the practice of utilizing genetics (the study of single genes) and genomics (the study of the whole genome) to personalize or tailor care to individual patients. To explore the past, present, and future landscape of genetics in medicine and to propose a path forward for equitable adoption of emerging technologies, a qualitative research study was performed by interviewing those with lived experiences and other experts. This report represents a summary of the interviews and presents policy recommendations based on the findings.

METHODS: One-hour, in-depth interviews were conducted virtually between November 2022 and February 2023 with 15 experts in one of five areas related to equitable precision medicine (community/patient advocates, social science research, genomics research, genetics clinicians, and industrial representatives). It should be noted that many of the interviewees had expertise or direct experience in several areas (i.e., a clinician may also participate in research). Interviewees were contacted by email and interviewed for 60 minutes, with the opportunity for written follow-up if required. Video recordings of interviews were converted to text-based transcripts by a third-party, and subsequently analyzed by a team of researchers. This project was categorized IRB-exempt through the University of Illinois Chicago (ID: STUDY2022-1388). Supplemental resources for this report were identified by manual screening of literature using Google Scholar or PubMed databases identified by interviewees.

DISCUSSION. Interviewees described many ways in which precision medicine intersects with health equity. For example, interviewees described the ways in which the troubling history of the American eugenics movement still reverberate in the health care setting, or the underlying datasets used to evaluate genetic conditions are predominantly based on samples of European ancestry. To help address these concerns, interviewees described promising practices which include the role of community members in designing and executing research, or the movement away from race- or ethnicity-based clinical guidelines and reimbursement. Other topics, such as research recruitment strategies, the role of law enforcement, ongoing practices of social exclusion, and the economic ties between clinical practitioners and genetic testing companies are also explored.

CONCLUSION. The goal of precision medicine has been to tailor care for the individual patient. In its idealized form, it would eliminate much of the unconscious biases from historical approaches and social constructs that may impact diagnosis and treatment. In its current form, precision medicine and its implementation continue to struggle with familiar issues of inequity, often stemming from an inability to demonstrate trustworthiness. Experts remain highly optimistic about the future of precision medicine and health equity, as long as it comes with the recognition that significant work must still be done to ensure that everyone benefits from these advancements.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-I-23

Subject: Precision Medicine and Health Equity

Presented by: David J. Welsh, MD, MBA, Chair

Referred to: Reference Committee K

In continuance of the American Medical Association's (AMA) commitment to health equity, the Council on Science and Public Health has initiated this report, based on in-depth interviews conducted by the AMA focused on precision medicine and its intersections with health equity. The Council believes there is value in sharing these findings with the House of Delegates as there are important policy recommendations to consider. Precision medicine, for the purposes of this report, will refer to the practice of utilizing genetics (the study of single genes) and genomics (the study of the whole genome) to personalize or tailor care to individual patients. To explore the past, present, and future landscape of genetics in medicine and to propose a path forward for equitable adoption of emerging technologies, in-depth interviews were conducted with individuals who have had personal experiences with precision medicine as well as precision medicine experts. This report presents a summary and recommendations based on the findings from those interviews.

Emphasis for this report has been placed on areas in which genetic research and precision medicine offer unique challenges to equity and trustworthiness, such as eugenics, privacy, genetic essentialism, and social exclusion. Some facets, such as cost, access, workforce diversity, and other aspects of institutionalized racism and other inequities, are present in the adoption of precision medicine and discussed where appropriate but may ultimately be better addressed by other AMA efforts.

METHODS

One-hour, in-depth interviews were conducted virtually between November 2022 and February 2023 with 15 experts in one of five areas related to equitable precision medicine (community/patient advocates, social science research, genomics research, genetics clinicians, and industrial representatives). It should be noted that many of the interviewees had expertise or direct experience in several areas (i.e., a clinician may also participate in research). Interviewees were contacted by email and interviewed for 60 minutes, with the opportunity for written follow-up if required.

All interviewees were provided with two definitions prior to starting the interview: precision medicine ("the prevention and treatment of disease that takes into account individual variations in genes or using genetic and genomic testing to assist in the prevention, diagnosis and treatment of diseases") and health equity ("assurance of the conditions for optimal health for all people"). An interview guide was used in each interview, but conversation was permitted to develop naturally to allow potential unexpected themes and ideas to arise. The guide outlined five topics: (1) the concept of race, ethnicity, and ancestry in medicine, (2) earning and building trust, (3) social

drivers of health and precision medicine, (4) economics of access and benefits, and (5) challenges implementing precision medicine moving forward.

Interviewees were compensated $200 by Amazon gift card for their participation and will not be identified beyond general descriptions of their expertise and profession (ex: social science researcher). Video recordings of interviews were converted to text-based transcripts by a third-party, and subsequently analyzed by a team of researchers. This project was categorized IRB-exempt through the University of Illinois Chicago (ID: STUDY2022-1388). Supplemental resources for this report were identified by manual screening of literature using Google Scholar or PubMed databases identified by interviewees.

HISTORY OF GENETIC RESEARCH AND HEALTH EQUITY IN THE UNITED STATES

The United States has a deplorable history of eugenics. Dating back to at least the 20th century, leading eugenicists felt that the quality of the human race could be improved by selective breeding for certain traits, such as intelligence or physical ability.[1] This deeply flawed belief led directly to harm and abuses of marginalized and minoritized populations that were deemed "undesirable" and included abhorrent practices such as forced sterilization and restrictions on immigration, and are viewed today as a thinly veiled guise to reinforce segregation.[2] Through entities such as the Eugenics Record Office, propaganda and lobbying efforts resulted in forcible, state-endorsed sterilization of Black, Latinx, and Indigenous people, and those with disabilities.[3] This history of eugenics was heard throughout the interviews.

> *Black men, for example, or Latina women subjected to sterilization, that is exactly how communities have been viewed, for years, as subjects of experimentation, or treated for years as subjects of experimentation, rather than as patients deserving of the latest and greatest that science and medicine have to offer*. (Participant 3 – Community Representative)

While some may believe that the eugenics movement is a historical oddity, there are many still bearing the scars today. The Family Planning Services and Population Research Act of 1970 (later to be known as 'Title X'), subsidized the treatment of family planning services for those receiving Medicaid or through the Indian Health Service. Title X is a critical tool for funding contraceptive and family planning services in the United States – but under the same program, an estimated 25 percent of Indigenous women of child-bearing age in the United States were sterilized by their physicians over a 6-year period.[4] It is reported that many of these procedures were either performed coercively or without the individual's knowledge.[5]

Beyond eugenics, interviewees noted a long legacy of abuse and exploitation of marginalized and minoritized populations by genetic researchers. For example, interviewees described the experiences of the Havasupai tribe, in which researchers approached the community offering to investigate if there was a genetic cause of the elevated rates of Type 2 diabetes, but subsequently used those same DNA samples for stigmatizing schizophrenia research and human migration studies which were never consented to.[6] Similarly, the Nuu-chah-nulth of the Pacific Northwest were approached to study higher incidence of arthritis in their community, and subsequently were studied for human migration without their consent.[7] In the case of the Karitiana, an Indigenous population of Brazil, they were approached by a genetics research company which subsequently sold their samples for $85 per sample for two decades without compensating the tribe.[8] Now, interviewees noted, genetic testing companies often donate testing kits to Indigenous people but retain intellectual property rights rather than the individual or the community.

> *[Companies] have wanted to give out freely genetic tests to Indigenous patients as a means of service, but really it's a means of collecting information from Indigenous peoples to improve their own algorithms, which are patentable and also subject to intellectual property rules and trademarking and all those other types of restricted things.* (Participant 1 – Community Representative)

Interviewees also noted the parallels that many research projects and genetic databases share with the story of Henrietta Lacks. Lacks, a Black woman with cervical cancer, unknowingly had her tumor biopsied and subsequent cells immortalized and used for research without her consent.[9,10] These then-named HeLa cells, one of the most ubiquitously used cell lines for *in vitro* research, have been commercialized and used as the foundation for generating billions of dollars in profit from biomedical advances. Additionally, genetic researchers have published the genetic information of the HeLa cell line, thus exposing potentially sensitive information about not only Henrietta Lacks, but her direct and extended family as well.[11] In August 2023, it was announced that the Lacks family reached a settlement with Thermo Fisher Scientific for their commercialization of HeLa cells.[12]

Interviewees noted how Henrietta Lacks' story can seem all-too-familiar for marginalized and minoritized communities being asked to participate in genetic research – the companies making the request benefit greatly, while those same communities, who take on significant personal risk, will never benefit from the new technologies that are created.

> *Everything from the Tuskegee syphilis study to Henrietta Lacks, to the average everyday health disparity that many African-Americans experience in their medical care that leads to a situation of distrust for the average African-American with regard to the medical establishment. And that distrust breeds a lack of a desire to participate. It's like, 'I don't trust you, so why do I even want to associate with you?'* (Participant 2 – Community Representative)

ONGOING IMPACTS

Interviewees highlighted that many abusive or inequitable practices continue to impact the quality of care those groups receive today. Much genetic research is based on genome-wide association studies (GWAS), which find statistical correlations between populations with certain genetic mutations and their subsequent health outcomes. While sometimes these GWAS result in identifying underlying mechanisms of disease (for example, a rs6025 mutation results in deficient human factor V function, thus increasing risk of thrombosis and embolism), many genetic associations are correlations based on statistical analysis of patient samples held within large databases rather than an identification of a direct biological cause.[13]

If a patient receives a genetic test result that notes a genetic mutation that has not been sufficiently researched, it is marked as a variant of unknown significance (VUS), or functionally an unactionable result, which may sometimes be interpreted as a negative result.[14] When certain groups are poorly represented in genetic research databases, that means the underlying statistical certainty is weaker, resulting in higher rates of VUS, which manifests in fewer referrals to specialty care, and increased morbidity and mortality.[15-19] According to the GWAS Diversity Monitor, a tool which analyzes data from the National Human Genome Research Institute and European Bioinformatics Institute's GWAS Catalog, as of July 2023, approximately 95 percent of all GWAS

participants are of European ancestry.[20] Only 3 percent are of Asian ancestry, 0.15 percent are of African ancestry and 0.3 percent are of Hispanic or Latin American ancestry.

> *What I encounter on a day-to-day [basis] is just the lack of data. There's a lot more research and datasets available for European ancestry people than everybody else, […] And that kind of trickles down into how these European ancestry genetic datasets are used to make all of our genomic discoveries, then that trickles down into discoveries being more applicable to people of European ancestry than other populations.* (Participant 7 – Genetics Researcher)

Additionally, one statistician described how in much of genetic research, samples from individuals identifying as multiple races or ethnicities ('admixed race') are often excluded entirely from any correlative research, or simply defined as "other," as it adds additional complexity that most statistical models cannot adequately handle.

> *If you include mostly European individuals and then have also some admixed individuals in there, there's a concern that you can get false positive hits. […] So the easiest thing to get around that is to just not deal with it, and exclude anybody who's not cleanly fitting into whatever you think is a homogeneous category. […] Even when there is data for diverse people, it's getting thrown out.* (Participant 7 – Genetics Researcher)

The discrepancies in participation rates are multifactorial, but past research behavior has demonstrated to many underrepresented communities that the genetics ecosystem may not be trustworthy with their data. Interviewees noted that some groups, such as the Navajo Nation, have gone so far as to place a moratorium on members participating in genetics research due to the risk of abuse and exploitation.[21]

Other interviewees noted that past practices which resulted in these deep inequities have now placed individuals from marginalized and minoritized groups in a cycle with seemingly no correct decision – since precision medicine approaches have lower value for them, why would they ever agree to participate? For example, a practicing clinical geneticist described their struggles with communicating the realities of the system that has been created while trying to care for the patient in front of them.

> *Depending on where your ancestors came from and how much we know about genetic relevance of disease to specific variants, can I give you useful information? And at the end of the day, if I'm giving you a lot of gobbledygook that basically is just confusing and not medically useful to your doctors, then why did you waste your time?* (Participant 15 – Clinical Practitioner)

> *If the folks who are contributing the most important information to genetics research don't even have access to genomic medicine because of published data on just lower referral rates for genetic testing, lower rates of follow up, just lots of different assumptions being made about what insurance people have. Then you create a system where people are being asked to take a risk in offering up their DNA sample, potentially [to] not ever have the benefit from it or potentially have their descendants not have benefit from it*

> *if they don't have access to the medicine.* (Participant 8 – Genetics Researcher)

This raises an interesting conundrum for precision medicine – unlike many other forms of medical research, an individual's choice to participate will have direct impact on members of their community, and conversely, the community at large's willingness to participate will have direct impact on the value that an individual receives from a given test. Many interviewees noted that genetic research recruitment campaigns for underrepresented groups often focus on messaging that emphasizes something to the effect of "if you want your community to benefit from new medical research, you need to participate," which some interviewees responded positively to, while others noted how coercive this approach can be.

> *I have a scripture from the Book of Hosea that I frequently [use] that says that "my people perish for lack of knowledge". And I explain, for our community, particularly the African-American community, knowledge of our collective genomes is knowledge we can't afford to lack. It'll actually put us behind the eight-ball further with regard to our health outcomes because if we continue to not participate, we'll continue to not know about what genotypes are specific, what variants of significance are in our genomes that lead to disease and that lead to us understanding our risk of certain disease earlier and therefore, improving our health outcomes.* (Participant 2 – Community Representative)

> *One of the tendencies I'm noticing with precision medicine is that it's like, "Make sure you're getting involved and being included as research subjects in this, because you're going to miss the boat. And your communities are not going to benefit from these advances." It's sort of operating in a coercive manner in that way, and Indigenous people have experienced that coercive dynamic since the creation of these countries.* (Participant 4 – Social Science Researcher)

As a direct result of unrepresentative research databases, inequity has now been institutionalized in the way clinical guidelines and reimbursement are made for genetic testing – a clear example of ongoing, modern race-based medicine. For example, interviewees noted that people of Ashkenazi Jewish descent often have expanded carrier screening options, or that people of Asian ancestry are more likely to be offered, and have insurance reimburse, genetic testing for a highly toxic side effect when prescribing carbamazepine.[22,23] Interviewees described how these guidelines directly result in decreased access to genetic testing and precision medicine. Although these guidelines were put into place to specifically suggest genetic testing for patients whose ancestries present these genetic variations more frequently, interviewees described how these guidelines concurrently decrease access to genetic testing and precision medicine for populations that do not have an "insurance covered ancestry." Additionally, they noted that these guidelines reinforce the concept of racial essentialism by thinking of conditions such as cystic fibrosis as a "white" disease or sickle cell anemia as a "Black" disease.

> *There are more individuals now being born with Tay-Sachs disease that are non-Ashkenazi Jewish because of the effective carrier screening efforts that were directed at those populations. […] The people of Ashkenazi Jewish descent were aware of their risk and took advantage of reproductive technologies that could avoid the birth of a child that has a severe fatal*

> *disease. Whereas in populations where we don't think about this, there's that risk.* (Participant 9 – Clinical Practitioner)

Law Enforcement and Personal Privacy

In recent years, there have been several high-profile instances from which genetic databases have been leveraged by law enforcement entities for identifying suspects.[24,25] Given the discrepancies and inequity around law enforcement and race, many interviewees described how marginalized and minoritized communities view this as another significant barrier to participation. Interviewees, particularly those directly engaged with the health care system, pointed towards the data security provisions of the Health Insurance Portability and Accountability Act (HIPAA) and the Genetic Information Non-Discrimination Act (GINA). Some pointed out how many of these instances of genetic databases being used for law enforcement purposes were from direct-to-consumer companies which may not be bound by HIPAA and GINA, but others noted that it is very difficult to differentiate between clinical and consumer genetics in terms of public perception, and it is important to call out where abuses have occurred and rectify them before one can be perceived as trustworthy.

> *So we have a prison system, a policing system, an education system, a medical system that are all based on the idea that there are fundamental innate differences about people on the basis of some basic physical attributes like skin color and a couple facial features, skin and hair and eye color, texture, shape.* (Participant 8 – Genetics Researcher)

> *I think it really depends how the data is used. I mean, we've seen the risk of the direct-to-consumer model of testing where people all of a sudden find each other and there's a lot of social risks and genomics gets connected to [law enforcement databases] and criminal investigations and all of those things. Some people actually see that as a benefit. Some people see it as a risk. I think it depends on, again, people's level of knowledge about their family structures and concerns about policing.* (Participant 6 – Social Science Researcher)

Even if strides were made to improve the trustworthiness of direct-to-consumer genetic testing databases, there have also been instances in which clinical screening programs have been improperly leveraged for law enforcement purposes. For example, in New Jersey in 2022, police subpoenaed, without a warrant, heel prick blood samples from the state-run newborn screening program for the purposes of genetic identification of samples from a 1996 cold case.[26] A regulatory landscape analysis found that approximately one-third of states have laws which would allow law enforcement to access newborn screening blood samples for the purposes of genetic identification, while another quarter of states had no discernable policy barring it.[27] Parents that wish to protect their families from warrantless investigations from law enforcement are thus forced to sue the state to destroy blood samples, or opt-out entirely from their child receiving critical early-life disease screening.[28] It should be noted that state-run newborn screening programs are covered by HIPAA and GINA protections, however HIPAA has specific exemptions for law enforcement.

In the wake of the *Dobbs v. Jackson Women's Health Organization* Supreme Court decision and the subsequent restrictions on abortion, interviewees were asked if they were aware of any concerns regarding patient privacy, including carrier screening results and law enforcement action if the termination of a pregnancy were suspected. At the time the interviews were performed, no

interviewee described any known instances, but this will be an issue that is monitored closely moving forward.

GROUP CONSENT AND COMMUNITY-INVOLVED RESEARCH

Genetics research is unique in the impact that individual participation can have on the broader sub-populations they may belong to. As such, many interviewees described their desire to rethink what informed consent looks like in a genetics research context. Some described a concept of "group consent," in which leaders of a community explicitly consent to research. However, at the time of writing, it is not known if any successful models of group consent have been utilized in genetics research, and the concept may be more aspirational than obtainable. Others, instead, described a model where informed consent more explicitly outlines the impacts that individual participation can have on a community.

> *It could be something like a clause stating that your information could be used to make inferential statements about the group or community to which you belong to or to which you belong, and that could have unforeseen effects or impacts on your group or community's rights to resources, if any.* (Participant 1 – Community Representative)

Others noted that a simple approach for obtaining consent is to simply make sure that the impacted communities are the ones involved in, or calling for, the research itself.

> *I think that it works better when the people who are doing the work are the people who it's going to apply to. They are the ones who will decide whether something is a good idea and ethical and appropriate for their community.* (Participant 5 – Social Science Researcher)

> *[Indigenous communities] are not interested so much in questions of ancestry and population migrations. They're thinking about, "Our community's experiencing high levels of H. Pylori, and therefore stomach cancer. How can we address these kinds of real-life issues facing our community and our people?"* (Participant 4 – Social Science Researcher)

> *We asked, 'Why not use Indigenous samples to study conditions that affect Indigenous peoples? How is that for a concept?' [The companies] basically stated that we constitute 3 percent of the US's population and therefore we're not profit-generative for that type of approach.* (Participant 1 – Community Representative)

In addition to providing a more complete model of informed consent, interviewees described how community representation in the research design phase can be a step towards demonstrating trustworthiness.

> *The way that I am able to interact with marginalized communities is just so much more effective, because of that inherent trust. Because the face looks like your face. Or the face is speaking your language, and it makes a huge difference for patients.* (Participant 13 – Industry Representative)

As described above, one of the underlying concerns from historic and current behavior from the genetic research ecosystem is the failure to properly compensate communities for their research

participation, such as the experience of the Karitiana. Interviewees noted that when researchers come from the community itself, they are more likely to appropriately compensate participants. Others discussed how compensation is perhaps an appropriate vehicle for initiating meaningful discussions that build trust with a community. For example, one industry representative described how some companies are providing stock or establishing public benefit corporations to support the community and research participants, particularly when genetic-informed treatments can be very costly. Others described how the actions of researchers tell a lot about their level of commitment to the communities they are studying. For example, if a community is experiencing higher-than-average levels of preventable disease, pairing studies into potential genetic causes with investments in preventative care resources sends a clear signal that the researchers are genuinely interested in improving the well-being of a community, rather than just observing how different they are.

Further, some raised concerns around the unusual relationships that may occur between clinicians, researchers, and the pharmaceutical companies developing precision medicines. Typically borne from lower rates of reimbursement and coverage, health systems may be pushed to offer genetic testing and genomic sequencing through partnerships with for-profit biotechnology companies, which can increase access, but also raises questions about privacy and financial benefit. There is disagreement among genetics practitioners and researchers about the value and ethics of these relationships. Several genetics practitioners and industry representatives describe these partnerships as necessary, given the financial realities of genomic research. Some even see partnerships with biotechnology companies as advancing equity by working to ensure all populations are represented in drug developments.

> *We wanted to get genetic information for all of our patients and we want to sequence their genomes and we need a way of being able to fund this, and there are for-profit groups that would come in and say, 'yep, I would do that for you'. And the quid pro quo is you get the data, that's great. […] We get the data and we get some genetic data and some clinical information that goes with that. And of course we're using that information to develop drugs or to develop treatments. And so that's why we're willing to make the investment and you should want to have your patients represented because if you don't, we're going to develop the wrong drugs for the wrong people.* (Participant 15 – Clinical Practitioner)

Others believe partnerships reinforce perceptions that genomic research and development extracts valuable information from communities without providing benefits back.

> *The problem is we aren't allowed to see the memorandums of understanding between these companies and medical centers. So, we don't actually even know exactly what's been agreed to. […] [Company] will have access to the medical records for those individuals, and they'll be able to link it without identifying anybody because they have the genotype data, they have medical records linked to the genotype data, then they have the genome sequence which they can figure out which genome it is based on the genotypes, and then link to the medical records and nobody else has access to any phenotype data.* (Participant 8 – Genomics Researcher)

Social Exclusion

While community-involved research may initially start as an effort to build trust, it also is a critical opportunity to assess whether researching potential genetic causes is even appropriate in the first

place. Interviewees highlighted that while we may often think of the eugenics movement as long in the past, there are still concerning practices around the pathologizing of social identities, which advocates worry will lead to exclusion or erasure of their communities. Prestigious academic journals are still actively publishing research seeking to identify genetic variation that may be associated with sexual and gender identity..[29-31] While researchers state that their intent is to investigate things such as evolutionary pressure or human behavior, the resulting impact and message it sends to the described community is unmistakable. By implying that there may be an underlying genetic cause to a socially constructed identity, that then suggests that there may be attempts to "cure," or erase from existence, that same community.

> *The idea where someone's sociopolitical identity is strongly informed by or based on an element of variation in one's sex characteristics, in one's sexual orientation, in one's gender identity—that this can be traced back to the genome points in the direction of eugenics. The idea that if we could just get rid of these variations, we would have a "more perfect human race."* (Participant 3 – Community Representative)

> *There are entire populations that are still being abused and have recently experienced things like forced sterilization. […] And so we get to decide whether or not we have a kid. Whether or not we have a history of Huntington's in our past. If I give you that information, does that mean that you get to sterilize me? Right? Because we don't want that.* (Participant 11 – Clinical Practitioner)

Interviewees then went on to describe other areas of medical practice which are unfortunately too familiar for those wishing to escape from the history of eugenics, particularly around the perception of disability.[32] For example, there are varying opinions on the appropriateness of genetic research or screening for conditions such as loss of hearing or deafness (with a lowercase "d"). Members of the Deaf (with a capital "D") community frequently view genetic testing more critically than the hearing community – Deaf individuals often fear that those who poorly understand their culture will view their identity as less desirable, use genetic testing and/or treatments to select against it, and ultimately destroy a vibrant community with its own languages, customs, and traditions.[33] Others may argue that screening for deafness may be a critical step to allow expecting parents to connect with resources, learn sign language, or otherwise better prepare to support a Deaf child. These concerns, which span communities such as those with autism spectrum disorders, schizophrenia, Huntington's disease, or achondroplasia, only further highlight the importance of community involvement in designing appropriate research. Understanding when, where, and why to screen for these traits, and the critical need of acknowledging the medical community's historic role in eugenics, are key steps to demonstrating trustworthiness.[34]

GENETIC ESSENTIALISM AND MISCONCEPTIONS OF RACE

Finally, interviewees described how research and medical ecosystems often have a fundamentally flawed view of race, ethnicity, and genetic ancestry and how it impacts health. Current AMA policy, such as H-65.953, "Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice" and D-350.981, "Racial Essentialism in Medicine," clearly outline that race is a social construct and is inappropriate to use as a proxy for genetics.

> *There's history and momentum behind it, meaning there's this really long, deep-seated history of classifying humans into different groups that are not*

> *scientific, that was done specifically and explicitly for the purpose of justifying, capturing people from their homes and taking them to new continents, enslaving them, treating them as shadow property, and then pretending that never happened, that's what race categories are all about.* (Participant 8 – Genetics Researcher)

Despite growing awareness, researchers' and clinicians' misunderstandings of race, ethnicity, and genetic ancestry continue to provide barriers to individuals seeking care. One social scientist identified the problem that they describe broadly as 'race-based medicine.' In practicing 'race-based medicine,' social scientists say clinicians make assumptions about a patient's health or risk factors based on the patient's phenotypic appearance. The social scientist cited the pharmaceutical drug BiDil as an example of 'race-based medicine.' BiDil (isosorbide dinitrate/hydralazine HCl) was a drug indicated by the FDA exclusively for treatment of congestive heart failure for Black patients.[35] In this interviewee's view, approving a drug for a single racial group is not supported by science or an appropriate understanding of race as a social, and not biological, category.

> *We can't default to the idea of if you are of African descent that you have an increased risk for kidney disease. If you look at African populations at a country level or even more deeply at ancestral tribal levels, the range of risk is enormous.* (Participant 9 – Clinical Practitioner)

As described previously, current clinical guidelines and reimbursement around genetic testing can often be linked directly to certain racial, ethnic, or ancestry categories, despite how they may be based on non-representative cohorts found in genetic databases. Additionally, these guidelines may require patients to self-identify their background (or worse, rely on a clinician's perception of a patient's appearance), which can often not accurately capture the genetic variations associated with ancestry that is relevant for testing.

> *Many of my patients are Dominican. And if I were to look at the DNA from any of my patients, I would see that they come with some of their genetic roots from West Africa. […] But if I ask those people to fill out a form that says […] by race and ethnicity, many of them will say, I'm Latina. But they would never say that they're Black. […] And in some ways I don't care. It's what you, in terms of acculturation and the customs, [believe] and all of those end up being incredibly important because there are certain customs and certain values and traditions that come with being Latina. […] But yet there are certain genetic variants that absolutely trace their roots to West Africa.* (Participant 15 – Clinical Practitioner)

> *There's a lot of diversity within any given checkbox that is just not being captured. So how informative that is about somebody's genetic predisposition, it's hard to say. An individual who self-identifies as African American lives in the US for example, is obviously going to have a very different genetic makeup than somebody who lives in South Africa currently or something like that. You know what I mean? But if they're on the census form, they might both check the same box.* (Participant 7 – Genetics Researcher)

Distinguishing cultural and social labels from genetic labels is important to ensure clinicians and researchers know what information is genetically relevant for an individual and that the various

identities a patient holds are not mislabeled or debased. They emphasize that you simply cannot precisely assess an individual's genetic risk based on their phenotype, cultural, or racial identity.

CONCLUSION

The goal of precision medicine has been to better understand and tailor care for the individual patient. In its idealized form, it would eliminate much of the unconscious biases from historical approaches and social constructs that may impact diagnosis and treatment. In its current form, precision medicine and its implementation continues to struggle with familiar issues of inequity, often stemming from an inability to demonstrate trustworthiness. There is optimism about the future of precision medicine and health equity, as long as it comes with the somber recognition that significant work must still be done to allow everyone to benefit from these advancements.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1. That our AMA:

    A. recognizes past and ongoing practices in the field of genetics, including eugenics, have resulted in harm and decreased the quality of care available to minoritized and marginalized groups, and undermined their trust in the available care. Our AMA strongly supports efforts to counter the impact of these practices.

    B. supports efforts to increase the diversity of genetics research participants and for research participants and impacted communities to be appropriately compensated.

    C. strongly opposes the use of race, ethnicity, genetic ancestry, sexual orientation, or gender identity as the basis for genetic testing recommendations, or the insurance coverage of genetic tests.

    D. supports policies which restrict access to genetic databases, including newborn screening samples or carrier screening results, by law enforcement without a warrant. States should clearly outline procedures for law enforcement to obtain access to genetic databases when there are compelling public safety concerns, consistent with AMA patient privacy policy.

    E. supports an affirmative consent or "opt-in" approach to genetics research including samples stored within large databases and encourages those in stewardship of genetic data to regularly reaffirm consent when appropriate.

    F. recognizes that an individual's decision to participate in genetics research can impact others with shared genetic backgrounds and encourages researchers and funding agencies to collaborate with impacted community members to develop guidelines for obtaining and maintaining group consent, in addition to individual informed consent. Our AMA supports widespread use of a robust consent process which informs individuals about what measures are being taken to keep their information private, the difficulties in keeping genetic information fully anonymous and private, and the potential harms and benefits that may come from sharing their data.

G. strongly opposes research seeking to find genetic causes for protected traits, including gender identity, sexual orientation, and differences in ability, unless specifically requested by, or in direct collaboration with, the impacted community. (New HOD Policy)

2. That current AMA policies H-315.983, "Patient Privacy and Confidentiality," H-65.953 "Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice," and D-350.981 "Racial Essentialism in Medicine" be reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: minimal less than $1,000

CITED AMA POLICIES

H-315.983. Patient Privacy and Confidentiality
1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.
2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.
3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.
4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.
5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.
6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.
7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.
8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.
9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.
10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of

identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.
11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures
12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.
13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.
14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.
15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.
16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.
17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.
18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.
19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.
20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.
21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.
BOT Rep. 9, A-98. Reaffirmation I-98. Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99. Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99. Reaffirmation A-00. Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01. Reaffirmed: BOT Rep. 19, I-01. Appended: Res. 524, A-02. Reaffirmed: Sub. Res. 206, A-04. Reaffirmed: BOT Rep. 24, I-04. Reaffirmed: BOT Rep. 19, I-06. Reaffirmation A-07. Reaffirmed: BOT Rep. 19, A-07. Reaffirmed: CEJA Rep. 6, A-11. Reaffirmed in lieu of Res. 705, A-12. Reaffirmed: BOT Rep. 17, A-13. Modified: Res. 2, I-14. Reaffirmation: A-17. Modified: BOT Rep. 16, A-18. Appended: Res. 232, A-18. Reaffirmation: I-18. Reaffirmed: Res. 219, A-21. Reaffirmed: Res. 229, A-21. Reaffirmed: BOT Rep. 12, I-21. Reaffirmed: BOT Rep. 22, A-22. Reaffirmation: A-23.

H-65.953. Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice
1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.
2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.
3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how

the category "race" can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.
4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.
Res. 11, I-20.

D-350.981 Racial Essentialism in Medicine
1. Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities.
2. Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics.
3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.
4. Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors.
5. Our AMA will support research that promotes antiracist strategies to mitigate algorithmic bias in medicine.
Res. 10, I-20

REFERENCES

1. Harper PS. Paul A Lombardo: A Century of Eugenics in America. From the Indiana Experiment to the Human Genome Era. *Human Genetics.* 2011;130(5):701-702.
2. Allen GE. The Eugenics Record Office at Cold Spring Harbor, 1910-1940: An Essay in Institutional History. *Osiris.* 1986;2(1):225-264.
3. McKinnon S. The American Eugenics Record Office: Technologies for Terminating 'Degenerate' Family Lines and Purifying the Nation. *Social Analysis.* 2021;65(4):23-48.
4. Pegoraro L. Second-rate victims: the forced sterilization of Indigenous peoples in the USA and Canada. *Settler Colonial Studies.* 2015;5(2):161-173.
5. Lawrence J. The Indian Health Service and the Sterilization of Native American Women. *American Indian Quarterly.* 2000;24(3):400-419.
6. Sterling RL. Genetic research among the Havasupai: A cautionary tale. *AMA Journal of Ethics.* 2011;13(2):113-117.
7. Dalton R. Tribe blasts 'exploitation' of blood samples. *Nature.* 2002;420(6912):111-111.
8. Rohter L. In the Amazon, Giving Blood but Getting Nothing. *New York Times*2007.
9. Wolinetz CD, Collins FS. Recognition of Research Participants' Need for Autonomy: Remembering the Legacy of Henrietta Lacks. *JAMA.* 2020;324(11):1027-1028.
10. Lee SSJ, Cho MK, Kraft SA, et al. "I don't want to be Henrietta Lacks": diverse patient perspectives on donating biospecimens for precision medicine research. *Genetics in Medicine.* 2019;21(1):107-113.
11. Zimmer C. A Family Consents to a Medical Gift, 62 Years Later. *The New York Times*2013.
12. Roberts A, Belson D. Family of Henrietta Lacks celebrates settlement of HeLa cell lawsuit against biotech giant. *The Baltimore Sun.* August 1, 2023.
13. Visscher PM, Wray NR, Zhang Q, et al. 10 Years of GWAS Discovery: Biology, Function, and Translation. *The American Journal of Human Genetics.* 2017;101(1):5-22.
14. Eccles BK, Copson E, Maishman T, Abraham JE, Eccles DM. Understanding of BRCA VUS genetic results by breast cancer specialists. *BMC Cancer.* 2015;15(1):936.
15. Need AC, Goldstein DB. Next generation disparities in human genomics: concerns and remedies. *Trends in Genetics.* 2009;25(11):489-494.
16. Ndugga-Kabuye MK, Issaka RB. Inequities in multi-gene hereditary cancer testing: lower diagnostic yield and higher VUS rate in individuals who identify as Hispanic, African or Asian and Pacific Islander as compared to European. *Familial Cancer.* 2019;18(4):465-469.
17. Hall MJ, Reid JE, Burbidge LA, et al. BRCA1 and BRCA2 mutations in women of different ethnicities undergoing testing for hereditary breast-ovarian cancer. *Cancer.* 2009;115(10):2222-2233.
18. Chapman-Davis E, Zhou ZN, Fields JC, et al. Racial and Ethnic Disparities in Genetic Testing at a Hereditary Breast and Ovarian Cancer Center. *Journal of General Internal Medicine.* 2021;36(1):35-42.
19. Kwon DH-M, Borno HT, Cheng HH, Zhou AY, Small EJ. Ethnic disparities among men with prostate cancer undergoing germline testing. *Urologic Oncology: Seminars and Original Investigations.* 2020;38(3):80.e81-80.e87.
20. Mills MC, Rahal C. The GWAS Diversity Monitor tracks diversity by disease in real time. *Nature Genetics.* 2020;52(3):242-243.
21. Claw KG, Dundas N, Parrish MS, et al. Perspectives on Genetic Research: Results From a Survey of Navajo Community Members. *Frontiers in Genetics.* 2021;12.
22. Baskovich B, Hiraki S, Upadhyay K, et al. Expanded genetic screening panel for the Ashkenazi Jewish population. *Genet Med.* 2016;18(5):522-528.

23. Ferrell PB, McLeod HL. Carbamazepine, HLA-B*1502 and risk of Stevens–Johnson syndrome and toxic epidermal necrolysis: US FDA recommendations. *Pharmacogenomics.* 2008;9(10):1543-1546.
24. Hazel J, Wright Clayton E. Law Enforcement and Genetic Data. The Hastings Center. Bioethics Briefings Web site. https://www.thehastingscenter.org/briefingbook/law-enforcement-and-genetic-data/. Published 2021. Accessed2023.
25. Guerrini CJ, Robinson JO, Petersen D, McGuire AL. Should police have access to genetic genealogy databases? Capturing the Golden State Killer and other criminals using a controversial new forensic technique. *PLOS Biology.* 2018;16(10):e2006906.
26. Hughes IV R, Choudhury S, Shah A. Newborn Screening Blood Spot Retention And Reuse: A Clash Of Public Health And Privacy Interests. *Health Affairs Forefront.* 2022.
27. Ram N. America's hidden national DNA database. *Texas Law Review.* 2021;100:1253.
28. Whelan AM. That's My Baby: Why the State's Interest in Promoting Public Health Does Not Justify Residual Newborn Blood Spot Research Without Parental Consent. *Minn L Rev.* 2013;98:419.
29. Chaladze G. Heterosexual Male Carriers Could Explain Persistence of Homosexuality in Men: Individual-Based Simulations of an X-Linked Inheritance Model. *Archives of Sexual Behavior.* 2016;45(7):1705-1711.
30. Sanders AR, Beecham GW, Guo S, et al. Genome-Wide Linkage and Association Study of Childhood Gender Nonconformity in Males. *Archives of Sexual Behavior.* 2021;50(8):3377-3383.
31. Zietsch BP, Sidari MJ, Abdellaoui A, et al. Genomic evidence consistent with antagonistic pleiotropy may help explain the evolutionary maintenance of same-sex sexual behaviour in humans. *Nature Human Behaviour.* 2021;5(9):1251-1258.
32. Madeo AC, Biesecker BB, Brasington C, Erby LH, Peters KF. The relationship between the genetic counseling profession and the disability community: A commentary. *American Journal of Medical Genetics Part A.* 2011;155(8):1777-1785.
33. Middleton A, Hewison J, Mueller RF. Attitudes of deaf adults toward genetic testing for hereditary deafness. *Am J Hum Genet.* 1998;63(4):1175-1180.
34. Rubeis G, Steger F. A burden from birth? Non-invasive prenatal testing and the stigmatization of people with disabilities. *Bioethics.* 2019;33(1):91-97.
35. Brody H, Hunt LM. BiDil: Assessing a Race-Based Pharmaceutical. *The Annals of Family Medicine.* 2006;4(6):556-560.

REPORT 3 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-23)
HPV-Associated Cancer Prevention
(Reference Committee K)

EXECUTIVE SUMMARY

BACKGROUND. American Medical Association (AMA) Policy H-440.872 "HPV-Associated Cancer Prevention," as adopted by the House of Delegates (HOD), asked that our AMA study requiring HPV vaccination for school attendance and report its findings to the AMA House of Delegates by the 2023 Interim Meeting.

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms "HPV vaccination", "HPV vaccine mandates," "mandated vaccines AND schools" and "school attendance AND HPV vaccine mandate". Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies; applicable organizations were also reviewed for relevant information.

DISCUSSION. HPV vaccination remains the best method for preventing cancer-causing infections and precancers. HPV infections and cervical precancers have dropped since 2006, when HPV vaccines were first used in the United States. Among teen girls, infections with HPV types that cause most HPV cancers and genital warts have dropped 88 percent and among young adult women, they have dropped 81 percent. Among vaccinated women, the percentage of cervical precancers caused by the HPV types most often linked to cervical cancer have dropped by 40 percent. Routine HPV vaccination is widely recommended for age- and guideline-eligible male and female adolescents and young adults by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP).

Few states mandate the HPV vaccine for school attendance in part because HPV is a sexually transmitted infection, and it is not likely to be transmitted in schools. Adding vaccines to the list required for attendance is viewed by some as putting up unnecessary roadblocks for school attendance. Opponents have also expressed moral objections related to a vaccination mandate for a sexually transmitted infection. However, proponents of the HPV vaccine mandates for school entry argue that it is important to promote immunization when the vaccine is most effective – before the initiation of sexual activity and exposure to HPV. Those already infected with HPV can also benefit from the vaccine because it can prevent infection against HPV strains that they may not have contracted. Additionally, the vaccine elicits a higher immune response in adolescents ages 11 to 12 than in older teens.

CONCLUSION. Current available evidence shows that without widespread public support, monitoring, sanctions for noncompliance, or changes to the method of vaccine administration, school-entry HPV vaccine mandates do little to encourage uptake. Stronger health care practices such as more in-depth discussions with hesitant parents and establishing vaccination as the default are strategies to improve vaccination coverage rates. This report is specifically focused on the history of vaccine mandates for school entry, the legality of vaccine mandates, public health ethical considerations, assessment on the effectiveness of HPV vaccine mandates on HPV vaccination rates, and other interventions to increase HPV vaccination rates.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 3-I-23

Subject: HPV-Associated Cancer Prevention

Presented by: David J. Welsh, MD, MBA, Chair

Referred to: Reference Committee K

INTRODUCTION

American Medical Association (AMA) Policy H-440.872 "HPV-Associated Cancer Prevention," as adopted by the House of Delegates (HOD), asked that our AMA study requiring HPV vaccination for school attendance and report its findings to the AMA House of Delegates by the 2023 Interim Meeting.

BACKGROUND

Since licensure in the United States (U.S.) in 2006, the human papillomavirus (HPV) vaccine has been shown to be a safe, effective, and durable method for decreasing HPV-related infections and subsequent sequelae, including genital warts and cervical, vulvar, vaginal, penile and anal cancers and potentially oropharyngeal cancers.[1] Routine HPV vaccination is widely recommended for age- and guideline-eligible male and female adolescents and young adults by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP).[2] HPV vaccine is recommended for routine vaccination at age 11 or 12 years and for everyone through age 26 years if not adequately vaccinated when younger.[3] For adults ages 27 through 45 years, clinicians can consider discussing the HPV9 vaccination with people who are most likely to benefit.[4]

HPV vaccination remains the best method for preventing cancer-causing infections and precancers. HPV infections and cervical precancers have dropped since 2006, when HPV vaccines were first used in the U.S. For example, among teen girls, infections with HPV types that cause most HPV cancers and genital warts have dropped 88 percent and among young adult women they dropped 81 percent.[5] Among vaccinated women, the percentage of cervical precancers caused by the HPV types most often linked to cervical cancer has dropped by 40 percent.[3]

Although recommendations by ACIP provide clinical guidance, school vaccination requirements are generally determined by state legislatures or state health departments. Few states require the HPV vaccine for school attendance in part because HPV is considered a sexually transmitted infection (STI), and it is not likely to be transmitted in schools.[6] Adding vaccines to the list required for school is viewed by some as putting up unnecessary roadblocks for school attendance. For the HPV vaccine, some have expressed moral objections related to a vaccination mandate for a STI.[7] This report is specifically focused on the history of vaccine mandates for school entry, the legality of vaccine mandates, assessment on the effectiveness of HPV vaccine mandates on HPV vaccination rates, and other interventions to increase HPV vaccination rates.

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms "HPV vaccination", "HPV vaccine mandates," "mandated vaccines AND schools" and "school attendance AND HPV vaccine mandate". Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and applicable organizations were also reviewed for relevant information.

DISCUSSION

Background on HPV

HPV is a group of more than 200 related viruses, some of which are spread through vaginal, anal, or oral sex.[8] The majority of HPV infections are self-limited and are asymptomatic. Sexually transmitted HPV types fall into two groups, low and high risk.[6] Low-risk HPVs generally cause no disease.[6] However, a few low-risk HPV types can cause warts on or around the genitals, anus, mouth, or throat. High-risk HPVs can cause several types of cancer.[6] There are about 14 high-risk HPV types including HPV16 and HPV18, which are responsible for most HPV-related cancers.[6] Nearly all people are infected with HPV within months to a few years after becoming sexually active. Around half of these infections are with a high-risk HPV type.[6] HPV can infect anyone regardless of their sex, gender identity, or sexual orientation. HPV vaccination is the best method to prevent infection with disease-causing HPV types, preventing many HPV-related cancers and cases of genital warts. Before HPV vaccines were introduced, approximately 355,000 new cases of ano-genital warts occurred every year.[9]

Prevalence of HPV-associated cancers

Long-lasting infections with high-risk HPVs can cause cancer in parts of the body where HPV infects cells, such as in the cervix, oropharynx, anus, penis, vagina, and vulva.[6] HPV infects the squamous cells that line the inner surfaces of these organs. For this reason, most HPV-related cancers are squamous cell carcinomas. Some cervical cancers come from HPV infection of gland cells in the cervix and are adenocarcinomas.[6] Each year, there are about 45,000 new cases of cancers in parts of the body where HPV is often found, and HPV is estimated to cause about 36,000 of these.[6]

Background on HPV Vaccines and Recommendations for Vaccination

The FDA approved first-generation Gardasil®, produced by Merck, in 2006, which prevented infection of four strains of HPV – 6, 11, 16, and 18.[10] In December 2014, Gardasil®9 was approved by the FDA.[8] This vaccine protects against 9 strains of HPV: the four strains approved in the previous Gardasil vaccine, as well as 31, 33, 45, 52, and 58.[8] These strains are associated with the majority of cervical cancer, anal cancer, and throat cancer cases as well as most genital warts cases and some other HPV-associated ano-genital diseases.[11] The vaccine was initially approved for cervical cancer prevention, but in 2020 the FDA broadened its approval to include the prevention of oropharyngeal cancer and other head and neck cancers.[12]

With over 120 million doses of HPV vaccines distributed in the United States, robust data demonstrate that HPV vaccines are safe.[13] There have been relatively few adverse events reported after HPV vaccination. Commonly reported symptoms include injection-site reactions such as pain, redness and swelling, as well as dizziness, fainting, nausea, and headache.[14] Current research suggests the vaccine protection is long-lasting: more than 10 years of follow-up data indicate the

vaccines are still effective and there is no evidence of waning protection, although it is still unknown if recipients will need a booster.[15] Further, HPV vaccination has not been associated with initiation of sexual activity or sexual risk behaviors.[16] HPV vaccine is recommended for routine vaccination at age 11 or 12 years. Vaccination can be started at 9 years of age. ACIP also recommends vaccination for everyone through age 26 years if not adequately vaccinated when younger. HPV vaccination is given as a series of either two or three doses, depending on age at initial vaccination.[15] HPV vaccines are currently not recommended for use in pregnant persons.[15] HPV vaccines can also be administered regardless of history of ano-genital warts, abnormal Pap test or HPV test, or ano-genital precancer.[15]

VACCINE MANDATES

Legality of Vaccination Mandates

In the early 19th century, smallpox remained one of the largest threats to public health. Amid frequent smallpox outbreaks, Massachusetts passed the nation's first vaccine mandate in 1810. The Massachusetts law gave local health boards the authority to require vaccination when outbreaks occurred, imposing fines or quarantine for non-compliance.[17] In 1827, Boston enacted the first school vaccine mandate for smallpox; other cities and states soon followed.[18] Today, four common childhood vaccinations – DtaP, MMR, polio, and varicella – are required for children to enroll in kindergarten in every state,[1] with 44 states also requiring a hepatitis B vaccination before kindergarten and 30 states requiring a meningitis vaccination before entering later grades.[19] Until the COVID-19 pandemic, vaccine mandates in the United States have mostly been enacted by state and local governments in relation to public venues, schools, and health care facilities, with the military also requiring certain vaccines.[20] Vaccine mandates require that individuals be vaccinated against certain illnesses, usually as a condition of entry to or participation in certain activities. The most common vaccine mandates are applied to enrollment in schools. However, vaccine mandates are not absolute. School vaccine mandates in every state allow for exemptions.

The legal basis for vaccine mandates typically lies within the police powers of a state. Police powers encompass the broad power of a state to regulate matters affecting the health, safety, and general welfare of the public, housed within the Tenth Amendment of the Constitution.[2,21] While school vaccination requirements are framed as conditional, courts often view them as compulsory; however, these compulsory mandates have been widely accepted and judicially sanctioned.[18] The legitimacy of compulsory vaccination programs depends on both scientific factors and constitutional limits. Scientific factors include the prevalence, incidence, and severity of the contagious disease; the mode of transmission; the safety and effectiveness of any vaccine in preventing transmission; and the nature of any available treatment. Constitutional limits include protection against unjustified bodily intrusions, such as forcible vaccination of individuals at risk for adverse reactions, and physical restraints and unreasonable penalties for refusal.[22] Vaccination programs have been legally challenged as inconsistent with federal constitutional principles of individual liberty and due process, an unwarranted governmental interference with individual autonomy, and an infringement of personal religious beliefs under First Amendment principles.[2]

The U.S. Supreme Court has only officially addressed vaccine mandates in two cases. In 1905, the Court upheld the constitutionality of vaccine mandates in the seminal case *Jacobson v. Massachusetts*.[23] Jacobson challenged the Massachusetts law mentioned earlier that gave local health boards the authority to require vaccination when outbreaks occurred. The Court held that a vaccine mandate was valid so long as there was a danger to public health and safety and the

[1] With the exception of Iowa, which does not require a mumps vaccine.

mandate had a real or substantial relation to the goal of protecting public health. In 1922, the Court upheld vaccine mandates as a condition of school attendance in *Zucht v. King*.[24] In its brief, three paragraph opinion, the Court reaffirmed the broad discretion of the states to employ police powers and states' authority to delegate those powers to municipalities to determine under which conditions health regulations become operative.

The most frequently used arguments against compulsory vaccination are the religious clauses in the First Amendment. Supreme Court jurisprudence outside the realm of vaccination has clarified that the right of free exercise of religion does not relieve an individual of the obligation to comply with a valid and neutral law of general applicability.[2] The majority of states grant religious exemptions to school vaccine mandates, but even laws that do not provide for religious exemptions have been deemed constitutional.[25] Arguments have also been made under the Equal Protection Clause of the Fourteenth Amendment, but courts have rejected arguments that school vaccine mandates discriminate against school children to the exclusion of other groups because school children are not a constitutionally protected class.[2]

Other constitutional arguments have had even less success. Constitutional rights are generally framed as the right to be free of some form of government intrusion or restriction. As such, courts have found that the Constitution does not guarantee any "positive" rights, e.g., any requirement that the government provide anything. This includes education, thus there is no limit on the sort of reasonable regulations that a state may choose to impose on the privilege of a public education.[2] Arguments that vaccine requirements are arbitrary, capricious, or unreasonable have also failed, as well as arguments that school vaccination laws constitute illegal searches and seizures that violate the Fourth Amendment.[2]

Vaccine Exemptions

Vaccine exemption laws vary by jurisdiction. All 50 states and Washington D.C. (D.C) allow for vaccine exemptions for medical reasons. There are 45 states and D.C. that grant religious exemptions.[26] Currently, 15 states allow philosophical exemptions for children whose parents object to immunizations because of personal, moral or other beliefs. How exemptions are enforced also varies among states. Examples of how states have addressed enforcement include: parental notarization or affidavit in the exemption process, and education about the benefits of vaccination and risk of being unvaccinated.[27] To reduce non-medical exemptions, the CDC recommends that states strengthen the rigor of the application process, frequency of submission, and enforcement as strategies to improve vaccination rates.[27]

There is a growing body of evidence regarding the impact of state vaccination requirements for school age children on vaccination coverage and the association of non-medical exemption rates with increased disease incidence. The use of philosophical exemptions and under immunization tend to cluster geographically, putting some communities at greater risk for outbreaks. This geographic clustering of exemptions is associated with increased local risk of vaccine-preventable diseases, such as pertussis and measles.[27]

Possibility of HPV Vaccine Mandates

When discussion surrounding an HPV vaccine mandate first began, it was riddled with controversy. Being initially recommended only for females aged 11-12 years,[28] parents were uncomfortable with the idea of giving a vaccine for a STI to young girls, especially as the manufacturer mounted an expensive lobbying campaign to get it mandated.[29] Though the idea that parents do not need to vaccinate their children against STIs at a young age remains prevalent, studies routinely show that

parents underestimate their children's sexual activity.[30] Moreover, communication about sexual activity before a child's sexual "debut" correlates with less risky sexual behavior for the child.[31,32] The traditional rationale of tying vaccination to school attendance, is to prevent the spread of a disease outbreak that would prevent large numbers of children from attending school. However, there are already precedents that do not meet those narrow conditions. The tetanus part of the Tdap vaccine protects against an illness that is not communicable between humans at all. The traditional justification for tying vaccination to school entry not only fails to comprehensively weigh the risks and benefits of HPV vaccination, it also does not reflect the realities of mandatory vaccination today. In *Boone v. Boozman*, an Arkansas court explained in the context of hepatitis B vaccines that the method of transmission is not the only factor by which a disease can be judged dangerous and thus require mandated vaccination.[33] The caveat to *Boone* is that the court noted that the longevity of the virus on fomites added to the danger warranting a vaccination requirement for the high-traffic environment of a school setting, which may not be said of HPV.

Equity Implications of HPV Vaccine Mandates

Studies have shown that awareness of HPV, and HPV vaccination rates, are lower among Black and Hispanic women as compared to non-Hispanic Whites.[34] For mandated vaccines, by contrast, there is no evidence of racial disparity in rates of vaccination.[34] Black and Hispanic children receive these vaccines at comparable rates to other children, suggesting that mandates would be an effective tool for reducing disparities in vaccination and cervical cancer.[34] Mandating vaccination is not a substitute for improved education, screening, and treatment in minority populations, but it can be an important means of achieving greater health equity with respect to HPV-associated disease.[34]

Among adolescents aged 13–17 years in 2021, HPV vaccination coverage (at least 1 dose and HPV vaccine up to date) increased to approximately 58.6 percent.[35] Despite overall progress in vaccination coverage among adolescents, coverage disparities remain, particularly by geographic area. HPV vaccination was lower among adolescents living in rural areas than among adolescents living in urban areas.[31] These geographic disparities were statistically significant only among adolescents living at or above poverty level.[31] Access to the Vaccines for Children (VFC) program might contribute to higher vaccination coverage and lack of a geographic disparity for adolescents living below the poverty level among those in rural and urban areas. **Error! Bookmark not defined.**,[31]

Cost is not likely to be a concern in the equitable distribution of the HPV vaccine, since payment for vaccines is covered by a variety of sources. Under the Patient Protection and Affordable Care Act, all health insurance plans in the insurance marketplace must cover the HPV vaccine without cost sharing as it is recommended by the ACIP. The Vaccines for Children (VFC) program also pays for ACIP-recommended vaccination for all children through age 18 who are Medicaid-eligible, uninsured, American Indian or Alaskan Native, or underinsured. The Children's Health Insurance Program (CHIP) must cover ACIP-recommended vaccines since beneficiaries are not covered under VFC. Merck, the manufacturer of one approved HPV vaccine, Gardasil, also provides vaccines free of charge to eligible individuals, primarily the uninsured who, without our assistance, could not afford needed Merck medicines.[36]

Barriers to Implementing Vaccine Mandates

The COVID-19 pandemic highlighted several barriers to vaccine mandates overall. There was speculation that rampant misinformation related to the COVID-19 vaccine would lead to a spillover of distrust into vaccination in general, potentially leading to a reduction in childhood vaccination rates in general.[35] Online public opinion polls show that there is no evidence of such spillover, in fact, trust in the safety of vaccines and the public health institutions that promote them increased

overall.[35] However, attitudes regarding school requirements for routine vaccinations became more negative, suggesting a spillover of anti-mandate sentiments more broadly.[37] Further, one study noted that during the 2020–21 school year, national coverage with state-required vaccines among kindergarten students declined from 95 percent to approximately 94 percent.[38] In the 2021–22 school year, coverage for all state-required vaccines among kindergarten students further decreased to approximately 93 percent.[39] Another study found that for the first time since 2013, the proportion of 13–17-year-olds who received their first doses of the HPV vaccine did not increase.[40] Instead, vaccination coverage decreased among Medicaid-insured teens and remained lowest among uninsured teens, two of the four groups eligible for the VFC program.[37] This highlights that despite widespread return to in-person learning, COVID-19–related disruptions continue to affect vaccination coverage, preventing a return to pre-pandemic coverage levels among kindergarten students and adolescents.

Public support for school requirements for routine childhood vaccination dropped by 10 to 12 percentage points between 2019 and 2023 (down to only 70-74 percent support three years into the pandemic).[37] This left about one-quarter of U.S. adults (25-28 percent) opposed to vaccine requirements in 2023, which is the highest level of opposition to routine childhood vaccination requirements in recent history.[37] Notable drops in support during this time occurred among Republicans and those leaning Republican, as well as among adults who are not vaccinated against COVID-19.[37]

Moreover, when those opposing routine childhood vaccine requirements for school were asked about potential reasons why, the top reason cited by approximately half of those in opposition was that "it should be the parents' choice to decide for their child" (49 percent).[37] Most of the public believes routine vaccines are very safe, and this attitude is distinct from support for government requirements to be vaccinated.[37]

LESSONS FROM STATES WITH HPV VACCINE MANDATES

Hawaii, Rhode Island, Virginia, and D.C. have laws that require HPV vaccination for school entry. D.C. and Virginia require the HPV vaccine for girls to enter the sixth grade but allow parents to opt out of the requirement due to medical, moral, or religious reasons.[41] Rhode Island requires all seventh-grade students to be vaccinated.[38] While girls must still access HPV vaccines via a health professional, these mandates encourage a standardized age of vaccine administration and require schools to distribute information about the benefits of HPV vaccination to all parents. Parents are expected to review this information before opting their daughters out of HPV vaccination. It was hypothesized that these mandates were expected to facilitate the equal distribution of basic knowledge about HPV vaccines across various groups, promote uniformity in health care provider recommendations, and as a result, lessen inequities in uptake.[42]

One study aimed to understand the effects of mandates on HPV vaccine uptake in Virginia and D.C. years after implementation.[39] The study showed that there were improved clinician vaccine recommendations for some racial-ethnic minority girls.[39] However, the study also showed that mandates did not influence vaccine completion. Unexpectedly, rates of initiation and completion were lower in mandated (vs. non-mandated) jurisdictions in the post- mandate period, and completion declined in mandated jurisdictions once mandates came into effect. This suggests low enforcement of—and adherence to—HPV vaccine mandates, which was surprising given school-entry mandates have been effective for achieving high uptake of other adolescent and childhood vaccines.[43,44] However, these findings complement other studies identifying no impact of school-entry HPV vaccine mandates on overall uptake.[45,46]

The study interestingly noted reverse disparities in vaccine initiation in mandated jurisdictions for adolescents with the least educated parents.[39] This is in part due to D.C. and Virginia's broad opt-out provisions, which allow parents to refuse HPV vaccination after reviewing educational materials.[47] Further, the study showed that health care professionals' failure to discuss HPV vaccination with patients contributes to non-vaccination—particularly for low-income and racial-ethnic minority adolescents.[39]

Overall, the findings show that school-entry HPV vaccination mandates may disperse health-enhancing knowledge more equally across the population; however, they did not significantly change the rates of individuals who were up to date on HPV vaccination.[39] Further, barriers to uptake (i.e., lack of health care access, time constraints) may persist and differences in clinician behaviors may continue to shape patterns of uptake.

INTERVENTIONS FOR INCREASING HPV VACCINATION RATES

Studies have demonstrated that the most effective intervention to increase vaccine uptake in individuals is strong recommendation for vaccination by their health care professional.[39,48] Research documenting HPV vaccination inequities suggests low-income and Black (vs. White) girls are less likely to receive a strong health care professional recommendation for vaccination and the racial gap in recommendations has waned, but not disappeared, over time.[49,50] School-entry HPV vaccination mandates may have provided the incentive for clinicians to discuss HPV vaccination with eligible individuals and their parents as part of routine care, mitigating inequities in recommendation receipt.[39] Other studies found that reminder-based interventions for health care professionals such as standing orders and social media campaigns have improved vaccination coverage.[51] Finally, studies have found that environmental interventions, particularly school-based and childcare center-based vaccination programs were most effective in increasing vaccination coverage.[52]

The Community Preventive Services Task Force (CPSTF) has also released the following findings on what works in public health to improve vaccination rates based on available evidence. The following interventions could be applied to increasing HPV vaccination rates:

- Home visits to increase vaccination rates.[53]
- Vaccination programs in schools and organized child-care centers.[54]
- Vaccination programs in WIC settings.[55]
- Immunization information systems set up to create or support effective interventions, such as client reminder and recall systems, provider assessment and feedback, and clinician reminders for vaccination or missed vaccination opportunities.[56]

EXISTING AMA POLICY

AMA policy H-440.872 "HPV-Associated Cancer Prevention" urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine HPV related cancer screening. This policy also states that the AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public. Further, it recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination and encourages interested parties to investigate means to increase HPV vaccination

rates by facilitating administration of HPV vaccinations in community-based settings including school settings.

AMA policy H-440.970, "Nonmedical Exemptions from Immunizations" states that the AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in the community at large. It also supports the immunization recommendations of ACIP for all individuals without medical contraindications and recommends that states have in place an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues based upon the recommendations of the ACIP and policies that permit immunization exemptions for medical reasons only.

The AMA also continues to develop material and publish new stories on how doctors can effectively communicate with patients to help build vaccine confidence.[57,58]

CONCLUSION

HPV is a common virus, some types of which spread through sexual contact.[59] Some sexually transmitted HPVs can cause genital warts, whereas others, called high-risk or oncogenic HPVs, can cause cancer.[54] High-risk HPVs cause virtually all cervical cancers, most anal cancers, and some vaginal, vulvar, penile, and oropharyngeal cancers.[6] Research has demonstrated that the HPV vaccine is a safe and effective way to decrease HPV-related cancers. However, the vaccination rate in the U.S. is suboptimal.

When first proposed, HPV school vaccine mandates were controversial. Some parents were uncomfortable with the idea of giving a vaccine for a STI to young girls age 11-12.[25] The United States is one of many countries with a long history of using school mandates to increase vaccination rates; these mandates have been consistently upheld by US courts against claims that they violate individual rights.[60] Currently, Hawaii, Rhode Island, Virginia, and D.C. have laws that require HPV vaccination for school entry. D.C. and Virginia require the HPV vaccine for girls to enter the sixth grade but allow parents to opt out of the requirement due to medical, moral, or religious reasons.[40]

Data studying jurisdictions with HPV vaccine mandates have shown that broad opt-out provisions, low enforcement of—and adherence to—HPV vaccine mandates, and no mechanism to ensure completion of the HPV vaccine series have limited the success of mandates. Further, other studies have shown that without widespread public support, monitoring, sanctions for noncompliance, or changes to the method of vaccine administration, school-entry HPV vaccine mandates do little to encourage uptake.[39] Rather, emphasis should be put on educating parents on the benefits of vaccination within the community and clinical settings.[61] Stronger health care practices such as more in-depth discussions with hesitant parents and establishing vaccination as the default are strategies that could help improve vaccination coverage rates.[55] Finally, other interventions such as strong recommendations from health care professionals, parent education, and school and childcare center-based vaccination programs are effective ways to increase initiation of HPV vaccination and ensure completion of the HPV vaccine series.[50-53]

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

1. That our AMA amend policy H-440.872, "HPV-Associated Cancer Prevention" by addition and deletion to read as follows:

HPV-Associated Cancer Prevention, H-440.872

1. Our AMA (a) strongly urges physicians and other health care professionals to educate themselves, appropriate patients, and patients' parents when applicable, about HPV and associated diseases, the importance of initiating and completing HPV vaccination, as well as routine HPV related cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs.

2. Our AMA will work with interested parties to intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public.

3. Our AMA supports legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers.

4. Our AMA:

(a) encourages the integration of HPV vaccination and ~~routine cervical~~ appropriate HPV-related cancer screening into all appropriate health care settings and visits,

(b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups ~~that benefit most from preventive measures~~, including but not limited to low-income and pre-sexually active populations,

(c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.

5. Our AMA encourages ~~will encourage~~ all efforts by interested parties ~~appropriate stakeholders to investigate means~~ to increase HPV vaccine availability, and HPV vaccination rates by facilitating administration of HPV vaccinations in community-based settings ~~including school settings~~ such as local health departments, schools, and organized childcare centers.

~~6. Our AMA will study requiring HPV vaccination for school attendance.~~

6~~7~~. Our AMA encourages collaboration with interested parties to make available human papillomavirus vaccination to people who are incarcerated for the prevention of HPV-associated cancers.

8. Our AMA will encourage continued research into (a) interventions that equitably increase initiation of HPV vaccination and completion of the HPV vaccine series; and (b) the impact of broad opt-out provisions on HPV vaccine uptake. (Amend Current HOD Policy)

2. That our AMA reaffirm Policy H-440.970, "Nonmedical Exemptions from Immunizations." (Reaffirm HOD Policy)

Fiscal Note: $5,000 - $10,000

REFERENCES

[1] Markowitz LE, Gee J, Chesson H, Stokley S. *Ten Years of Human Papillomavirus Vaccination in the United States.* Acad Pediatr. 2018 Mar;18(2S):S3-S10. doi: 10.1016/j.acap.2017.09.014. PMID: 29502635.
[2] Markowitz LE, Dunne EF, Saraiya M, et al. Human papillomavirus vaccination: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR Recomm Rep 2014;63(No. RR-05)
[3] Centers for disease Control and Prevention (CDC). HPV Vaccination Recommendations. Available at https://www.cdc.gov/vaccines/vpd/hpv/hcp/recommendations.html.
[4] Meites E, Kempe A, Markowitz LE. *Use of a 2-Dose Schedule for Human Papillomavirus Vaccination - Updated Recommendations of the Advisory Committee on Immunization Practices.* MMWR Morb Mortal Wkly Rep. 2016 Dec 16;65(49):1405-1408. doi: 10.15585/mmwr.mm6549a5. PMID: 27977643.
[5] Center for Disease Control. *HPV Vaccine*. Accessed August 1, 2023. Available at https://www.cdc.gov/hpv/parents/vaccine-for-hpv.html.
[6] National Academy for State Health Policy. *States Address School Vaccine Mandates*. Accessed August 1, 2023. Available at https://nashp.org/states-address-school-vaccine-mandates-and-mask-mandates/.
[7] Shelton RC, Snavely AC, De Jesus M, Othus MD, Allen JD. *HPV vaccine decision-making and acceptance: does religion play a role?* J Relig Health. 2013 Dec;52(4):1120-30. doi: 10.1007/s10943-011-9553-x. PMID: 22076049; PMCID: PMC4616263.
[8] National Cancer Institute. *HPV and Cancer*. Accessed August 1, 2023. Available at https://www.cancer.gov/about-cancer/causes-prevention/risk/infectious-agents/hpv-and-cancer.
[9] CDC. *Human Papillomavirus (HPV) Infection*. Accessed August 1, 2023. Available at https://www.cdc.gov/std/treatment-guidelines/hpv.htm.
[10] CDC. *HPV Vaccine Information for Clinicians*. Accessed August 1, 2023. Available at https://www.cdc.gov/hpv/hcp/need-to-know.pdf.
[11] Joura E, et al. (2007). *Efficacy of a Quadrivalent Prophylactic Human Papillomavirus (types 6, 11, 16, and 18) L1 virus-like-particle vaccine against high-grade vulval and vaginal lesions: A combined analysis of three randomized clinical trials.* The Lancet, 369(9574); Garland, S., et al. (2007). Quadrivalent vaccine against Human Papillomavirus to prevent anogenital diseases. NEJM, 356(19).
[12] Kaiser Family Foundation. *The HPV Vaccine: Access and Use in the U.S.* Accessed August 1, 2023. Available at https://files.kff.org/attachment/fact-sheet-the-hpv-vaccine-access-and-use-in-the-u-s.
[13] CDC. *Vaccine Safety.* Accessed August 1, 2023. Available at https://www.cdc.gov/vaccinesafety
[14] CDC. *Human Papillomavirus (HPV) Vaccine*. Accessed August 1, 2023. Available at https://www.cdc.gov/vaccinesafety/vaccines/hpv-vaccine.html.
[15] Goldstone SE. *Human papillomavirus (HPV) vaccines in adults: Learnings from long-term follow-up of quadrivalent HPV vaccine clinical trials.* Hum Vaccin Immunother. 2023 Dec 31;19(1):2184760. doi: 10.1080/21645515.2023.2184760. Epub 2023 Mar 13. PMID: 36916016; PMCID: PMC10038021.
[16] Mayhew A, Mullins TL, Ding L, et al. *Risk perceptions and subsequent sexual behaviors after HPV vaccination in adolescents.* Pediatrics 2014;133:404–11. PMID:24488747 https://doi.org/10.1542/peds.2013-2822.
[17] Jess McHugh, *First U.S. vaccine mandate in 1810 launched 200 years of court battles* (The Washington Post; Dec. 12, 2021). https://www.washingtonpost.com/history/2021/12/12/first-vaccine-mandate-massachusetts-waterhouse/?utm_source=pocket_saves
[18] James G. Hodge Jr. & Lawrence O. Gostin, *School Vaccination Requirements: Historical, Social, and Legal Perspectives*, Kentucky Law Journal: Vol. 90, Iss. 4, Art. 7 (2002). https://uknowledge.uky.edu/cgi/viewcontent.cgi?article=1480&context=klj
[19] CDC, *State School Immunization Requirements and Vaccine Exemption Laws* (Feb. 2022). https://www.cdc.gov/phlp/docs/school-vaccinations.pdf
[20] Minami Funakoshi, *U.S. Vaccine Mandates in Schools*, Reuters (Sept. 15, 2021). https://www.reuters.com/graphics/HEALTH-CORONAVIRUS/BIDEN/zgpombrajpd/
[21] Library of Congress, *State Police Power and Tenth Amendment Jursiprudence*. https://constitution.congress.gov/browse/essay/amdt10-3-2/ALDE_00013622/

[22] Wendy K. Mariner, George J. Annas, & Leonard H. Glantz, Jacobson v Massachusetts*: It's Not Your Great-Great-Grandfather's Public Health Law*, American Journal of Public Health 95, no. 4 (Apr. 1, 2005): pp. 581-590. https://doi.org/10.2105/AJPH.2004.055160
[23] *Jacobson v. Massachusetts*, 197 U.S. 11 (1905).
[24] *Zucht v. King*, 260 U.S. 174 (1922).
[25] *See Brown v. Stone*, 378 So. 2d 218, 223 (Miss. 1979): "To the extent that it may conflict with the religious beliefs of a parent, however sincerely entertained, the interests of the school children must prevail."
[26] National Conference of State Legislatures. States With Religious and Philosophical Exemptions From School Immunization Requirements. https://www.ncsl.org/health/states-with-religious-and-philosophical-exemptions-from-school-immunization-requirements
[27] CDC, *Improving Vaccination Coverage Fact Sheet*, (Apr. 2015). https://www.cdc.gov/vaccines/imz-managers/laws/downloads/Improving-Vax-Coverage-Factsheet.pdf
[28] CDC, *Quadrivalent Human Papillomavirus Vaccine: Recommendations of the Advisory Committee on Immunization Practices (ACIP)*, MMWR Vol. 56 RR-2 (Mar. 23, 2007). https://www.cdc.gov/mmwr/PDF/rr/rr5602.pdf
[29] Richard Knox, *HPV Vaccine: The Science Behind the Controversy*, NPR (Spt. 19, 2011). https://www.npr.org/2011/09/19/140543977/hpv-vaccine-the-science-behind-the-controversy
[30] *See generally* S. Mollborn and B. Everett, *Correlates and Consequences of Parent-Teen Incongruence in Reports of Teens' Sexual Experience*, Journal of Sex Research 47, no. 4 (2010): 314-329; L. O'Donnell, A. Stueve, and R. Duran, et al., *Parenting Practices, Parents' Underestimation of Daughters' Risks, and Alcohol and Sexual Behaviors of Urban Girls*, Journal of Adolescent Health 42, no. 5 (2008): 496-502; B.F. Stanton, X. Li, J. Galbraith, et al. *Parental Underestimates of Adolescent Risk Behavior: A Randomized, Controlled Trial of a Parental Monitoring Intervention*, Journal of Adolescent Health 26, no. 1 (2000): 18-26.
[31] M. K. Beckett, M. N. Elliot, S. Martino, et al., *Timing of Parent and Child Communication About Sexuality Relative to Children's Sexual Behaviors*, Pediatrics 135, no. 1 (2010): 33-41.
[32] Jonathan T. Scott, *The Difficult Road to Compelling Vaccination for Sexually Transmitted Diseases – How Gardasil and Those to Follow Will Change the Way that States Require Inoculation*, Kentucky Law Journal: Vol. 97: Iss. 4, Article 5 (2009). https://uknowledge.uky.edu/klj/vol97/iss4/5
[33] *Boone v. Boozman*, 217 F. Supp. 2d 938, 954 (E.D. Ark., 2002).
[34] Michelle J. Bayefsky, *The Ethical Case for Mandating HPV Vaccination*, Journal of Law, Medicine & Ethics: Vol. 46, Iss. 2 (2018). https://doi.org/10.1177/1073110518782957
[35] CDC, National Vaccination Coverage Among Adolescents Aged 13–17 Years — National Immunization Survey-Teen, United States, 2021, MMWR: Vol. 71, No. 35 (Sept. 2, 2022). https://www.cdc.gov/mmwr/volumes/71/wr/pdfs/mm7135a1-H.pdf
[36] Kaiser Family Foundation, *The HPV Vaccine: Access and Use in the U.S.*, (Jul. 12, 2021). https://www.kff.org/womens-health-policy/fact-sheet/the-hpv-vaccine-access-and-use-in-the-u-s/
[37] Gillian K. SteelFisher et al., *Has COVID-19 Threatened Routine Childhood Vaccination? Insights From US Public Opinion Polls*, Health Affairs (June 6, 2023). https://www.healthaffairs.org/content/forefront/has-covid-19-threatened-routine-childhood-vaccination-insights-us-public-opinion-polls
[38] Seither R, Laury J, Mugerwa-Kasujja A, Knighton CL, Black CL. Vaccination coverage with selected vaccines and exemption rates among children in kindergarten—United States, 2020–21 school year. MMWR Morb Mortal Wkly Rep 2022;71:561–8. https://doi.org/10.15585/mmwr.mm7116a1 PMID:35446828
[39] Seither R, Calhoun K, Yusuf OB, et al. Vaccination Coverage with Selected Vaccines and Exemption Rates Among Children in Kindergarten — United States, 2021–22 School Year. MMWR Morb Mortal Wkly Rep 2023;72:26–32. DOI: http://dx.doi.org/10.15585/mmwr.mm7202a2.
[40] Pingali C, Yankey D, Elam-Evans LD, et al. Vaccination Coverage Among Adolescents Aged 13–17 Years — National Immunization Survey–Teen, United States, 2022. MMWR Morb Mortal Wkly Rep 2023;72:912–919. DOI: http://dx.doi.org/10.15585/mmwr.mm7234a3.
[41] Immunize.org. *HPV Vaccine Mandates for Elementary and Secondary Schools.* Accessed August 1, 2023. Available at https://www.immunize.org/laws/hpv.asp.
[42] Polonijo N., Andrea. The impact of school-entry mandates on social inequalities in human papillomavirus vaccination. Population Health. 2020; https://doi.org/10.1016/j.ssmph.2020.100647.
[43] Abrevaya, J., & Mulligan, K. (2011). *Effectiveness of state-level vaccination mandates: Evidence from the varicella vaccine.* Journal of Health Economics, 30, 966–976.

[44]Olshen, E., Mahon, B. E., Wang, S., & Woods, E. R. (2007). *The impact of state policies on vaccine coverage by age 13 in an insured population.* Journal of Adolescent Health, 40, 405–411.
[45] Cuff, R. D., Buchanan, T., Pelkofski, E., Korte, J., Modesitt, S. P., et al. (2016). *Rates of human papillomavirus uptake amongst girls five years after introduction of statewide mandate in Virginia.* American Journal of Obstetrics and Gynecology, 214, 752. e1–752.e6.
[46] Perkins, R. B., Lin, M., Wallington, S. F., & Hanchate, A. D. (2016). *Impact of school entry and education mandates by states on HPV vaccination coverage: Analysis of the 2009–2013 National Immunization Survey–Teen.* Human Vaccines & Immunotherapeutics, 12, 1615–1622.
[47] Moghtaderi, A., & Adams, S. (2016). The role of physician recommendations and public policy in human papillomavirus vaccinations. Applied Health Economics and Health Policy, 14, 349–359.
[48] Holman, D. M., Benard, V., Roland, K. B., Watson, M., Liddon, N., & Stokley, S. (2014). *Barriers to human papillomavirus vaccination among US adolescents: A systematic review of the literature.* JAMA Pediatrics, 168, 76–82.
[49] Burdette, A. M., Webb, N. S., Hill, T. D., & Jokinen-Gordon, H. (2017). *Race-specific trends in HPV vaccinations and provider recommendations: Persistent disparities or social progress?* Public Health, 142, 167–176.
[50] Polonijo, A. N., & Carpiano, R. M. (2013). *Social inequalities in adolescent human papillomavirus (HPV) vaccination: A test of fundamental cause theory.* Social Science & Medicine, 82, 115–125.
[51] Niccolai M.L., Hansen C.E. *Practice- and Community-Based Interventions to Increase Human Papillomavirus Vaccine Coverage: A Systematic Review*. JAMA Pediatr. 2015;169:686–692. doi: 10.1001/jamapediatrics.2015.0310.
[52] Walling E.B., Benzoni N., Dornfeld J., Bhandari R., Sisk B.A., Garbutt J., Colditz G. *Interventions to Improve HPV Vaccine Uptake: A Systematic Review*. Pediatrics. 2016;138 doi: 10.1542/peds.2015-3863.
[53] The Community Guide. CPSTF. Vaccination Programs: Immunization Information Systems. Accessed August 1, 2023. Available at https://www.thecommunityguide.org/findings/vaccination-programs-home-visits-increase-vaccination-rates.
[54] The Community Guide. CPSTF. Vaccination Programs: Immunization Information Systems. Accessed August 1, 2023. Available at https://www.thecommunityguide.org/findings/vaccination-programs-schools-and-organized-child-care-centers.
[55] The Community Guide. CPSTF. Vaccination Programs: Immunization Information Systems. Accessed August 1, 2023. Available at https://www.thecommunityguide.org/findings/vaccination-programs-special-supplemental-nutrition-program-women-infants-children-wic.
[56] The Community Guide. CPSTF. *Vaccination Programs: Immunization Information Systems.* Accessed August 1, 2023. Available at https://www.thecommunityguide.org/media/pdf/Vaccination-Immunization-Info-Systems.pdf.
[57] American Medical Association. *Marie Brown, MD, discusses vaccination hesitancy.* Available at https://www.ama-assn.org/delivering-care/public-health/marie-brown-md-discusses-vaccination-hesitancy
[58] Sara Berg. *How to have crucial conversations with vaccine-hesitant patientsAmerican Medical Association.* Available at https://www.ama-assn.org/delivering-care/public-health/how-have-crucial-conversations-vaccine-hesitant-patients.
[59] Burd EM. *Human papillomavirus and cervical cancer.* Clin Microbiol Rev. 2003 Jan;16(1):1-17. doi: 10.1128/CMR.16.1.1-17.2003. PMID: 12525422; PMCID: PMC145302.
[60] AMA J Ethics. 2020;22(1):E36-42. doi: 10.1001/amajethics.2020.36.
[61] CDC. *Improving Vaccination Coverage Fact Sheet*. Accessed August 1, 2023. Available at https://www.cdc.gov/vaccines/imz-managers/laws/downloads/improving-vax-coverage-factsheet.pdf.

REPORT 4 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH
Supporting and Funding Sobering Centers (Resolution 913-I-22)
(Reference Committee K)

EXECUTIVE SUMMARY

BACKGROUND. The objective of this report is to provide a comprehensive overview of sobering centers and their role in addressing the needs of individuals who are acutely intoxicated. This report highlights the current landscape, research, and implementation barriers to establishing safe and effective sobering centers in the U.S.

METHODS. English language articles and grey literature were selected from searches of PubMed and Google Scholar using the search terms “sobering center,” “sober center,” “stabilization program,” “inebriate program,” “inebriate center,” and “diversion center.” Additional articles were identified by manual review of the reference lists of pertinent publications. Searches of selected medical specialty society, national, and local government agency websites were conducted to identify definitions, guidelines, statements, and reports.

RESULTS. Sobering centers may play a role in diverting individuals who are acutely intoxicated from emergency departments and jails, providing a supportive environment for sobering care. The lack of standardized guidelines and best practices poses challenges for these centers, impacting their ability to effectively serve diverse populations and address safety and health equity concerns. Funding and financial sustainability remain significant barriers, with limited options for reimbursement from traditional insurers. Additionally, gaining community acceptance for sobering centers in neighborhoods can be challenging due to stigma and misconceptions.

CONCLUSION. Sobering centers provide a supportive environment for individuals who are acutely intoxicated, effectively diverting them from emergency departments and jails. However, the evidence-based resources and peer-reviewed research for sobering centers are limited, with most reports being based on annual operating data or individual sites. As most sobering centers are funded and operated by local governments, there is limited cross-collaboration on the national level in researching cost effectiveness, health outcomes and standardizing data collection or best practices. Comprehensive external validation of sobering centers is necessary to establish their efficacy and impact on the individuals they serve.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 4-I-23

Subject: Supporting and Funding Sobering Centers

Presented by: David J. Welsh, MD, MBA, Chair

Referred to: Reference Committee K

At the 2022 Interim Meeting of the American Medical Association (AMA), the House of Delegates Resolution 913 "Supporting and Funding Sobering Centers," was referred. Resolution 913 asked that our AMA recognize the utility, cost effectiveness, and racial justice impact of sobering centers; support the maintenance and expansion of sobering centers; support ongoing research of the sobering center public health model; and support the use of state and national funding for the development and maintenance of sobering centers.

This report investigates the various aspects of sobering centers, including available evidence, best practices, implementation challenges, access issues, and health equity considerations. Through an analysis of the current state of sobering centers, this report sheds light on their effectiveness and identifies areas for improvement and further research. This report serves as the Council on Science and Public Health's (CSAPH) findings and recommendations regarding sobering centers.

METHODS

English language articles and grey literature were selected from searches of PubMed and Google Scholar using the search terms "sobering center," "sober center," "stabilization program," "inebriate program2," "inebriate center," and "diversion center.". Additional articles were identified by manual review of the reference lists of pertinent publications. Searches of selected medical specialty society, national, and local government agency websites were conducted to identify definitions, guidelines, statements, and reports.

BACKGROUND

Sobering Centers (SCs), also known as stabilization programs, support and connection centers, and diversion centers, were established in The Uniform Alcoholism and Treatment Act of 1971 as an alternative to jail admission for public intoxication and the emergency department (ED) for individuals who are acutely intoxicated, non-violent, and do not present with acute medical conditions or co-existing medical complaints.[1,2] The act legally allows states to create treatment solutions to monitor, stabilize and coordinate care for individuals who are acutely intoxicated on alcohol.[3] Over time states and localities have broadened the scope of SCs to encompass intoxication from substances beyond alcohol.

SCs typically prioritize one of three main programmatic purposes: jail diversion, ED diversion and homeless/social welfare practices.[1] Prior to the establishment of SCs, the prevalent approach to dealing with public intoxication involved detaining individuals in jail cells, often referred to as "drunk tanks." During this process, individuals were charged with drunk and disorderly or public

intoxication offenses. These jail cells were commonly unmonitored, and individuals who are intoxicated often faced adverse consequences, including preventable fatalities resulting from overdose, suicide, or unidentified medical conditions such as head trauma.[3,4]

Public intoxication is addressed in a variety of ways by states across the U.S. As of 2016, 22 states had laws making public intoxication illegal, while 12 states specified that intoxication is not a crime, although municipalities within those states might still have laws against it.[5] In states where public intoxication is still considered a crime, individuals are typically charged with a misdemeanor, punishable by jail time and/or a fine.[6] Racial and ethnic disparities in ticket, arrest, and incarceration rates exist, as the people most frequently impacted are disproportionately Black, have a substance use disorder, and are unstably housed, though the overlap is unclear.[7] Despite similar substance use rates between racial groups, the arrest rates for Black, Latinx, and Indigenous peoples are exponentially higher when compared to Whites for substance use, public intoxication, and associated charges such as disorderly conduct.[8]

The criminalization of public drunkenness or intoxication has also resulted in class bias in law enforcement, without producing significant rehabilitative or deterrent effects.[9] A key policy change to avoid unnecessary removal of people from public spaces and prevent arrest and incarceration would be to repeal existing public intoxication laws. By decriminalizing public intoxication—defined as the elimination of criminal penalties so that individuals are not arrested or incarcerated solely for being intoxicated—we can shift the focus of law enforcement from penalizing a state of being. It is important to note that this policy change would not affect laws designed to prevent specific harmful actions to self or others while using a substance, such as driving under the influence (DUI).

There are approximately 52 known SCs located in approximately 23 states in both rural and urban settings, with 25 percent of the nation's known SCs located in California.[4,10] It is possible that additional SCs exist, but are not identified in available sources. In 2019, SCs had approximately 30,000 encounters in California alone, indicating a possible utility for the services in other jurisdictions across the US.[4] Currently, there is no collated national data on SCs and most are run at the local level by the city or county. This results in disjointed information regarding their use and creates barriers to assessing best practices, implementation, health outcomes, and societal impact. A study of 18 SCs found that a majority (56.6 percent) are located on the West coast and are concentrated in both small and large cities.[11] Additionally, 82 percent are a part of a non-profit organization, as opposed to stand-alone sites.[11]

In general, SCs are low-threshold, 24/7 short-term care facilities for individuals who are acutely intoxicated. However, there is no standard or consensus definition of a SC. According to Oregon statute, a SC is a facility that provides a safe and supervised environment for individuals who are acutely intoxicated until they are no longer intoxicated.[12] Under Oregon code, SCs are affiliated with an approved substance use disorder (SUD) treatment program and has comprehensive written policies for the safety of individuals who are intoxicated, staff, and volunteers. These policies include case consultation, training, advice, and a plan for making referrals to SUD treatment. While the majority are open 24/7, other SCs vary widely in their hours, capacity, accommodations, health services offered, staffing, and budgets. Some SCs have a co-located detoxification or withdrawal management facility, mental health counseling, and residential inpatient treatment located in the same building for easy triage, but there are many that are stand-alone and work within their community to refer people to local health and social services.

DISCUSSION

Sobering Center Context

The intersection of the criminal-legal system, housing insecurity, and ED utilization highlights a complex web of social, racial, and health disparities in the U.S. with relation to SCs. In 2019, the U.S arrested approximately 316,032 people for "drunkenness" or "public intoxication" and 1,558,862 people for drug violations with the vast majority of those arrested being Black or Latinx.[13] Racial disparities exist throughout the criminal-legal system and result in exacerbated negative health outcomes. Whereas 32 percent of the population in the U.S is Black or Latinx, they comprise of 56 percent of people incarcerated – with Blacks incarcerated at more than 5 times the rate of whites.[14]

Homelessness, frequently interconnected with substance use, exacerbates adverse health outcomes, and is influenced by various social drivers of health (e.g., health care access, employment, education, poverty). The association between homelessness and substance use is bidirectional. While substance use can be a factor that results in homelessness, people experiencing homelessness may use substances as a coping mechanism to deal with the safety risks and trauma of being unhoused.[15] LGBTQ+ youth and veterans experience higher rates of homelessness and substance use, largely attributable to psychological stressors including trauma and social and structural stressors including social marginalization, discrimination, and health care inequities.[16,17] Homelessness has also been associated with increased substance use disorder disease severity and poorer health outcomes[18–20] While substance use affects all socioeconomic categories, research indicates higher rates of ED use and recidivism for those with co-occurring homelessness and substance use disorders, exacerbating the need for comprehensive support and evidence-based interventions that support these populations.[21]

The ED serves as a critical point of contact for individuals who are unhoused and use substances. A Substance Abuse and Mental Health Services Administration (SAMHSA) conducted analysis of participating hospitals determined that the top ten drugs in drug-related ED visits in 2022 were related to alcohol (45 percent), opioids (12.7 percent), cannabis (11.9 percent), methamphetamine (8.2 percent), and cocaine (5.8 percent).[22] Alcohol was found as the most common additional substance involved in methamphetamine, cannabis, and cocaine related ED visits.[22] (See Table 1) Acute alcohol intoxication is a known risk factor for frequent utilization of the ED,[23] and while acute alcohol intoxication can require emergency medical intervention due to potential complications, such as respiratory depression or liver failure, studies have shown that fewer than 1 percent of individuals assessed with uncomplicated alcohol intoxication need emergency services.[24] However, there is a need for national-level research to quantify the number of individuals admitted to EDs for uncomplicated alcohol intoxication versus complicated cases. Such data would help evaluate the extent to which alternative services like SCs could benefit the population at large.

Limited resources and time in most EDs make it challenging to provide monitoring for individuals who do not have critical medical complications.[3,4] In response to the emerging needs of these populations, states and localities have instituted sobering centers (SCs) as an approach to stabilize individuals intoxicated on drugs (alcohol, opioids, methamphetamines, or cocaine).[4] While supportive services and referral to evidence-based treatment may be available on-site, SCs are not treatment facilities for people who use substances or have substance use disorders.[4]

Sobering Center Components

The most comprehensive survey conducted on SCs in the U.S. provides valuable insights into the diversity of clientele, practices, and staffing within these centers. The survey collected self-reported data from 11 sobering centers located in 14 states, offering a view of their operations.[1] Further research on sobering centers not included in the survey, provides a broader perspective on the practices and characteristics of these facilities. The collective data from the surveyed centers and additional research shed light on the various approaches and differences found among sobering centers across the country.

Referral and Admissions

Typically, SCs receive direct referrals from law enforcement with some centers solely receiving referrals from law enforcement.[1] Centers also accept referrals from EMS/ambulatory personnel and non-ambulance vans or outreach vans that respond to 911 calls that involve public intoxication.[1] While self-referral and walk-ins are an option at some SCs, referrals can also be made from EDs, social services, clinics, or community programs.[3,25] In a survey conducted of 18 SCs, 69 percent accepted referral from law enforcement, 62 percent from EDs, and 54 percent walk-in/self-referral.[11] (See Table 2 for referral flowchart)

All SC clients are admitted voluntarily.[1] The number of individuals able to receive services in SCs varies from 11 to 84 persons. Individuals are primarily referred to SCs for alcohol intoxication, but an undetermined amount of SCs have expanded to include people intoxicated from other substances such as opioids, methamphetamine, cannabis, and cocaine, in an effort to expand the scope of services given the evolving substance landscape.[4,26]

SCs in New York City accept individuals with active psychiatric disorders.[2] These centers are a part of a multi-agency effort to provide a health-centered alternative to emergency room visits and criminal-legal interventions, serving as a vital component in the city's broader strategy to address mental health and substance use as interconnected public health issues.[2] This strategy differs from other SCs that solely admit individuals who are intoxicated, and those presenting to a SC with active psychiatric disorders are triaged to a higher level of care, such as an ED. There is a wide variation in the number of clients a SC sees annually. From 2019-2020, one SC only admitted 10 clients while another admitted 13,325, with approximately 20 percent being repeat clients.[11] The agencies were deidentified in the report, so it is unclear whether location impacted admitted clients. The report lacked specificity regarding whether the estimated clients admitted were unique or if SCs served dual purposes, such as drop-in cooling centers during summer months.[11] However 67 percent of the SCs are co-located with other programs which could account for the varying client admittance. [11]

All SCs report having a triage process in place, although the specific procedures vary.[1] In terms of admitting clients, in centers where staff lacks medical training the assessment is informal and might involve a breathalyzer for alcohol, but does not include taking vital signs.[1] In Cambridge, the assessment revolves around determining if a client can walk safely when they arrive on their own or are brought in by the police.[1] Other centers use triage checklists completed by pre-hospital transport (EMS or outreach van), intake staff, or both.[25] (See Table 3 for sample inclusion criteria) These checklists typically focus on complaints and vital signs, with clients considered unsuitable for the center if they have medical issues or abnormal vital signs. However, none of the checklists used have been externally validated or recognized by a national organization as safe practices, but

many have input from local emergency medical staff, local public health officials, and other sobering centers.

Clients

The types of clients that are admitted into SCs usually fall into two categories. The first population consists of clients characterized by chronic use, cognitive impairment, or co-occurring homelessness, who face severe disorganization in their lives,[4] essentially, functioning as shelters that admit people who are intoxicated. The second population is comprised of individuals who may be housed or unhoused but can independently manage their daily activities.[4] This group primarily seeks a secure space to metabolize alcohol or other substances and does not require intensive services. The issue becomes complex when all available beds are consistently occupied, some by individuals with no other housing options and others who require only short-term sobering care. Both populations have acute needs, and the scarcity of beds suggests systemic limitations. Striking a balance between meeting the needs of both populations is essential to ensure effective and equitable utilization of SC resources.[4]

Length of Stay

The average length of stay for clients in SCs varies. In California, length of stays typically range from 7 to 12 hours.[4] However, some centers have a minimum stay requirement of 4 hours, while others may have no minimum length of stay.[1] The duration of stay in SCs is influenced by several factors, including the individual's level of intoxication, their ability to recover safely, and the center's specific protocols and resources. These timeframes aim to provide sufficient time for individuals to stabilize, ensure their safety, and potentially access additional support or services before being discharged.

Staffing

The credentials of the people who staff SCs varies widely. The majority of SCs fall across a spectrum of staffing non-physician providers such as licensed nurses, emergency medical technicians (EMTs), paramedics, and/or health care technicians.[4] For example, in San Francisco one SC has registered nurses (RNs), medical assistants, and non-medical personnel, while SCs located in Cambridge, MA and San Diego, CA have all non-medical personnel.[1] It should also be noted that many SCs are co-located within medical facilities and have access to behavioral health staff including physicians, even if they are not staffed as part of the SC, as opposed to stand-alone SCs.

Services

SCs offer a range of services and typically include hospitality, supportive care, wound care, and provision of essential daily living materials such as clothing, showers, and hygiene supplies. Additionally, SCs facilitate linkages to primary care, mental health services, and substance use disorder treatment. Peer support and counseling services are also commonly available, along with connections to social services and housing resources. It is important to note that while some centers may have a co-located medically supervised withdrawal program (ASAM level 3.7), this is not universally offered across all SCs. The scope of services provided by SCs can vary from one location to another while some are co-located with residential treatment, others only provide referral. For example, in Portland, Oregon, the SC operates as part of a centralized facility that

offers comprehensive services for people experiencing homelessness or with SUD. On the other hand, in Bethel, Alaska the SC is a stand-alone facility with no long-term services.[1] SCs report the majority of individuals who are intoxicated do not need a higher level of emergency care and greater than 90 percent of the clients were "appropriate" for the center.[1] However, 5 SCs (41.7 percent) reported experiencing a client fatality at some point in their operation. The circumstances around these deaths were not included in the report.[11]

SCs have different approaches to client monitoring and supervision. All programs typically have at least two members on staff at all times, and it is considered best practice to continuously check-in on clients, however it is unclear what interval is most appropriate especially when compared to monitoring practices in EDs.[1] According to a subject matter expert, an essential aspect of a sobering center is the strategic placement of medical staff, ensuring that they have a clear view of every individual in the room.[27] Alternatively, continuous bedside monitoring at intervals of 5 or 10 minutes may also be implemented.[27] At least one wrongful death lawsuit, *Ryder v. MFI Recovery Center*, has been filed against a SC alleging falsified observation logs concerning the frequency with which staff monitored a client, leading to a fatal overdose.[28] The SCs license has since been revoked by the California Department of Health Care Services.[29] Of note, in many cases, the safety and monitoring of clients surpasses the level of care provided in jails by law enforcement, which begs the question of if SCs are a more appropriate setting for people who are intoxicated than jail.

In terms of discharge policies, each SC has established its own protocols for discharge practices that typically include evaluating a client's ability for self-care, including ambulation, having a plan after leaving, and meeting hygiene needs.[1] Discharge assessments may involve screening vital signs, modified mini-mental status exams, resolution of signs and symptoms of intoxication as characterized in the DSM-4, as well as general well-being checks conducted by non-medical staff. While these specific signs and symptoms were not outlined in the report, it is important to note the potential for complications due to precipitated withdrawal by sudden cessation for those who have dependence or use disorder.[30] In two programs, a specific blood alcohol level, an estimated measurement through breathalyzer, is used as a clinical indication for discharge.[1]

Secondary transport of clients is uncommon. A study conducted at a SC in San Francisco revealed that the majority of visits to the center did not require ambulance discharge, and only 4.4 percent (506 individuals) needed to be transferred to the ED.[25] The main reasons for transfer included tachycardia (26 percent), alcohol withdrawal (19 percent), pain (19 percent), altered mental status (13 percent), and emesis (13 percent).[25] The study concludes that clients who were transferred to the sobering center after being medically cleared in the ED had slightly higher rates of discharge back to the ED. [25] This suggests the importance of having medically trained staff at sobering centers to monitor individuals and effectively triage and provide care for their needs. (See Table 4 for Clinical Indications & Table 5 for Reasons for Secondary Transfer)

National statistics on recidivism rates specific to SCs are not available. However, a study conducted in Houston, Texas, from 2013 to 2017 found that out of the 25,282 clients admitted, 77 percent (19,486 individuals) were admitted more than once, and 23 percent (5,814 individuals) were admitted three or more times.[26] Similarly, a SC in Iowa has reported instances of recidivism, where individuals are encouraged to return to the center multiple times as a step toward eventual treatment.[31] However, there may be limits on the number of times individuals can access the center within a specific time frame, such as per week, to ensure equal access for all individuals seeking services.

Cost-Effectiveness Analysis

Cost savings associated with the implementation of SCs are substantial and far-reaching. By diverting individuals from incarceration, SCs offer a cost-effective alternative to the high expenses of housing inmates. For instance, Harris County jail admission costs $286 per day, while a SC, operating at full capacity, would incur a significantly lower cost of $127 per admission.[26] SCs contribute to substantial savings by reducing unnecessary emergency care expenses. A cost analysis comparing the San Francisco SC with direct ED costs per encounter found that acute intoxication care at the SC resulted in savings of $243 per client with the SC care being less costly ($274) when compared to the ED ($518).[32] There is currently no research comparing the costs of SCs staffed with medical personnel to those staffed solely with non-medical personnel. SCs also alleviate the burden of unnecessary law enforcement processing. For example, the Santa Cruz Recovery Center demonstrated a 53 percent reduction in law enforcement processing, translating to $83,290 in savings in officer costs.[33]

The financial impact of SCs can extend to city and state levels as well. Houston reported a positive fiscal impact of $2.9 million in the first 20 months after opening its sobering center.[34] However there is still further data needed, as the study did not estimate or denote the cost of SC admission, which can vary greatly depending on physical location and number of clients admitted. In New York City, the government spent $51 million on establishing a SC in East Harlem, but in the first 6 months only admitted 45 people, which averages to $1.1 million per visit.[35] This highlights a significant need for enhanced cross-collaboration and open communication among stakeholders involved in the implementation of sobering centers. Effective dialogue among healthcare providers, law enforcement agencies, community organizations, and policymakers is essential for the successful establishment, maintenance, and optimal utilization of sobering centers.

Nationally, when considering the cost of ED visits, SC visits, and sobering center start-up costs, a budget analysis estimated annual cost savings ranging from $230 million to $1 billion, assuming a diversion rate of 50 percent based on previous studies.[36] A challenge to consider in implementation is the utilization of the centers when compared to the cost of long-term solutions such as an overdose prevention site or supportive housing. There is limited data available on the in-depth cost-effectiveness analysis of SCs. SCs may be cheaper than jail or ED stays but the appropriate comparison for people experiencing homelessness with substance use disorder is permanent supportive housing (PSH).

PSH with a housing first approach, is a competitive model for sobering care for people who are unhoused. PSH is defined as long-term and affordable housing with ongoing supportive services (e.g., counseling, treatment, conflict resolution, nutrition) by staff (e.g., case managers, social workers, and health care professionals) to assist people living with mental health and/or substance use disorders who have experienced housing insecurity or homelessness. The harm reduction and community housing model of PSH ensures that residents can be monitored for intoxication, if needed, while concurrently obtaining supportive services. However, this does not address the clients that would be admitted to a SC for short-term monitoring that already have permanent housing. Overall, the limited cost-effectiveness research suggests SCs are less expensive alternatives that can benefit individuals in crisis and yield potential economic advantages for communities and states.

Best Practices

Assessing standards and best practices among SCs is challenging due to the lack of uniformity across different centers. Members of the *American College of Emergency Physicians Public Health and Injury Prevention Committee on Sobering Centers* surveyed 11 SCs. The respondents shared best practices which include motivational interviewing, housing first philosophy, case management,

inter-organizational communication, peer support, and harm reduction.[37] The California Health Care Foundation identifies three foundational best practices for SCs.[4] First, a low-barrier and compassionate service model ensures easy access for individuals by minimizing paperwork, eligibility requirements, and complex intake processes.[4] Second, SCs play a central role in care coordination, with many offering around-the-clock staffing and services to provide immediate crisis response and facilitate communication with other service providers.[4] Lastly, programmatic flexibility is crucial, allowing SCs to meet the specific needs of individuals and the community, such as offering longer stays on a case-by-case basis, providing shelter during inclement weather, or caring for high-need individuals who may not meet standard eligibility criteria.[4]

Another example of a best practice observed at SCs is their commitment to accommodating individuals despite challenging behavior, with only rare instances of permanent restrictions from accessing services.[4] For instance, individuals who exhibit violent or threatening behavior may face short-term restrictions from sobering services, typically lasting a few weeks, or undergo regular risk assessments during each visit.[4] Some centers establish safety committees consisting of frontline and managerial staff who regularly review behavioral incidents and may establish permanent restrictions on SC visits for individuals with severe substance use disorder who experience substantial health and cognitive decline, necessitating higher levels of care.[4] While these best practices support accessible, coordinated, and adaptable care within SCs, there is still a need for the establishment of standardized and externally validated intake and discharge protocols, and internal clinical best practices that are publicly available to localities for implementation.

Law Enforcement and Criminal-Legal Implications

SCs can play a critical role in promoting health equity by providing a non-punitive approach and access to health services for individuals. However, there are concerns regarding the potential misuse of sobering centers as an alternate form of punishment by law enforcement. Around 75 percent of SCs have formal partnerships with law enforcement agencies, raising questions about the ongoing criminalization of people who are unhoused and use substances which can lead to dangerous behaviors, such as hurried substance use in public or isolated locations, increasing the risk of fatal overdose.[11,15] There are barriers and challenges to achieving equitable health outcomes. Expanding law enforcements' scope to triage and determine what is medically necessary or critical to send individuals to the ED, jail, or SCs, can impact health outcomes and create disparities in access to hospital-based and SC-based services.

In a survey of police agencies, 65 percent indicated they leave the decision to use a SC to the officers' discretion and use formal written policies and informal practices to provide guidance.[11] And while 80 percent of police agencies reported training officers on using SCs, 20 percent do not provide officers with any guidance regarding the use of SCs.[11] A major concern with any law enforcement interaction especially for communities of color, people with disabilities, LGBTQ+, people who use drugs, low-income, migrant, and unhoused individuals is inequitable exposure to law enforcement action, injuries, violence, and death – which can effect individuals likelihood to seek health services and treatment, achieve positive health outcomes, and lead to compounding structural and systematic existing health inequities.[38] For these reasons, many states and localities have begun using unarmed non-law enforcement officers to address nonviolent social and medical issues in an effort to limit the scope of police power and to prevent unnecessary arrests and police violence.[39]

SCs also have the potential to serve as a connection point to treatment and health services for minoritized and marginalized populations. They can act as a steppingstone towards more comprehensive care and treatment, promoting access to vital resources. The provision of free

services and triage based on need rather than ability to pay aligns with principles of health equity, ensuring that individuals receive the care they require without financial barriers.

The presence of SCs has shown promising results in decreasing jail admissions for public intoxication, with significant declines reported in some areas. For example in Houston, Texas after the opening of a SC, jail admissions for public intoxication decreased by 95 percent (from 15,387 to 835).[26] Similarly, the Santa Cruz County Sheriff's Office reported a 53 percent decline in public intoxication bookings after the opening of the SC.[33] Overall, SCs have the potential to advance health and racial equity, however there are challenges to address. It is crucial to develop clear policies and guidelines to ensure equitable access to SC services and mitigate potential biases in decision-making. Strong collaborative efforts between law enforcement, healthcare providers, and community stakeholders are essential in fostering a non-punitive, supportive, and equitable environment to accessing SCs, particularly for populations who have been historically marginalized or underserved.

Implementation Barriers

Implementation barriers for SCs encompass various factors. One significant barrier is the lack of specific certification or accreditation programs for sobering services. While organizations operating SCs may have accreditation for other programs such as detoxification or rehabilitation, there is currently no specialized accreditation for sobering centers themselves.[3] Pursuing satellite status under an existing Federally Qualified Health Center (FQHC) may be feasible if the center is associated with a community health center that offers additional clinical services.[3] However, achieving FQHC status as a standalone sobering center is challenging.[3] The implementation of SCs in a rural or suburban setting could also present additional challenges including the ability for the SC to triage effectively between hospitals, behavioral health centers, shelters, and law enforcement due to lack of funding and resources. However, there is no data or research that addresses the specific barriers that rural and suburban SCs have encountered when compared to SCs in cities.

Funding and financial sustainability present significant challenges, particularly for services in SCs that contribute to individual well-being but lack proper reimbursement mechanisms. These services may include hygiene resources like showers and nutritional support such as food. SCs typically operate as nonprofit organizations, and rely on diverse funding sources including public and private grants, fundraising, and state-based grants.[27] Billing through traditional insurers such as Medicaid or other third-party payers is not common practice.[1]

However, as of 2021, some states including California, have made progress in securing federal funding through the "in-lieu of services" (ILOS) mechanism under the Centers for Medicare and Medicaid Services (CMS) using the state's 1915(b) waiver.[40,41] California's Medi-Cal reform proposal, CalAIM, includes a "Whole Person Care" (WPC) pilot program that authorizes sobering centers as one of fourteen "community supports" that can substitute certain medical services covered by Medi-Cal, such as ED visits or inpatient hospital care.[40,41] Although collaborative models between health plans and sobering centers have not emerged, California encourages managed care plans to offer as many of the Community Supports as possible.[4,40] CMS and Medi-Cal financing of sobering centers offers a potential pathway for licensing of the programs through California's Department of Health Care Services with certification from Medi-Cal for both county and privately owned and operated SCs. Despite these advancements, there is still a lack of guidance on billing Medi-Cal for sobering services, posing ongoing challenges for financial sustainability.[13]

Other reported implementation challenges are regarding workflows with external partners. For example, issues with reimbursement coverage for EMS services have led to EMS dropping

individuals off in the ED instead of the SCs.[31] To effectively establish and run SCs, strong coordination and community collaboration are crucial. The development of protocols and Memorandums of Understanding (MOUs) between various stakeholders enable smoother operations. Another common consensus among SCs highlights the lack of available resources for clients seeking stabilization, including detoxification, residential treatment, housing, and long-term care leading to some clients rotating in and out of short-term services, resulting in potential challenges in achieving sustained recovery and stability.[4]

Overcoming stigma and gaining community acceptance for a SC in a neighborhood is a significant challenge, often referred to as NIMBYism (Not In My Backyard). Neighbors may express concerns about the potential impacts of having a SC in their community, leading to resistance and reluctance. Building community engagement, education, and buy-in becomes particularly challenging when addressing the stigma surrounding these services. It is essential to engage with the community openly, providing accurate information and dispelling misconceptions about SCs to foster understanding and acceptance. Effective communication and transparency can play a crucial role in gaining support and ensuring the successful integration of sobering centers into the communities they serve.

Future Research Needs

While the existing research provides valuable insights into the operations and impact of SCs, there remain significant gaps that require further investigation. Key areas for further research include exploring the short-term and long-term health outcomes of individuals who utilize these centers and conducting more rigorous cost effectiveness analysis studies comparing SCs to permanent supportive housing and overdose prevention sites for people experiencing homelessness who are also using substances. Understanding the effectiveness of substance use treatment referrals made by SCs, as well as the attendance and longevity of individuals in such programs, is crucial to evaluating the overall effectiveness of these interventions. Additionally, follow-up data and comprehensive studies are needed to gain a deeper understanding of the long-term effects and potential benefits of SCs on individuals' health and well-being. Further research in these areas is essential for developing evidence-based strategies, interventions, and best practices to optimize the impact of SCs on the health and recovery of the populations they serve.

EXISTING AMA POLICY

AMA currently has policies related to substance use, substance use disorders (SUD) and community-based programs. Policy D-95.987, “Prevention of Drug-Related Overdose,” notes AMA’s support for compassionate treatment of patients with SUD and people who use drugs, urges that community-based programs offering naloxone, opioid overdose, drug safety, and prevention services continue to be implemented in order to further develop best practices, and encourages the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose. Policy D-95.962, “Enhanced Funding for and Access to Outpatient Addiction Rehabilitation,” advocates for sustained funding to states in support of evidence-based treatment for patients with SUD and/or co-occurring mental disorder.

CONCLUSION

SCs provide a supportive environment for individuals who are acutely intoxicated, effectively diverting them from emergency departments and jails. However, the evidence-based resources and peer-reviewed research for sobering centers are limited, with most reports being based on annual operating data or individual sites. It's important to note that different centers may have varying

resources and offer diverse levels of support, reflecting the distinct community needs they aim to address. As most SCs are funded and operated by local governments, there is limited cross-collaboration on the national level in researching cost effectiveness, health outcomes and standardizing data collection or best practices. Comprehensive external validation of SCs is necessary to establish their efficacy and impact on the individuals they serve. While the research on SCs is limited, there is a considerable level of interest and support for their development.[37]

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 913-I-22, and the remainder of the report be filed:

1. That our AMA will:
   A. Monitor the scientific evidence and encourage further research of sobering centers and similar entities for best practices including:
      (1) Health outcomes from sobering center utilization;
      (2) Partnerships with medical personnel and health care entities for policies, protocols and procedures that improve patient outcomes, such as transitions of care and safety measures;
      (3) The appropriate level of medical collaboration, evaluation, support, and training of staff in sobering centers;
      (4) Health economic analyses for sobering care models in comparison to existing health care, criminal-legal, and community-based systems; and
      (5) Best practices for sobering centers based on location (e.g., urban, suburban, and rural).

   B. Support state and local efforts to decriminalize public intoxication.

   C. Support federal and state-based regulation of sobering centers.

   D. Encourage and support local, state, and federal efforts (e.g., funding, policy, regulations) to establish safe havens for sobering care, as an alternative to criminalization, with harm reduction services and linkage to evidence-based treatment in place of EDs or jails/prisons for medically uncomplicated intoxicated persons. (New HOD Policy)

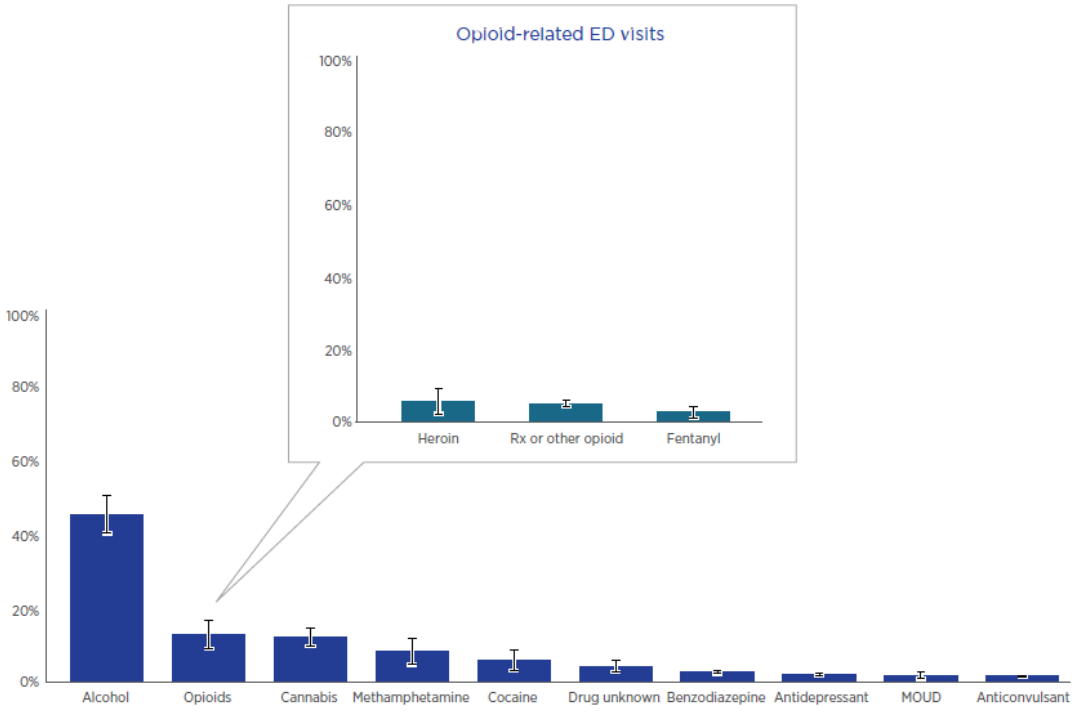
2. That our AMA reaffirm the following policies HOD policies:
   - H-345.995, "Prevention of Unnecessary Hospitalization and Jail Confinement of the Mentally Ill,"
   - H-95.912, "Involuntary Civic Commitment for Substance Use Disorder,"
   - H-95.931, "AMA Support for Justice Reinvestment Initiatives,"
   - H-515.955, "Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes," and
   - D-430.993, "Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections." (Reaffirm HOD Policies)

Fiscal Note: $1,000 - $5,000

TABLE 1: SAMHSA TOP 10 SUBSTANCES INOLVED IN DRUG-RELATED ED VISITS, 2022

Substance Abuse and Mental Health Services Administration. *Findings from Drug-Related Emergency Department Visits 2022,* Drug Abuse Warning Network. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration; 2022. Accessed July 14, 2023. https://store.samhsa.gov/sites/default/files/pep23-07-03-001.pdf

Figure 4.A Top ten substances involved in drug-related ED visits, 2022



Note: Opioid includes heroin, fentanyl, and other prescription opioids. See Appendix B for other drug definitions. Multiple substances can be reported in a single ED visit, so percentages can add up to more than 100 percent.

In 2022, alcohol was the substance most reported (45.0%) in drug-related ED visits, followed by opioids (12.7%) and cannabis (12.0%). Among 4.2 percent of drug-related ED visits, an unknown drug was reported as at least one of the substances involved. Within opioids, heroin (5.6%) and Rx or other opioids (5.0%) were reported significantly more often than fentanyl (2.7%).

TABLE 2: Referral Flowchart from Sobering Center in Houston, TX

Jarvis SV, Kincaid L, Weltge AF, Lee M, Basinger SF. Public Intoxication: Sobering Centers as an Alternative to Incarceration, Houston, 2010–2017. *Am J Public Health*. 2019;109(4):597-599. doi:10.2105/AJPH.2018.304907

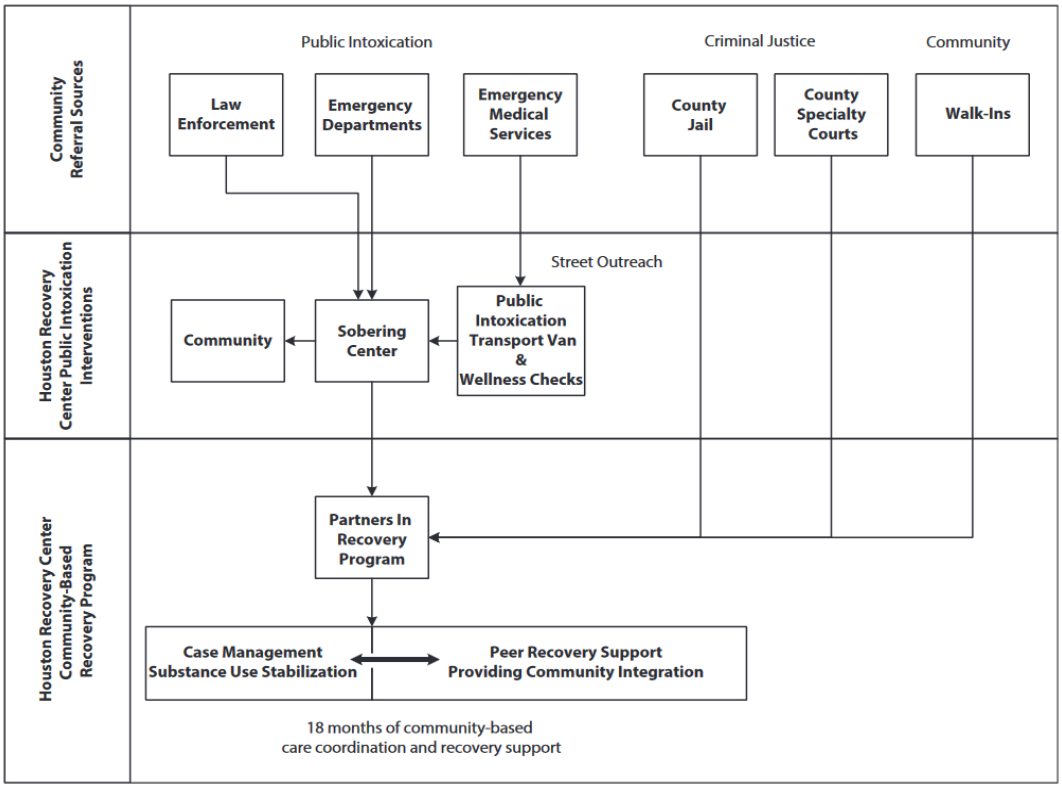


FIGURE 1—Houston Recovery Center Current Proactive Intervention for Public Intoxication and Substance Use: Houston, TX

TABLE 3: Destination Inclusion Criteria from Sobering Center in San Francisco, CA

Smith-Bernardin SM, Kennel M, Yeh C. EMS Can Safely Transport Intoxicated Patients to a Sobering Center as an Alternate Destination. *Annals of Emergency Medicine*. 2019;74(1):112-118. doi:10.1016/j.annemergmed.2019.02.004

1. DESTINATION INCLUSION CRITERIA
    a. Sobering Services: Intoxicated patients with no acute medical condition(s) or co-existing medical complaints may be transported to the San Francisco Sobering Center, if the patient meets the following criteria:
        i. Be at least 18 years or older;
        ii. Found on street / in a shelter or in Police Department custody;
    b. Voluntarily consent or have presumed consent (when not oriented enough to give verbal consent) to go to the Sobering Center;
    c. Not be on the San Francisco Sobering Center "Exclusion List."*
    d. Be medically appropriate by meeting ALL of the following criteria:
        i. Indication of alcohol intoxication (odor of alcoholic beverages on breath, bottle found on person);
        ii. Glasgow Coma Score of 13 or greater;
        iii. Pulse rate greater than 60 and less than 120;
        iv. Systolic blood pressure greater than 90;
        v. Diastolic blood pressure less than 110;
        vi. Respiratory rate greater than 12 and less than 24;
        vii. Oxygen saturation greater than 89%;
        viii. Blood glucose level greater than 60 and less than 250;
        ix. No active bleeding;
        x. No bruising or hematoma above clavicles;
        xi. No active seizure; and,
        xii. No laceration that has not been treated.

**Exclusion List: Periodically, a client may be deemed inappropriate by sobering center staff for use of the sobering center for a fixed amount of time. The client is then placed temporarily on an exclusion list. The most common reasons for placement on the exclusion list are physical violence against staff or other clients and repeated inability to care for basic needs and activities of daily living once sober. There are typically 3 to 8 persons on this list at any one time.*

Figure 1. Criteria for paramedic triage to the San Francisco Sobering Center.

TABLE 4: Clinical Indications for Secondary Transfer for Sobering Center in San Francisco, CA

Smith-Bernardin SM, Kennel M, Yeh C. EMS Can Safely Transport Intoxicated Patients to a Sobering Center as an Alternate Destination. *Annals of Emergency Medicine*. 2019;74(1):112-118. doi:10.1016/j.annemergmed.2019.02.004

Table 1. Clinical indications for secondary transfer from the San Francisco Sobering Center to an ED.

Clinical Indicator	Range
Pulse, unstable, beats/min	>100 (high); <60 (low)
Blood pressure, unstable, mm Hg	>160 systolic or >100 diastolic (high); <100 systolic (low)
Temperature, °F/°C	>100/37.8 (high); <95/35 (low)
Respiration, breaths/min	>20 (high); <7 (low)
SpO_2, %	<90 (low)
Blood glucose level, mg/dL (finger stick)	>250 (high); <50 (low)
Alcohol withdrawal, suspected	Clinical note may include tremors, hallucinations/delusions, headache, nausea, Clinical Institute Withdrawal Assessment score. Excludes seizure activity.
Injury	Clinical note includes reference to physical signs of trauma, laceration, abrasion, swelling, or incidence of or client statement of injury. Injuries may have occurred on site or before admission to sobering center.
Fall	Clinical note indicates client fall on site with or without injury, including fall from standing or out of bed
Patient complaint of pain	Complaint of acute pain, excluding chest pain
Chest pain	Indicates specific complaint of chest pain or discomfort
Seizure activity	Includes both witnessed seizures and suspected seizure followed by sudden change in mental status, difficult arousal, incontinence, bleeding
Altered mental status	Includes either a decrease in mental status after admission or a persistent altered state that has not improved with time
Drugs, other	Includes client statement of ingestion of other drugs, or corresponding symptoms with or without the presence of paraphernalia or other drugs
Suicidal ideations or attempt	Includes client statement of intent to harm self, inability to contract for safety, signs of injury, and witnessed attempts at self-harm
Emesis	Indicates active vomiting as opposed to nausea
Client request	Client request not accompanied with signs of need for higher level of care

TABLE 5: Clinical Reasons for Transfer for sobering center in San Francisco, CA

Smith-Bernardin SM, Kennel M, Yeh C. EMS Can Safely Transport Intoxicated Patients to a Sobering Center as an Alternate Destination. *Annals of Emergency Medicine*. 2019;74(1):112-118. doi:10.1016/j.annemergmed.2019.02.004

Table 2. Clinical reason for transfer to the ED.

Clinical Reason for Discharge	EMS and ED Combined (n=213, 168 Unduplicated Clients), No., % (95% CI)	EMS Referrals (n=151), No., % (95% CI)	ED Referrals (n=62) No., % (95% CI)
Pulse high, >100 beats/min	56, 26 (21–33)	27, 18 (13–25)	29, 47 (34–59)
Alcohol withdrawal, suspected	41, 19 (13–28)	19, 13 (8–23)	22, 36 (22–58)
Complaint of pain	40, 19 (14–25)	26, 17 (12–24)	14, 23 (14–35)
Emesis	28, 13 (9–18)	18, 12 (8–18)	10, 16 (9–28)
Altered mental status	28, 13 (9–18)	27, 18 (13–25)	1, 2 (0–11)
Blood pressure high, >160 systolic, >100 diastolic, mm Hg	25, 12 (8–17)	12, 8 (5–14)	13, 21 (12–33)
Client request (no obvious need)	25, 12 (8–17)	16, 11 (7–17)	9, 15 (8–26)
Chest pain	18, 8 (5–13)	6, 4 (2–9)	12, 19 (11–31)
Seizure	16, 8 (5–12)	9, 6 (3–11)	7, 11 (5–22)
Fall	15, 7 (4–11)	14, 9 (6–15)	1, 2 (0–11)

REFERENCES

1. Warren O, Smith-Bernardin S, Jamieson K, Zaller N, Liferidge A. Identification and Practice Patterns of Sobering Centers in the United States. *Journal of Health Care for the Poor and Underserved*. 2016;27(4):1843-1857. doi:10.1353/hpu.2016.0166
2. City of New York. Mayor Adams Opens New, Innovative Behavioral Health Facility for New Yorkers. Published July 13, 2022. Accessed August 2, 2023. http://www.nyc.gov/office-of-the-mayor/news/499-22/mayor-adams-opens-new-innovative-behavioral-health-facility-new-yorkers-experiencing-mental
3. Smith-Bernardin S. Sobering Centers Explained: An Innovative Solution for Care of Acute Intoxication. Published online July 2021.
4. Smith-Bernardin S. Sobering Centers Explained: An Environmental Scan in California. *California Health Care Foundation*. Published online September 2021. https://www.chcf.org/wp-content/uploads/2021/07/SoberingCentersExplainedEnvironmentalScanCA.pdf
5. Bolten KA. Should public drunkenness be a crime? *The Des Moines Register*. https://www.desmoinesregister.com/story/news/local/government/2016/02/11/public-intoxication-iowa-legislature/80205668/. Published February 11, 2016. Accessed August 2, 2023.
6. Justia. Public Intoxication Laws. Justia. Published October 2022. Accessed August 2, 2023. https://www.justia.com/criminal/drunk-driving-dui-dwi/alcohol-related-crimes/public-intoxication/
7. Jones A, Sawyer W. Arrest, release, repeat: How police and jails are misused to respond to social problems. Prison Policy Initiative. Published August 2019. Accessed August 2, 2023. https://www.prisonpolicy.org/reports/repeatarrests.html
8. Hinton E, Cook D. The Mass Criminalization of Black Americans: A Historical Overview. *Annual Review of Criminology*. 2021;4(1):261-286. doi:10.1146/annurev-criminol-060520-033306
9. Egger S, Cornish A, Heilpern H. Public Drunkenness - A Case History in Decriminalisation. U.S Department of Justice Office of Justice Programs. Published 1983. Accessed August 3, 2023. https://www.ojp.gov/ncjrs/virtual-library/abstracts/public-drunkenness-case-history-decriminalisation-issues-criminal
10. National Sobering Collaborative. Sobering Center Directory. National Sobering Collaborative. Accessed July 12, 2023. https://nationalsobering.org/directory/
11. Isaza G, Engel R, Cherkauskas JC. *Examining the Utility of Sobering Centers*. National Policing Institute; 2022. chrome-extension://efhttps://www.policinginstitute.org/wp-content/uploads/2022/12/Evaluating-the-Utility-of-Sobering-Centers_National-Survey-Report_FINAL.pdf
12. Oregon Admin. Code tit. 35 § 430.306 (2023)
13. Federal Bureau of Investigation. 2019 Crime in the United States. U.S Department of Justice. Published 2019. Accessed July 14, 2023. https://ucr.fbi.gov/crime-in-the-u.s/2019/crime-in-the-u.s.-2019/tables/table-29/table-29.xls
14. NAACP. Criminal Justice Fact Sheet. Published May 24, 2021. Accessed July 13, 2023. https://naacp.org/resources/criminal-justice-fact-sheet
15. Doran KM, Fockele CE, Maguire M. Overdose and Homelessness—Why We Need to Talk About Housing. *JAMA Netw Open*. 2022;5(1):e2142685. doi:10.1001/jamanetworkopen.2021.42685
16. Siconolfi D, Tucker JS, Shadel WG, Seelam R, Golinelli D. Health, Homelessness Severity, and Substance Use among Sexual Minority Youth Experiencing Homelessness: A Comparison of Bisexual Versus Gay and Lesbian Youth. *The Journal of Sex Research*. 2020;57(7):933-942. doi:10.1080/00224499.2019.1695723

17. Nichter B, Tsai J, Pietrzak RH. Prevalence, correlates, and mental health burden associated with homelessness in U.S. military veterans. *Psychol Med*. 2023;53(9):3952-3962. doi:10.1017/S0033291722000617
18. Collins SE. Associations Between Socioeconomic Factors and Alcohol Outcomes. *Alcohol Res*. 2016;38(1):83-94.
19. Eyrich-Garg KM, Cacciola JS, Carise D, Lynch KG, McLellan AT. Individual characteristics of the literally homeless, marginally housed, and impoverished in a US substance abuse treatment-seeking sample. *Soc Psychiat Epidemiol*. 2008;43(10):831-842. doi:10.1007/s00127-008-0371-8
20. Linton SL, Celentano DD, Kirk GD, Mehta SH. The longitudinal association between homelessness, injection drug use, and injection-related risk behavior among persons with a history of injection drug use in Baltimore, MD. *Drug and Alcohol Dependence*. 2013;132(3):457-465. doi:10.1016/j.drugalcdep.2013.03.009
21. Holtyn AF, Jarvis BP, Subramaniam S, et al. An intensive assessment of alcohol use and emergency department utilization in homeless alcohol-dependent adults. *Drug and Alcohol Dependence*. 2017;178:28-31. doi:10.1016/j.drugalcdep.2017.04.025
22. Substance Abuse and Mental Health Services Administration. *Preliminary Findings from Drug-Related Emergency Department Visits, 2022*. Drug Abuse Warning Network. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration; 2022. Accessed July 14, 2023. https://store.samhsa.gov/sites/default/files/pep23-07-03-001.pdf
23. Mandelberg JH, Kuhn RE, Kohn MA. Epidemiologic Analysis of an Urban, Public Emergency Department's Frequent Users. *Acad Emergency Med*. 2000;7(6):637-646. doi:10.1111/j.1553-2712.2000.tb02037.x
24. Klein LR, Cole JB, Driver BE, Battista C, Jelinek R, Martel ML. Unsuspected Critical Illness Among Emergency Department Patients Presenting for Acute Alcohol Intoxication. *Annals of Emergency Medicine*. 2018;71(3):279-288. doi:10.1016/j.annemergmed.2017.07.021
25. Smith-Bernardin SM, Kennel M, Yeh C. EMS Can Safely Transport Intoxicated Patients to a Sobering Center as an Alternate Destination. *Annals of Emergency Medicine*. 2019;74(1):112-118. doi:10.1016/j.annemergmed.2019.02.004
26. Jarvis SV, Kincaid L, Weltge AF, Lee M, Basinger SF. Public Intoxication: Sobering Centers as an Alternative to Incarceration, Houston, 2010–2017. *Am J Public Health*. 2019;109(4):597-599. doi:10.2105/AJPH.2018.304907
27. Paley E. Sobering Centers Offer Low-Barrier Alternative to Jail or Emergency Rooms. Policy Research Associates. Published July 22, 2022. Accessed July 12, 2023. https://www.prainc.com/gains-sobering-centers/
28. Karri Maureen Ryder v. MFI Recovery Center, et al., Superior Court of the State of California (County of Riverside), Case No. CVRI2300682 (filed February 8, 2023)
29. California Department of Health Care Services. Probationary Status, Temporary Suspension Order, Revoked and Notice of Operation in Violation of Law Program List. Published July 21, 2023. Accessed August 2, 2023. https://www.dhcs.ca.gov/provgovpart/SUD-LCR/Pages/SUS-REV-NOV.aspx
30. Newman RK, Stobart Gallagher MA, Gomez AE. Alcohol Withdrawal. In: *StatPearls*. StatPearls Publishing; 2022. Accessed August 2, 2023. http://www.ncbi.nlm.nih.gov/books/NBK441882/
31. American Medical Association. Council on Science & Public Health Spring Hybrid Meeting. *American Medical Association*. Published online March 19, 2020.
32. Smith-Bernardin SM. *Evaluation and Comparative Cost Analysis of the San Francisco Sobering Center as an Alternative to the Emergency Department for Individuals with Acute Alcohol Intoxication*. UCSF; 2016. Accessed July 17, 2023. https://escholarship.org/uc/item/23b4j15s

33. Applied Survey Research. *Santa Cruz County Sheriff's Office: Recovery Center Final Program Evaluation Report*.; 2018. Accessed July 14, 2023. http://64.166.146.245/docs/2021/MXCAB/20210804_1868/46492_JAG-Final-Evaluations-Santa-Cruz.pdf
34. Weltge AF, Kincaid L, Ochoa A, et al. Impact of an Urban, Police Department-Initiated Jail Diversion of Inebriates to a Sobering Center. *Annals of Emergency Medicine*. 2016;68(4):S66-S67. doi:10.1016/j.annemergmed.2016.08.183
35. Smith GB, Blau R. Failure to Thrive: NYC's $100 Million 'Diversion Centers' for Mentally Ill Sit Empty or Barely Used. The City. Published May 9, 2021. Accessed August 3, 2023. https://www.thecity.nyc/2021/5/9/22426250/thrive-nyc-nypd-diversion-centers-for-mentally-ill-sit-empty
36. Scheuter C, Rochlin DH, Lee CM, Milstein A, Kaplan RM. Cost impact of sobering centers on national health care spending in the United States. *Translational Behavioral Medicine*. 2020;10(4):998-1003. doi:10.1093/tbm/ibz075
37. American College of Emergency Physicians. Sobering Centers. Published 2013. Accessed July 17, 2023. https://www.acep.org/by-medical-focus/mental-health-and-substanc-use-disorders/sobering-centers
38. American Public Health Association. Addressing law enforcement violence as a public health issue. National Collaborating Centre for Determinants of Health. Published November 13, 2018. Accessed July 14, 2023. https://nccdh.ca/resources/entry/addressing-law-enforcement-violence-as-a-public-health-issue
39. Subramanian R, Arzy L. Rethinking How Law Enforcement Is Deployed | Brennan Center for Justice. Brennan Center for Justice at NYU Law. Published November 17, 2022. Accessed August 2, 2023. https://www.brennancenter.org/our-work/research-reports/rethinking-how-law-enforcement-deployed
40. Tong M, Hinton E. California Efforts to Address Behavioral Health and SDOH: A Look at Whole Person Care Pilots. KFF. Published March 17, 2022. Accessed July 17, 2023. https://www.kff.org/medicaid/issue-brief/california-efforts-to-address-behavioral-health-and-sdoh-a-look-at-whole-person-care-pilots/
41. Centers for Medicare & Medicaid Services. Cal-AIM 1115 Approval Letter. Published online December 29, 2021. Accessed July 17, 2023. https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-Approval-Letter-and-STCs.pdf

REPORT 5 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-23)
Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room
(Reference Committee K)

EXECUTIVE SUMMARY

BACKGROUND. At the 2022 Interim Meeting of the House of Delegates, Resolution 936 was referred for study. That resolution asked that our American Medical Association advocate for research into and development of intended multi-use operating room equipment and attire over devices, equipment and attire labeled for "single-use" with verified similar safety and efficacy profiles.

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms "sustainability AND operating room," "single-use devices AND operating room," "surgical drapes AND reusable," and "pharmaceutical waste AND surgery." Additional articles were identified by manual review of the reference lists of relevant publications. Web sites managed by government agencies, particularly the U.S. Centers for Disease Control and Prevention (CDC), were also reviewed for relevant information.

DISCUSSION. The health care industry is a major contributor of both plastics waste and GHG emissions. The U.S. health sector is estimated to produce 6 billion tons of waste annually and to be responsible for 8.5 percent of U.S. GHG emissions.[4,5] Operating rooms (OR) are generally one of the most resource intensive areas within hospitals themselves, contributing roughly 20-33 percent of total health care waste and are a major driver of hospital GHG emissions.[4] Lastly, waste generation is costly to health care systems. It was estimated that the U.S. health care system spent 3.2 billion U.S. dollars in medical waste costs in 2017.[4] Thus, finding ways to reduce overall waste generation has been found to be an important cost savings strategy while also improving environmental impacts.[1]

CONCLUSION. To improve sustainability in OR and reduce overall waste, hospitals can choose from a number of strategies. The easiest, most cost-effective, and risk-neutral strategies are improving existing recycling programs for paper, glass, and plastics within the hospital and reducing the amount of equipment that is unpackaged but not used and thrown away. While improved recycling programs may help decrease waste generation, it may not have the largest ecological benefit. The second strategy involves modifying and improving surgical kits to reduce unnecessary items. This would require surgical teams to audit their current practices, identify the equipment needed, and work with kit manufacturers to make necessary updates.

Reusing and reprocessing medical equipment as well as switching to reusable textiles are also strategies for reducing waste in the OR which can result in large cost savings and overall waste reduction benefits. However, reusable and reprocessed equipment should be considered on a case-by-case basis and be informed on the risk level of the surgery. A decision to switch to a reusable device or piece of equipment should be preceded by a life-cycle assessment to ascertain whether it has a positive environmental impact (in comparison to a single use device). More studies are needed to understand whether there is an increased risk of infectious disease transmission from reusable equipment and textiles but there is little existing evidence to suggest that they are inherently riskier. Regardless of strategy, future sustainability efforts must be approached with leadership support and across departments to enact meaningful change.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 5-I-23

Subject:	Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room
Presented by:	David J. Welsh, MD, MBA, Chair
Referred to:	Reference Committee K

At the 2022 Interim Meeting of the House of Delegates, Resolution 936 was referred for study. That resolution asked that our American Medical Association (AMA) advocate for research into and development of intended multi-use operating room equipment and attire over devices, equipment and attire labeled for "single-use" with verified similar safety and efficacy profiles.

BACKGROUND

The development and growing use of single-use plastics has created a global crisis, as the production of these products increase greenhouse gas (GHG) emissions and the disposal of plastics has led to over 2 million tons of plastic pollution in oceans globally.[1,2] Increased GHG emissions from human activities over the last two centuries are well understood to be a major contributor to climate change.[3] The health care industry is a major contributor of both plastics waste and GHG emissions. The U.S. health sector is estimated to produce 6 billion tons of waste annually and to be responsible for 8.5 percent of U.S. GHG emissions.[4,5] Operating rooms (OR) are generally one of the most resource intensive areas within hospitals themselves, contributing roughly 20-33 percent of total health care waste and are a major driver of hospital GHG emissions.[4] Lastly, waste generation is costly to health care systems. It was estimated that the U.S. health care system spent 3.2 billion U.S. dollars in medical waste costs in 2017.[4] Thus, finding ways to reduce overall waste generation has been found to be an important cost savings strategy while also improving environmental impacts.[1]

The following report outlines the types of waste associated with ORs, with particular attention to single-use equipment and textiles, potential alternatives aimed at improving sustainability, and the benefits and downsides of those alternatives, relative to disposable products. This report focuses primarily on sustainability from the perspective of waste reduction, but there are other sustainability challenges in the OR that could be addressed in future resolutions or reports. These include the reduction of GHG emissions from anesthesia drugs[5] and overall energy consumption in the OR attributed to lighting, ventilation, etc.[6] These issues are outside of the scope of this report.

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms "sustainability AND operating room," "single-use devices AND operating room", "surgical drapes AND reusable," and "pharmaceutical waste AND surgery." Additional articles were identified by manual review of the reference lists of relevant publications. Web sites managed

by government agencies, particularly the U.S. Centers for Disease Control and Prevention (CDC), were also reviewed for relevant information.

DISCUSSION

Unnecessary waste generation in the OR comes from several sources. In many medical settings, the use of single-use devices and products generate a huge portion of hospital waste. Plastics from the packaging of sterile medical devices is also largely thrown away as opposed to being recycled. Additionally, there are often components of surgical kits or pieces of equipment that are laid out in preparation for surgery but are not used and then thrown away. This significantly contributes to overall waste generation and is very costly to hospitals.[5] It has also been documented that pharmaceutical waste is another critical issue, particularly with anesthetic drugs.[5,7] Lastly, there is evidence that at least a third of the materials going into the red bag waste stream[a] are not biohazardous and could be recycled or be disposed of in a less costly or GHG-emitting manner.[7] The potential solutions for reducing OR waste fall into the well-known three R's of sustainability: reduce, reuse, and recycle.

Reducing Unnecessary Waste

There are several potential solutions to reduce overall waste production that occurs with instruments and devices that are taken out of their packaging, not used, but still thrown away. Prior to surgery, devices or instruments perceived to be necessary for the procedure are taken out of their packaging and placed on a sterile tray. In many cases, not all these items are used but are disposed of as they are no longer sterile. Pre-packaged surgical kits may contain multiple devices to be used during a specific surgery. However, not all those devices are always used. In one study of unused surgical supplies in hand surgeries, researchers recorded surgical and dressing items disposed of and not used in 85 consecutive cases in a single surgeon's practice and found that, on average, 11.5 items were wasted per case.[8]

One potential solution is simply not retrieving and opening packages until they become necessary during the surgery, assuming the extra time it would take to retrieve and open the instruments would not pose a significant threat to the patient. Another potential solution is evaluating which disposable OR supplies generally remain unused during procedures and revising the surgical supply packs based on the evaluation results. An evaluation of such intervention was found to significantly reduce waste and hospital costs.[1]

One potential challenge with both solutions proffered above is the historical precedent of how pre-operation procedures have been dictated by the surgical team. As pointed out in one study, a major barrier to enacting any policy to improve sustainability is "related to behavioral inertia or reluctance to change current practice simply because changing it requires more effort."[9] Nurses and other staff responsible for preparing the OR are told by surgical staff what they want opened and available prior to surgery. Either solution mentioned above would most likely require working with the larger surgical team to assess which devices are necessary, working with surgical kit manufacturers, educating staff about the changes, and retraining.

Reducing pharmaceutical waste

[a] Red bag waste is considered biohazardous waste, or items that have been contaminated with blood or other infectious materials. Additionally, some evidence suggests close to 90% of red-bag waste does not meet red-bag waste criteria.[7]

As mentioned earlier, in addition to the unnecessary physical waste generation (i.e., trash), another component of unnecessary waste in the OR is pharmaceutical or medication waste. In the OR setting, anesthesia medication waste is well documented; propofol is the most wasted medication by volume whereas emergency medications, such as atropine, epinephrine, or phenylephrine, have the highest percentage of being opened but not used, and therefore must be thrown away.[5,10] Not only is pharmaceutical waste costly to hospitals, but it also has adverse environmental impacts, particularly in terms of surface, ground, and drinking water contamination.[5,7] Recommended strategies for reducing pharmaceutical waste in the OR include: using prefilled syringes for emergency medications, splitting vials for pediatric anesthesia to accommodate smaller dose volumes, and avoiding drawing up medications that may not be used.[5]

Reusing Equipment and Textiles

For the purposes of this report, it is important to define what is meant by reusable devices, single-use devices, and equipment reprocessing:

- Reusable medical devices are those devices that health care professionals can reprocess and reuse on multiple patients. These are generally made of materials that are designed and manufactured to withstand multiple rounds of sterilization, with chemicals and/or extreme heat.
- Single-use devices, also known as disposable devices, are those "intended for use on one patient during a single procedure . . . and is not intended to be reprocessed (cleaned, disinfected/sterilized) and used on another patient."
- Equipment Reprocessing is defined as the disinfecting, cleaning, sterilizing, packaging, labeling, and storing a used or opened package of a medical device, *that was intended as a single-use item*, to be placed into service again (as opposed to reprocessing items that were intended to be reusable).[11]

History of single-use devices in medicine

Prior to the 1970s, most medical devices were considered reusable. While the first single-use device was developed in 1948, the proliferation of single-use devices in medicine started in the 1970s (as well as the reuse of these products through sterilization and reprocessing) due to an increase in demand and complexity of equipment being used.[11, 12,13] There were also several high profile incidents in the 1970s that occurred with reused medical equipment that helped spur the move towards single-use devices.[12] In the United Kingdom, the increased use of disposable, single-use medical devices grew even more in the early 2000s resulting from the Creutzfeldt Jakob disease epidemic in the 1990s. Studies showing the persistence of proteins from the disease on reusable devices, even after sterilization, led to calls for single-use surgical instruments to prevent transmission of the disease, even though no cases were found to be a result of transmission through reusable medical devices.[12] Single-use equipment has now become the norm in medical settings and has increased the overall waste generation in health care settings.

Multi-use Equipment

Several studies have utilized life cycle assessment (LCA) to evaluate the environmental impacts of various OR reusable equipment in comparison to single-use equipment. Reusable equipment has been found in some circumstances to reduce costs, water consumption, energy consumption, waste, and GHG emissions.[14] However, the ecological benefits of multiple-use equipment over single-use equipment are not always clear. It depends on the complexity of the equipment and the sterilization method used[6] as well as where the study is being conducted (e.g., different countries have varying energy production portfolios, which can influence the LCA).

Reprocessed single-use devices

Reprocessing of single-use devices has been happening for almost 40 years. However, the Federal Drug Administration (FDA) only developed guidance for third-party businesses to reprocess single-use equipment in 2000. Currently, companies that reprocess medical devices are regulated by the FDA and are held to the same standards as manufacturers of medical devices. Reprocessing equipment represents significant cost savings for hospitals and can have ecological benefits. The Association of Medical Device Reprocessors (AMDR) estimates that hospitals can lower their costs for medical devices by 25-40 percent by using reprocessed equipment[15] and divert tens of millions of pounds of medical waste from landfills every year.[16]

Infectious disease risk with reused devices

It is important to note that there always exists a risk of infection for any reusable product or during any type of surgery. A major concern over reusable equipment or the reprocessing of single-use items is whether it is inherently riskier than a new single-use item. However, the benefits of single-use objects over reusable or reprocessed objects for infectious risk reduction is based on weak evidence and few studies have been done to compare the risk of infection.[11,14] A narrative review of the literature was published in 2021 on whether there was a difference between single-use devices versus reusable devices in terms of their environmental impact and risk of infectious/bacterial contamination, within anesthesia equipment specifically. Based on the review, the authors found the greatest risk of pathogen transmission came from improper hand hygiene and washing among the anesthesia team, not the equipment itself.[14] In another example, researchers studying the outcomes of cataract surgery in Avarind Eye Care System in southern India found lower rates of postoperative endophthalmitis than in the U.S., despite Avarind's reuse of as many of their surgical and pharmaceutical supplies as possible.[17] Additionally, a U.S. Government Accountability Office report published in 2008 found no increased health risk to consumers from using reprocessed single-use devices.[18]

According to the FDA, there are certain design features of medical products that make them easier and safer to reprocess for reuse, which include:

- Smooth surfaces, including smooth inner surfaces of the long, narrow interior channels;
- The ability to disassemble devices with multiple components;
- Non-interchangeable connectors for critical connections;
- Clear identification of connecting accessories, such as drainage tubing;
- Clear indication and identification of components that must be discarded after patient use and cannot be reprocessed or reused;
- Disposable components for the hardest to clean areas;
- Designs that address how fluid flows through the device, and areas of debris build-up within devices.[19]

Additionally, there are a number of devices that have been identified as being amenable to reprocessing, including cardiac catheters, trocars, laparoscopic staplers/vessel sealers, and external fixation devices.[6] However, there are still concerns over their safety and efficacy as "many single-use devices are reused without being adequately evaluated" for whether they sufficiently reduce infectious materials.[11] Also, the safety of reused equipment is highly dependent on making sure the process of sterilization and cleaning is done properly. There are important differences between third party and in-hospital reprocessing. Sterilization processes need to be followed exactly, which may not always happen in a hospital setting since they are not regulated or overseen by the FDA.

Third party reprocessing businesses must be registered with the FDA and meet similar safety standards as device manufacturers, and therefore operate under much more stringent regulations than hospitals.

Reusable versus disposable textiles

The use of sterilized surgical gowns and drapes has a long history in medicine. The first credited use of a sterilized surgical gown was in 1883 by German surgeon, Gustav Neuber of Kiel, and the first painting of a surgeon wearing a gown dates to 1889.[20] Beginning in the 19th century and for the first half of the 20th century, surgical gowns and drapes were made of reusable textiles, first cotton fabric and then later muslin, with the introduction of disposable drapes in the 1960s.[20] When it was found that muslin fabric was not an effective barrier to bacteria, research was conducted to find improved materials that were impervious to bacterial penetration. New paper-based garments were then introduced and "manufacturers of non-woven disposable surgical gowns and drapes launched a vigorous promotional and advertising campaign to the surgical community, claiming the advantages of their products for use in surgery," for both comfortability and safety.[20] Despite advances in woven and reusable textiles to improve safety and permeability since the mid-20th century, there has been a large increase in the use of disposable textiles in health care. As of an article published in 2021, approximately 80 percent of US hospitals use disposable surgical gowns.[6]

In terms of the evidence on the ecological impacts of reusable textiles in comparison to disposables, studies have largely shown that reusable textiles have ecological benefits on almost all accounts, except in some cases water usage due to the laundering required. In a review article of six LCA studies on reusable versus disposable gowns, the results showed that reusable gowns outperformed disposable on all four environmental indicators categories considered (i.e., energy consumption, greenhouse gas emissions, water consumption, and solid waste generation).[21] In another recent article, an LCA was conducted on reusable versus disposal surgical head covers. Reusable head covers were found to have a 56 to 61 percent lower carbon footprint than disposable head covers and, for 16 out of 17 secondary outcomes, reusable head covers had a lower environmental impact.[22]

While the ecological benefits of reusable textiles are well documented, the evidence comparing surgical site infection risks between reusable and disposable textiles is less well developed and the results are mixed. Earlier studies comparing reusable versus disposable textiles, which largely pushed hospitals to move towards disposable products, found disposables to have better infection control. However, many of these earlier studies are outdated due to updates in materials used to produce reusable gowns and drapes.[23] Additionally, many of these early studies were funded by disposable gown manufacturers and their objectivity has been called into question. Both the World Health Organization and CDC guidance documents have reported no meaningful evidence to support differences in the occurrences of surgical site infections between disposable and reusable materials.[24] However, similar to single-use devices, few studies have compared infection rates from reusable versus disposable textiles and the evidence is mixed.[25,26]

Benefits and challenges of reusable and reprocessed products

Beyond their cost savings and ecological benefits, another potential benefit of reusable and reprocessed products is improved system resiliency. The COVID-19 pandemic highlighted supply-chain issues that can occur when hospital systems rely primarily on single-use medical devices and disposable textiles produced in other countries and/or in areas affected by supply-chain disruptions.

The use of reusable products and reprocessed devices helps create resilience within the hospital system during times of device shortages.[27]

On the other hand, there are also additional challenges for the adoption of multi-use and reprocessed devices and attire. Different surgeons may have their own instrument requirements, even for the same surgery, which can complicate the development of a unified standard for reusable or reprocessed equipment in certain settings. Surgical teams would need to unify their instrument preferences around specific reusable products or ones that could be safely reprocessed to make meaningful change. Additionally, patient specific risk factors, such as age, whether they are immunocompromised, length of stay in the hospital, and medication allergies are just a few examples that may impact the risk of infection from reusable or reprocessed devices and attire.[20]

Recycling Programs

There are several barriers within hospital systems to recycling materials in the OR, which include a lack of knowledge about what can be recycled, proper separation of materials, concern for infectious diseases, limitations on space in the OR, and lack of time.[4,9] Several studies have shown that there is a lot of room for improvement in recycling programs and have demonstrated the effectiveness of recycling improvement programs in health care settings. A study in Australia of waste from the intensive care unit found that nearly 60 percent of the waste generated could be recycled and there was minimal infectious waste cross contamination.[28] Pilot studies have also shown that interventions to improve recycling of OR waste can have a positive impact in terms of reduced waste going into the landfill, particularly when the intervention is accompanied by staff education and training on proper recycling technique.[4] Lastly, an evaluation of 13 sustainability actions at a French hospital focused on the OR, which included seven waste reduction actions, five waste sorting actions, and one eco-responsible purchasing action, found significant ecological benefits as well as economic benefits for the hospital.[29]

While improving recycling programs may be one of the easier changes to implement within a hospital setting, it may be the least effective in terms of global ecological benefit and truly reducing waste generation, particularly since so much of the waste generated is plastic. Plastic recycling represents a very small percentage of overall materials recycled in the U.S. According to the EPA, plastics made up less than 5 percent of all recycled materials in 2018.[30] The primary issues of recycling plastics are that most plastics cannot be recycled at all or cannot be repeatedly recycled (like aluminum or paper) without quickly degrading in quality.[31,32]

Available Resources for Sustainable Purchasing

Sustainable purchasing practices has been highlighted as a critical step in the healthcare setting when establishing a sustainable or green agenda.[7] Several organizations have already developed best practices for reducing waste in the OR and/or guides for implementing more sustainable purchasing processes in health care, which are provided below.

- Practice Greenhealth
    - Sustainable Procurement in Healthcare Guide[33]
    - Greening the Operating Room™ Checklist[34]
- Healthcare without Harm
    - Purchasing Resources[35]

Joint Commission Standards

In March of 2023, the Joint Commission announced they were developing new requirements to address environmental sustainability for the Hospital (HAP) and Critical Access Hospital (CAH) accreditation programs.[36] The announcement noted that health care organizations can no longer ignore their contributions to GHG emissions.[36] Hospitals consume energy (such as electricity and natural gas) and use materials (such as disposables) that contribute to increased waste and GHG emissions. The proposed new standard, LD.05.01.01, would have required both hospitals and critical access hospitals to appoint an individual to oversee the reduction of greenhouse gas emissions in coordination with clinical and facility representatives.

Hospitals would be asked to measure three or more of the following:

- Energy use
- Purchased energy (electricity and steam)
- Anesthetic gas use
- Pressurized metered dose inhaler use
- Fleet vehicle gasoline consumption
- Solid waste disposal to landfills or through incineration

The hospital would then have to use the measures to reduce GHG emissions in a written plan. After receiving industry feedback, on the new proposed standards on sustainability, the Joint Commission noted their plans to roll them out as optional.[37]

EXISTING AMA POLICY

Policy H-480.959, “Reprocessing of Single-Use Medical Devices” notes that our AMA supports (1) the FDA guidance on "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals,” and (2) the development of device-specific standards for the reuse and reprocessing of single-use medical devices involving all appropriate medical and professional organizations and the medical device industry. This policy also encourages increased research by the appropriate organizations and federal agencies into the safety and efficacy of reprocessed single-use medical devices and supports the proper reporting of all medical device failures to the FDA so that surveillance of adverse events can be improved. The policy also notes that the AMA strongly opposes any rules or regulations regarding the repair or refurbishment of medical tools, equipment, and instruments that are not based on objective scientific data.

Under Policy H-135.973, “Stewardship of the Environment,” the AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development

programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

CONCLUSION

To improve sustainability in OR and reduce overall waste, hospitals can choose from a number of strategies. The easiest, most cost-effective, and risk-neutral strategies are improving existing recycling programs for paper, glass, and plastics within the hospital and reducing the amount of equipment that is unpackaged but not used and thrown away. While improved recycling programs may help decrease waste generation, it may not have the largest ecological benefit. The second strategy involves modifying and improving surgical kits to reduce unnecessary items. This would require surgical teams to audit their current practices, identify the equipment needed, and work with kit manufacturers to make necessary updates. Another strategy is donating supplies that are not being used and are not expired to nonprofit organizations that repurpose surplus medical supplies and equipment, such as Medwish International.

Reusing and reprocessing medical equipment as well as switching to reusable textiles are also strategies for reducing waste in the OR which can result in large cost savings and overall waste reduction benefits. However, reusable and reprocessed equipment should be considered on a case-by-case basis and be informed on the risk level of the surgery. Even modifying existing drapes to be shorter by removing unnecessary length at the ends could reduce overall waste generation. A decision to switch to a reusable device or piece of equipment should be preceded by a life-cycle assessment to ascertain whether it has a positive environmental impact (in comparison to a single use device). More studies are needed to understand whether there is an increased risk of infectious disease transmission from reusable equipment and textiles but there is little existing evidence to suggest that they are inherently riskier.

While not discussed in the peer-reviewed literature, manufacturers of medical devices and textiles could also take a more holistic and total life cycle approach to product creation, which would incorporate sustainability considerations at the design phase and at each component of the product's life. This would require considering sustainable options of material selection (e.g., choosing a bio-based material versus petroleum based product), product design (e.g., can the product be smaller or more amenable to reprocessing safely), manufacturing process (e.g., how can you reduce energy and water usage), packaging (e.g., can compostable packaging materials be used), distribution (e.g., how do you minimize transportation distances), and disposal (e.g., will this produce be reusable or recyclable).[38]

Regardless of strategy, future sustainability efforts must be approached with leadership support and across departments to enact meaningful change.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following recommendations be adopted and the remainder of this report be filed:

1. That Resolution 936-I-22, which asks for our AMA to advocate for research into and development of intended multi-use operating room equipment and attire over devices, equipment and attire labeled for "single-use" with verified similar safety and efficacy profiles be adopted. (New HOD Policy)

2. That Policy H-480.959, "Reprocessing of Single-Use Medical Devices," be reaffirmed. (Reaffirm Existing Policy)

3.That our AMA work with interested parties to establish best practices for safe reuse of equipment and improved surgical kits used in the operating room, and to disseminate best practices for reducing waste in the operating room as well as guides for implementing more sustainable purchasing processes in health care. (New HOD Policy)

Fiscal Note: $5,000 - $10,000

REFERENCES

1. Braschi C, Tung C, Chen KT. The impact of waste reduction in general surgery operating rooms. *Am J Surg*. 2022;224(6):1370-1373. doi:10.1016/j.amjsurg.2022.10.033

2. Paddison L. Ocean plastic pollution reaches “unprecedented” levels | CNN. *CNN*. https://www.cnn.com/2023/03/08/world/ocean-plastic-pollution-climate-intl/index.html. Published March 8, 2023. Accessed August 31, 2023.

3. Intergovernmental Panel on Climate Change. *Climate Change 2023 Synthesis Report: Summary for Policymakers*. IPCC; 2023:1-34. https://www.ipcc.ch/report/ar6/syr/downloads/report/IPCC_AR6_SYR_SPM.pdf

4. Azouz S, Boyll P, Swanson M, Castel N, Maffi T, Rebecca AM. Managing barriers to recycling in the operating room. *Am J Surg*. 2019;217(4):634-638. doi:10.1016/j.amjsurg.2018.06.020

5. Gordon D. Sustainability in the Operating Room. *Anesthesiol Clin*. 2020;38(3):679-692. doi:10.1016/j.anclin.2020.06.006

6. Yates EF, Bowder AN, Roa L, et al. Empowering Surgeons, Anesthesiologists, and Obstetricians to Incorporate Environmental Sustainability in the Operating Room. *Ann Surg*. 2021;273(6):1108-1114. doi:10.1097/SLA.0000000000004755

7. Kwakye G. Green Surgical Practices for Health Care. *Arch Surg*. 2011;146(2):131. doi:10.1001/archsurg.2010.343

8. Bravo D, Thiel C, Bello R, Moses A, Paksima N, Melamed E. What a Waste! The Impact of Unused Surgical Supplies in Hand Surgery and How We Can Improve. *Hand N Y N*. Published online April 29, 2022:15589447221084012. doi:10.1177/15589447221084011

9. Bolten A, Kringos DS, Spijkerman IJB, Weiland NHS. The carbon footprint of the operating room related to infection prevention measures: a scoping review. *J Hosp Infect*. 2022;128:64-73. doi:10.1016/j.jhin.2022.07.011

10. Chaudhary K, Garg R, Bhalotra AR, Anand R, Girdhar K. Anesthetic drug wastage in the operation room: A cause for concern. *J Anaesthesiol Clin Pharmacol*. 2012;28(1):56-61. doi:10.4103/0970-9185.92438

11. Joint Commission International. *Reuse of Single-Use Devices: Understanding Risks and Strategies for Decision-Making for Health Care Organizations*.; 2017. https://www.jointcommissioninternational.org/-/media/jci/jci-documents/offerings/other-resources/white-papers/jci_white_paper_reuse_of_single_use_devices.pdf

12. Cohoon BD. Reprocessing Single-use Medical Devices. *AORN J*. 2002;75(3):557-567. doi:10.1016/S0001-2092(06)61177-0

13. Single-Use Devices | Disinfection & Sterilization Guidelines | Guidelines Library | Infection Control | CDC. Published April 4, 2019. Accessed August 31, 2023. https://www.cdc.gov/infectioncontrol/guidelines/disinfection/reuse-of-devices.html

14. Reynier T, Berahou M, Albaladejo P, Beloeil H. Moving towards green anaesthesia: Are patient safety and environmentally friendly practices compatible? A focus on single-use devices. *Anaesth Crit Care Pain Med*. 2021;40(4):100907. doi:10.1016/j.accpm.2021.100907

15. AMDR. Cost Savings. AMDR | Association of Medical Device Reprocessors. Accessed August 31, 2023. https://amdr.org/cost-savings/

16. AMDR. Waste Reduction. AMDR | Association of Medical Device Reprocessors. Accessed August 31, 2023. https://amdr.org/waste-reduction/

17. Chang DF. Needless Waste and the Sustainability of Cataract Surgery. *Ophthalmology*. 2020;127(12):1600-1602. doi:10.1016/j.ophtha.2020.05.002

18. Government Accountability Office. *Reprocessed Single-Use Medical Devices*. United States Government Accountability Office; 2008. https://www.gao.gov/products/gao-08-147

19. U.S. Food & Drug Administration. Working Together to Improve Reusable Medical Device Reprocessing. *FDA*. Published online August 18, 2023. Accessed August 31, 2023. https://www.fda.gov/medical-devices/reprocessing-reusable-medical-devices/working-together-improve-reusable-medical-device-reprocessing

20. Laufman H, Belkin NL, Meyer KK. A critical review of a century's progress in surgical apparel: how far have we come?11No competing interests declared. *J Am Coll Surg*. 2000;191(5):554-568. doi:10.1016/S1072-7515(00)00706-7

21. Vozzola E, Overcash M, Griffing E. An Environmental Analysis of Reusable and Disposable Surgical Gowns. *AORN J*. 2020;111(3):315-325. doi:10.1002/aorn.12885

22. Cohen ES, Djufri S, Bons S, et al. Environmental Impact Assessment of Reusable and Disposable Surgical Head Covers. *JAMA Surg*. Published online September 6, 2023. doi:10.1001/jamasurg.2023.3863

23. Overcash M. A Comparison of Reusable and Disposable Perioperative Textiles: Sustainability State-of-the-Art 2012. *Anesth Analg*. 2012;114(5):1055-1066. doi:10.1213/ANE.0b013e31824d9cc3

24. WHO. Summary of a systematic review on drapes and gowns. In: *Global Guidelines for the Prevention of Surgical Site Infection*. World Health Organization; 2018. Accessed August 31, 2023. https://www.ncbi.nlm.nih.gov/books/NBK536409/

25. Kieser DC, Wyatt MC, Beswick A, Kunutsor S, Hooper GJ. Does the type of surgical drape (disposable versus non-disposable) affect the risk of subsequent surgical site infection? *J Orthop*. 2018;15(2):566-570. doi:10.1016/j.jor.2018.05.015

26. Showalter BM, Crantford JC, Russell GB, et al. The effect of reusable versus disposable draping material on infection rates in implant-based breast reconstruction: a prospective randomized trial. *Ann Plast Surg*. 2014;72(6):S165-169. doi:10.1097/SAP.0000000000000086

27. AMDR. Supply Chain Resiliency. AMDR | Association of Medical Device Reprocessors. Accessed August 31, 2023. https://amdr.org/supply-chain-resiliency/

28. McGain F, Story D, Hendel S. An audit of intensive care unit recyclable waste. *Anaesthesia*. 2009;64(12):1299-1302. doi:10.1111/j.1365-2044.2009.06102.x

29. Rouvière N, Chkair S, Auger F, et al. Ecoresponsible actions in operating rooms: A health ecological and economic evaluation. *Int J Surg*. 2022;101:106637. doi:10.1016/j.ijsu.2022.106637

30. US EPA O. National Overview: Facts and Figures on Materials, Wastes and Recycling. Published October 2, 2017. Accessed August 31, 2023. https://www.epa.gov/facts-and-figures-about-materials-waste-and-recycling/national-overview-facts-and-figures-materials

31. Greenpeace. New Greenpeace Report: Plastic Recycling Is A Dead-End Street—Year After Year, Plastic Recycling Declines Even as Plastic Waste Increases. Greenpeace USA. Accessed August 31, 2023. https://www.greenpeace.org/usa/news/new-greenpeace-report-plastic-recycling-is-a-dead-end-street-year-after-year-plastic-recycling-declines-even-as-plastic-waste-increases/

32. Top 25 recycling facts and statistics for 2022. World Economic Forum. Published June 22, 2022. Accessed August 31, 2023. https://www.weforum.org/agenda/2022/06/recycling-global-statistics-facts-plastic-paper/

33. Sustainable procurement guide | Practice Greenhealth. Accessed August 31, 2023. https://practicegreenhealth.org/sustainableprocurementguide/toolkit

34. Practice Greenhealth. Greening the Operating Room Checklist. https://practicegreenhealth.org/sites/default/files/upload-files/gor_checklist_r5_web.pdf

35. Purchasing Resources. Health Care Without Harm. Published April 28, 2013. Accessed August 31, 2023. https://noharm-uscanada.org/issues/us-canada/purchasing-resources

36. Joint Commission Online - March 22, 2023 | The Joint Commission. Accessed August 31, 2023. https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/joint-commission-online/march-22-2023#.ZBx2l3bMJPY

37. Gliadkovskaya A. Facing industry pushback, Joint Commission plans to introduce proposed sustainability measures as optional. Fierce Healthcare. Published April 27, 2023. Accessed August 31, 2023. https://www.fiercehealthcare.com/providers/joint-commission-plans-make-proposed-sustainability-standards-optional

38. Building Sustainability into Medical Devices. Inside Battelle. Accessed September 7, 2023. https://inside.battelle.org/blog-details/building-sustainability-into-medical-devices

REPORT 6 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH
Marketing Guardrails for the "Over-Medicalization" of Cannabis Use (Resolution 501-A-22)
(Reference Committee K)

EXECUTIVE SUMMARY

BACKGROUND. American Medical Association Policy D-95.958, “Marketing Guardrails for the "Over-Medicalization" of Cannabis Use,” adopted by the House of Delegates (HOD) at the 2022 Interim Meeting, directed the Council on Science and Public Health (CSAPH) to study marketing practices of cannabis, cannabis products and cannabis paraphernalia that influence vulnerable populations, such as children and pregnant people. CSAPH has issued seven previous reports on cannabis.

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms “cannabis”, “marijuana”, “marketing”, and “advertising”. Additional articles were identified by manual review of the reference lists of pertinent publications. Searches of selected stakeholders, national, and local government agency websites were conducted to identify definitions, guidelines, regulations, and reports.

RESULTS. States have diverse regulations regarding cannabis marketing, with some completely prohibiting it, while others have established guidelines through state-based regulatory bodies. Research indicates advertising can normalize substance use and disproportionately targets youth, reflected in studies on alcohol and tobacco industries. The U.S. cannabis industry's rapid growth has seen increasing advertising expenditure, yet knowledge gaps persist in understanding and regulating these practices, particularly on platforms accessible to minors like social media. States’ advertising, marketing, packaging restrictions and national public health campaigns aim to safeguard consumers, especially children, and promote safe behaviors.

CONCLUSION. Research on cannabis marketing regulation and enforcement is sparse, especially concerning its efficacy in safeguarding vulnerable groups, notably youth. While federal regulatory agencies oversee the marketing and advertising of hemp (including CBD), the regulation of cannabis and cannabis-derived products varies by state. The challenges in the field of cannabis products are accentuated by the lack of research and guidance on dosing and adverse effects, leading consumers to rely on potentially inaccurate marketing sources like dispensary staff or online sites, emphasizing the need to ensure accurate and consistent information in marketing despite the known harms posed by cannabis. A closer look at the marketing regulatory frameworks established for substances such as alcohol and tobacco could offer valuable insights into marketing and advertising practices for cannabis and its derived products.

REPORT 6 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 6-I-23

Subject: Marketing Guardrails for the "Over-Medicalization" of Cannabis Use

Presented by: David J. Welsh, MD, MBA, Chair

Referred to: Reference Committee K

BACKGROUND

American Medical Association (AMA) Policy D-95.958, "Marketing Guardrails for the "Over-Medicalization" of Cannabis Use," adopted by the House of Delegates (HOD) at the 2022 Interim Meeting, directed the Council on Science and Public Health (CSAPH) to study marketing practices of cannabis, cannabis products and cannabis paraphernalia that influence vulnerable populations, such as children and pregnant people. CSAPH has issued seven previous reports on cannabis. The most recent report, presented at the November 2020 HOD meeting, summarizes current state legislation legalizing adult cannabis and cannabinoid use, and reviews other pertinent information and developments in these jurisdictions to evaluate the public health impacts of legalization. This report investigates the marketing practices of cannabis products and serves as the Council on Science and Public Health's (CSAPH) findings and recommendations.

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms "cannabis", "marijuana", "marketing", and "advertising". Additional articles were identified by manual review of the reference lists of pertinent publications. Searches of selected stakeholders, national, and local government agency websites were conducted to identify definitions, guidelines, regulations, and reports.

INTRODUCTION

As of April 24, 2023, 38 states, the District of Columbia (D.C.), Guam, Puerto Rico, and the U.S. Virgin Islands have legalized the use of cannabis for medical purposes through either a legislative process or ballot measure.[1] As described in Council Report 5-I-17, these laws vary greatly by jurisdiction from how patients access the product (home cultivated or dispensary), to qualifying conditions, product safety and testing requirements, packaging and labeling requirements, the retail marketplace, and consumption method. In 2012, Colorado and Washington were the first U.S. jurisdictions to legalize the adult use of cannabis.[2] As of June 1, 2023, a total of 23 states, D.C., Guam, and the Northern Mariana Islands have legalized cannabis for adult use, 15 through the ballot measure process, and 11 via legislation, with three more states expected to include ballot measures in upcoming elections (Ohio, Florida, and Nebraska).[1]

In 2021, cannabis was consumed by an estimated 52.5 million people, or 18.7 percent of the U.S. population aged 12 or older.[3] Cannabis is a psychoactive substance consisting of distinctive compounds known as cannabinoids that include Cannabidiol (CBD) and Tetrahydrocannabinol (THC). Cannabis products containing THC remain Schedule I Controlled Substances, while CBD

products are regulated as an agriculture commodity. THC is the primary psychoactive compound in cannabis that produces the "high" sensation, along with altering perception, mood, and cognition. CBD (cannabidiol), on the other hand, is non-psychoactive and does not cause a “high” that is associated with THC. Each state that has legalized cannabis for medical or adult-use has its own unique requirements for marketing, advertising, and sale, with the main standardized requirement being that purchasers must be 21 years of age or older. There are challenges in developing marketing regulations due to scientific uncertainty (due to lack of research because of scheduling) regarding benefits and risks associated with the use of cannabis.[6] While millions of people in the U.S. use cannabis each month, evidence is mounting of harmful physical and mental health effects associated with heavy or long-term cannabis use and the negative impacts, particularly for vulnerable populations such as children, young adults, people with psychiatric disorders, and pregnant people.[7–9]

AMA policy separates cannabis legalization for medicinal (D-95.969) or adult use (H-95.924) also known as non-medical, or recreational use. AMA policy opposes state-based legalization of cannabis for medical use (whether via legislative, ballot, or referendum processes) and supports the traditional federal drug approval process for assessing the safety and efficacy of cannabis-based products for medical use. Medical use is defined as the use of cannabis or its derivatives to treat medical conditions or symptoms under the supervision of a health care provider. Additionally, AMA policy notes that cannabis products that have not been approved by the FDA (but are marketed for human ingestion in many states) should carry the following warning label: “[Cannabis] has a high potential for abuse. This product has not been approved by the FDA for preventing or treating any disease process” (D-95.969).

Marketing is categorized as “any commercial communication or other activity, including advertising, promotion, and sponsorship, that is designed to increase the recognition, appeal and/or consumption” of the product being marketed.[10] While the oversight of alcohol advertising and marketing falls under the jurisdiction of the Federal Trade Commission (FTC), a significant portion of alcohol advertisers voluntarily adheres to self-imposed codes and standards.[11] These standards are primarily aimed at limiting the marketing exposure to vulnerable groups. Although the FTC oversees the adherence to these codes to pinpoint violations, the general public can lodge complaints about non-compliant advertising or marketing to industry-specific organizations, including the Distilled Spirits Council, Beer Institute, or Wine Institute.

In the realm of tobacco, the landscape of marketing and advertising standards was largely shaped by the 1998 Master Settlement Agreement, where cigarette companies agreed to self-regulation. Currently, the marketing of tobacco is under federal jurisdiction, with the Federal Drug Administration (FDA) and FTC responsible for monitoring compliance. Contrastingly, the oversight of cannabis marketing predominantly falls to individual states, each governed by its respective regulatory body. This decentralized approach is largely due to cannabis's Schedule I status, which offers limited scope for federal regulatory bodies to provide consistent guidelines or oversight.

DISCUSSION

Controlled Substances Act Federal Implications

The U.S. Controlled Substances Act (CSA) of 1970 continues to categorize cannabis as a Schedule I controlled substance, citing its high potential for abuse, lack of currently accepted medical use, and unproven safety under medical supervision. The CSA bans “written advertisements that has the purpose of seeking or offering illegally to receive, buy, or distribute a Schedule I controlled

substance."[12] Despite federal law prohibiting the advertising of cannabis, most states have legalized cannabis advertising and marketing within their jurisdiction. Historically, the CSA exclusively prohibited written advertisements (e.g., magazines, newspapers, and publications). However more recently, the legislation was amended to prohibit advertising via the internet, resulting in conceptually stringent federal restrictions on cannabis marketing, particularly those activities extending beyond state lines, leaving significant potential conflicts with state-level marketing practices, though thus far enforcement of such restrictions has been limited.[13]

Federal Marketing Regulations

Both the FDA and FTC play crucial roles in regulating marketing and advertising practices in the U.S. and have specific areas of oversight. However, their roles often intersect, especially when it comes to consumer protection. The FDA is responsible for protecting public health by ensuring the safety and efficacy of drugs, food, supplements, and other products. As part of this mandate, it oversees advertising and promotion. As an example of FDA's enforcement of marketing, in 2021 they issued warning letters to companies for illegally selling over-the-counter CBD products for pain relief stating that the drugs had not gone through the FDA approval process to determine efficacy, safety, side-effects, or how they can interact with other drugs or products.[14] Similarly, the FDA issued warning letters to companies for selling products containing CBD with claims that they can treat medical conditions, including opioid use disorder or as an alternative to opioids.[15] Companies that are issued warning letters for their violation of the Federal Food, Drug and Cosmetic Act are subject to legal action, product seizure, and/or injunction if they fail to remedy the violations listed in warning letters.

In tandem, the FTC oversees consumer protection matters by ensuring that advertisements are not deceptive or misleading to the general public. As part of this, they oversee the use of endorsements and testimonials in advertising. While the FTC stipulates that advertising must adhere to standards of truthfulness, evidence-based support, and non-misleading content, with any limitations or disclosures being clearly articulated, FTC enforcement for marketing in the context of state-legalized cannabis products has been complex.[16,17] The FDA ensures that prescription drug advertisements provide a balanced presentation of both the risks and benefits of the drug and that the ads are not misleading. The FTC typically regulates over-the-counter (OTC) drug advertising, yet the FDA still plays a role, especially concerning labeling and ensuring claims are substantiated. Both the FDA and FTC have the authority to impose penalties on companies that breach marketing and advertising regulations. Due to the overlap in their regulatory domains, the two agencies frequently collaborate to maintain consistent and thorough oversight.

FDA approved cannabinoid products

The FDA has approved several synthetic cannabinoid products for medical purposes, reflecting a growing recognition of their therapeutic potential. Specifically, the synthetic THC analogs dronabinol (Marinol® and Syndros®) and nabilone (Cesamet®) are approved for treating nausea and vomiting associated with chemotherapy, with dronabinol also approved for anorexia in patients with AIDS.[18] The agency has also approved one cannabis-derived drug product cannabidiol (CBD) oral solution (Epidiolex®) for specific rare and severe forms of epilepsy.[18,19] Because these products have received FDA approval, their marketing and advertising activities are subject to federal regulations, just like other pharmaceutical drugs. Both the FDA and FTC oversee and enforce these regulations to ensure consumer safety and accurate information dissemination.

The Farm Bill: Impact on Cannabis and Hemp Marketing

The 2018 Farm Bill amended the CSA by exempting hemp and hemp-based products, a variant of cannabis with low THC content, from CSA jurisdiction, thereby recognizing it as an "agricultural commodity" and effectively legalizing the marketing of hemp by licensed growers.[18,20] Research analyzing hemp marketing is limited, but there have been significant regional variations in state-based marketing channels.[21] One study found that while Colorado hemp producers primarily market online (24 percent), Kentucky producers primarily use word of mouth (44 percent).[21] (See Table 1) However, it remains unclear whether the approach to cannabis marketing influences sales-related variables, such as buyer profiles, age groups, or demographics.

The Farm Bill legalized hemp and hemp-derived CBD on the federal level, it did not address other cannabis-derived products, such as delta-8 THC and delta-10 THC products.[16,22] Nonetheless, there have been cases where both the FDA and FTC have taken regulatory action. On July 5, 2023, they sent warning letters to six firms for the unauthorized sale of imitation food items containing delta-8 THC.[23] Such products, which closely resemble conventional foods like chips, cookies, candy, and gummies, have raised FDA concerns about the potential for inadvertent consumption, especially by children, or ingestion of higher doses than intended.[23]

The Farm Bill mandates that hemp cultivation needs to be licensed and regulated under "state plans." However, the legalization and regulation of hemp and hemp-derived products, including CBD, brought these products under the authority of both the FDA and the Department of Agriculture, adding another layer of complexity.[24] This has led to the FDA using its authority over drug regulation to prevent unsubstantiated claims about the therapeutic efficacy of CBD-containing products.[5]

Despite FDA warning letters to companies illegally selling products with CBD, marketers have found ways to adapt their messaging within the FDA regulatory framework.[25] Strategies include reliance on consumer reviews to support marketing rather than direct seller claims, referring to websites that promote but do not sell CBD, and conflating research on THC or whole cannabis with effects of CBD alone.[5] Additional challenges have emerged leading to issues such as inaccurate labeling, inconsistent CBD formulation concentration, and unintentional product contamination from pesticides or insufficient purification processes.[5]

In January 2023, the FDA determined that the existing regulatory structures for foods and supplements are not suitable for CBD because they do not comprehensively cover the safety concerns that have been noted with CBD.[26] To address this, they plan to collaborate with Congress to develop a new regulatory pathway enhancing industry oversight of CBD, especially in marketing and advertising.[26] This new regulatory pathway would provide “safeguards and oversight to manage and minimize risks related to CBD products.”[26] These risk mitigation strategies include among others clear labeling, content limitations, and minimum purchase age.[26]

Cannabis Marketing

States have varying approaches to the marketing of cannabis and THC-containing products. While some states have completely banned marketing and advertising, other states have developed guidelines and regulatory bodies. In the majority of states where adult-use or medical use is legal, states have established regulatory bodies, officers, and/or programs that provide licensing and industry oversight to ensure compliance of existing cannabis laws, the development of marketing and advertising guidelines, and the enforcement of violation penalties. However, there are no federal standardized regulations, guidelines, or laws.

The marketing and advertising landscape has changed over time as states have implemented legislation granting state-based regulatory bodies the authority to enforce cannabis marketing guardrails. Given the scarcity of research dedicated to cannabis-specific marketing, many researchers have relied on studies conducted in the alcohol and tobacco industries for guidance.[28] Evidence from these industries suggests that advertising can contribute to the normalization and increased likelihood of substance use, with adolescents and youth often being disproportionately targeted.[29–31]

The U.S. cannabis industry registered a record $21.1 billion in sales in 2022, with expected annual sales of $37 billion by 2026.[32] Marketing and advertising have grown with the legalization of cannabis. However, there is currently no data available detailing the extent of this increase. As a proxy for evaluation, the cannabis industry spent approximately $661 million on advertising in 2018 and is projected to spend $2 billion in 2023 with a projected increase to $4.5 billion by the year 2030.[33] Even though cannabis legalization is implemented across states, there is still a scarcity of knowledge about marketing and advertising practices, potentially leaving gaps in regulation that could expose vulnerable populations to substantial harm. As the legal adult-use cannabis market expands, an extensive retail landscape has evolved to meet consumer demand for various types of cannabis and THC-containing products including edibles, beverages, and concentrates.

State Approaches to Regulating Cannabis Marketing and Advertising

State-based regulations primarily focus on the content and placement of marketing to safeguard consumers, with special emphasis on protecting minors. Similar to the voluntary self-regulatory code followed by the alcohol industry, many states have adopted policies prohibiting cannabis advertising in media where it is expected that over 30 percent of the audience will be under 21 years old.[10,36,37] However, research from the alcohol industry suggests that such policies are not particularly effective in preventing youth from exposure or interaction with alcohol-related content, indicating potential analogous issues with cannabis.[10,29,38]

Certain states, such as Colorado, Washington, and New York, explicitly forbid direct cannabis marketing towards children, but this has not deterred the rise of online and social media advertisements easily accessible to underage individuals.[23] With dispensaries offering convenience features such as online pre-ordering and home delivery, there are growing concerns regarding the lack of consistent state guidance on online cannabis marketing and social media promotions.[10,23,29] This concern is amplified by prior studies suggesting that minors have been able to successfully purchase other regulated products online such as cigarettes.[23,39]

The Network for Public Health Law conducted an extensive comparison of advertising and marketing regulations of adult-use cannabis in various states.[40] This comparison includes advertising limitations across 17 distinctive jurisdictions, with some jurisdictions excluded due to the lack of developed advertising regulations or other specific variables. The analysis highlights the considerable variance between states in marketing and advertising standards and regulation, categorizing policy measures into three main areas: medium restrictions, content restrictions, and physical restrictions.[40] Despite the existence of laws regulating cannabis marketing and advertising practices in many states, the actual enforcement of these laws has remained relatively unexplored. (See Table 3 for a companion to the State Regulation of Adult-Use Cannabis Advertising Table)

Medium Restrictions: Medium restrictions on cannabis advertising vary across states and are specific to certain advertising media, such as broadcast, print, or internet. The majority of states surveyed have restrictions on broadcasting advertising, print-media advertising, and internet advertising for cannabis in order to limit exposure to minors.[40] To a lesser extent, a few states have

laws restricting cannabis event sponsorship and location-based marketing which leverages the geographic location of a mobile device to push notifications about products offered at a nearby establishment.[40]

Content Restrictions: Content restrictions address the specifications and limitations placed on the content within cannabis advertisements. The majority of states surveyed regulate therapeutic claims in cannabis advertising, but they all regulate it to varying degrees. While some ban therapeutic claims altogether, others list numerous conditions on their states' approved lists. For instance, hepatitis C, Crohn's disease, Parkinson's disease, and Tourette's syndrome are qualifying medical conditions by state law for the use of cannabis[41], but the efficacy is supported only by low-quality evidence.[42] Nevertheless, some dispensaries may be financially motivated to increase customer sales by citing these cases.[23,43] Only six jurisdictions regulate safety claims in cannabis advertising, ranging from complete prohibition on safety claims to requirements for scientific evidence supporting the claims.[40]

All states except one surveyed explicitly outlaw false and/or misleading statements in advertisements.[40] Some states go further by defining what constitutes a misleading statement such as ambiguity and omission.[40] All jurisdictions ban ads that target children; however the extent of these prohibitions varies by state. For example, while Michigan bans ads for individuals under the age of 21, New Jersey specifically bans the inclusion of elements such as toys or cartoon characters that might appeal to individuals under 21 (See Table 4).[40] Along the same lines, the majority of states require a product warning on cannabis advertisements, while the warning required vary they generally inform about potential health risks, age requirements, and lack of FDA approval.[40] Similar to warnings on cigarette packages, the discrepancies in cannabis labeling across states can create challenges for consumers in reading and identifying health warnings, particularly for first time users or people with vision impairment. (See Table 5) The warning label signs size, text, and color vary from state to state.[34] (See Table 6) Lastly, more than half of the jurisdictions have varying regulations against offering gifts, prizes, or other inducements related to cannabis sales.[40]

Physical Restrictions: Physical restrictions focus on the physical characteristics and placement of cannabis outdoor advertising. The majority of states have exclusion zones around schools and other child-centric places (e.g., playgrounds, public parks) for advertising varying from 200 feet to 1,500 feet.[40] However, less states have restrictions regarding advertising on public property, public transportation, or in general visibility zones such as on signs or billboards.[40] One study that included a small sample (N=172) of adolescents in 6 states that have legalized adult-use cannabis found that the prevalence of billboard or storefront advertisements influences adolescents' usage patterns.[35] These billboards may lead to increased likelihood of frequent use and symptoms of cannabis use disorder.[35] (See Table 7) The marketing strategies employed by cannabis companies, particularly their branding techniques, could influence the frequency and manner of cannabis use among minors.[35]

Packaging Restrictions: The design of cannabis product packaging is at the forefront of these regulatory measures, as it plays a pivotal role in minimizing the appeal of cannabis items, especially edibles, to children. With legalization, states have reported a surge in accidental cannabis ingestion by children.[36] Many states have implemented packaging guidelines to mitigate such risks. For instance, nine states mandate opaque packaging and three states mandate plain packaging, with each having its unique definition.[37] Furthermore, every state demands child-resistant packaging, often based on standards from the Poison Prevention Packing Act of 1970, albeit implemented differently across states.[37] Some states, like California, have detailed child-resistant packaging systems with specific requirements for various types of cannabis products.[37]

Tamper-evident packaging, which showcases visible signs if meddled with, is required in three states.[37]

Most states, with a few exceptions, have a general directive prohibiting cannabis packaging that could entice children.[37] Some, such as Illinois, have explicit bans on packaging showcasing images appealing to minors, like cartoons or toys. Furthermore, 14 states strictly forbid packaging that imitates commercially available foods to minimize accidental ingestion by children.[37] Beyond general prohibitions, some states specify particular imagery or wording that cannot be used due to their potential allure to children. For instance, Maine prohibits the depiction of humans, animals, or fruit on the packaging.[37] A notable safety measure, the inclusion of the poison control number on cannabis packaging, is mandatory in four states.[37] The overarching objective across all these regulations is to safeguard children from the risks of accidental cannabis consumption and ensure public safety.

Marketing Through Social Media

The prominence of social media as a conduit for accurate information, disinformation. and misinformation about cannabis[38], coupled with social media-based cannabis promotion[10,31,39,40], poses a public health concern. The widespread engagement with these platforms among underage populations[41], and the established associations between exposure to cannabis marketing and subsequent intentions, initiation, and frequency of use among both adolescents[10,42] and adults[43,44], underscores the need for marketing regulations.[16]

In a study that investigated the correlation between adolescents' exposure to cannabis marketing in states where cannabis is legal, and their cannabis use in the past year found that exposure to cannabis marketing on social media platforms significantly increased the likelihood of the teens using cannabis. [20] Specifically, exposure increased the odds by 96 percent for Facebook, 88 percent for Twitter, and 129 percent for Instagram.[20] With each additional social media platform where exposure was reported, the odds rose by 48 percent.[20] Despite existing restrictions on cannabis advertising via social media platforms, teens are still encountering this marketing, leading to cannabis use. The study suggests that states should further regulate and enforce regulations of cannabis marketing on these platforms.

In a similar study, 11 social media companies that are the most popular amongst youth in the U.S. (e.g., TikTok, SnapChat, Instagram, and Facebook) were analyzed based on their cannabis marketing policies. While all social media platforms prohibit cannabis sales, they had varying policies on advertising and promotion.[16] (See Table 2) Paid advertising on social media for cannabis and cannabis products were prohibited by nine of the 11 platforms, the remaining two companies allow paid advertising within jurisdictions where cannabis is legal.[16] In addition, four out of the 11 platforms have ambiguous policies prohibiting unpaid cannabis promotion, with seven of the platforms allowing varying degrees of promotion by proxy such as through a link in their biography or allowing cannabis content and discussion but not promotion.[16]

Every social media platform mentioned limitations on cannabis-related content access for minors or underage individuals including age restrictions (thresholds set to either 18 or 21 years of age) or general age restrictions not specific to cannabis. However, researchers have highlighted concerns regarding age verification methods on social media platforms, noting their ambiguous effectiveness.[16] While one platform may set a threshold age of 21 years for exposure to cannabis, alcohol, and tobacco content, aligning with the legal age, other platforms may not, suggesting a need to adjust access based on legal ages, and improve age verification processes.

Another issue is the exposure to cannabis promotions in regions where cannabis is not legalized on the state-level. Regulating paid cannabis-related content on social media is challenging due to its vast volume and the difficulty in pinpointing the source's location. Additionally, the increasing prevalence of sponsored posts by influencers, indirect political promotions, and often undisclosed financial relationships make these posts hard to spatially identify and regulate.[16] Given the challenges of monitoring marketing on social media, there is a pressing need for both social media platforms and regulatory agencies to devise advanced strategies to automatically detect cannabis-related content. Implementing concrete advertising and marketing regulations on social media-based platforms and across the internet could serve to protect the health of vulnerable populations.[29,45]

Public Health Campaigns

When states legalize adult-use cannabis, they often implement policies that earmark tax revenue from cannabis sales for health and social initiatives, including educational public health campaigns that highlight the health risks associated with cannabis use.[46,47] This funding approach, in which counter-marketing resources became available only after significant sales had taken place, often leaves governments and public health offices in a reactive position, attempting to counter pre-established industry marketing and associated narratives. Although counter-marketing has shown some efficacy in reducing harmful tobacco and alcohol consumption, its effectiveness in reducing cannabis use has yet to be extensively studied in the U.S.[48]

The National Highway Traffic Safety Administration (NHTSA), in collaboration with the Ad Council, has launched a comprehensive campaign to raise awareness about the hazards of drug-impaired driving and encourage safer decisions. This campaign employs a multi-channel approach encompassing television, radio, banners, print media, out-of-home advertisements, and online videos.[49] (See Table 8) The primary focus is to deter individuals from operating vehicles while under the influence of drugs, specifically cannabis. Scientific studies indicate that cannabis can adversely impact several critical driving skills, such as reaction time, distance judgment, and overall coordination.[50–52] Given these risks, the campaign specifically targets young men between the ages of 18 and 34.[49] The campaign's core message is that alterations in perception after cannabis consumption can drastically change driving capabilities.[49]

NHTSA is one of the many stakeholders that is continually researching the correlation between cannabis impairment and crash risks. Findings from their Drug and Alcohol Crash Risk Study have shown that cannabis users have a higher likelihood of being involved in accidents.[53,54] This elevated risk might be attributable, in part, to the demographic skew towards young men, who inherently have a higher crash risk.[53] Recent studies by NHTSA in 2020 have highlighted a rising prevalence of drug use, especially alcohol, cannabinoids, and opioids, among seriously injured or fatally wounded road users during public health emergencies compared to previous times.[53,55]

EXISTING AMA POLICY

AMA currently has policy related to cannabis, research, and marketing. Policy H-95.924, "Cannabis Legalization for Adult Use" notes that states that have legalized cannabis should be required to take steps to regulate the product effectively in order to protect public health and safety including in marketing and promotion intended to encourage use, requiring legible and child-resistant packaging with messaging about the hazards about unintentional ingestion in children and youth. Policy H-95.952, "Cannabis and Cannabinoid Research" calls for more cannabis and cannabinoid research including into the long-term cannabis use among youth, adolescents, pregnant women, and women who are breastfeeding. Policy H-95.936, "Cannabis Warnings for Pregnant

and Breastfeeding Women" advocates for regulations requiring point-of-sale warnings and product labeling for cannabis and cannabis-based products regarding the potential dangers of use during pregnancy and breastfeeding wherever these products are sold or distributed. Policy H-95.911, "CBD Oil Use and the Marketing of CBD Oil" supports banning the advertising of cannabidiol as a component of marijuana in places that children frequent, and supports legislation that prohibits companies from selling CBD products if they make any unproven health and therapeutic claims. In addition, our AMA's advocacy team has been active in encouraging the FDA to regulate inappropriate medical claims and direct-to-consumer advertising.

CONCLUSION

Research on cannabis marketing regulation and enforcement is sparse, especially concerning its efficacy in safeguarding vulnerable groups, notably youth. While federal regulatory agencies oversee the marketing and advertising of hemp (including CBD), the regulation of cannabis and cannabis-derived products varies by state. The challenges in the field of cannabis products are accentuated by the lack of research and guidance on dosing and adverse effects, leading consumers to rely on potentially inaccurate marketing sources like dispensary staff or online sites, emphasizing the need to ensure accurate and consistent information in marketing. A closer look at the marketing regulatory frameworks established for substances such as alcohol and tobacco could offer valuable insights into optimal marketing and advertising practices for cannabis and its derived products.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following recommendations be adopted and the remainder of the report be filed.

A. Our AMA supports and encourages:

1. research on the effects of cannabis marketing to identify best practices in protecting vulnerable populations, as well as the benefits of public health campaigns such as preventing impaired driving or dangerous use.
2. state regulatory bodies to enforce cannabis-related marketing laws and to publicize and make publicly available the results of such enforcement activities.
3. social media platforms to set a threshold age of 21 years for exposure to cannabis advertising and marketing and improve age verification practices on social media platforms.
4. regulatory agencies to research how marketing best practices learned from tobacco and alcohol policies can be adopted or applied to cannabis marketing. (New HOD Policy)

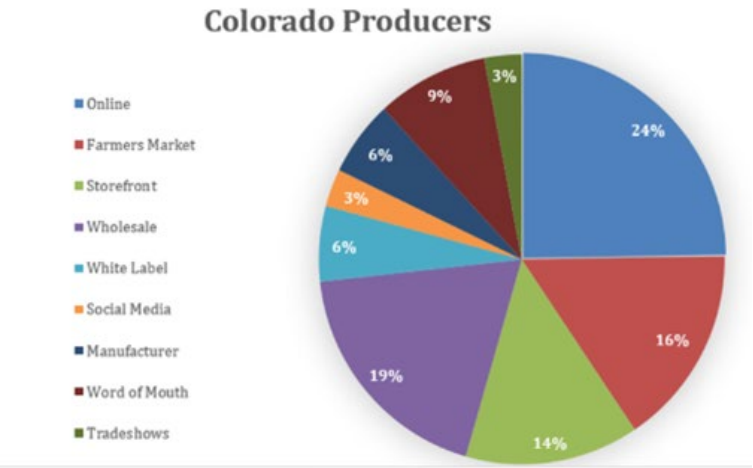
B. That our AMA reaffirm policies:

- H-95.952, "Cannabis and Cannabinoid Research," that calls for further funding for adequate and well-controlled studies of cannabis and cannabis derived products and support of the rescheduling of cannabis, and
- H-95.923, "Taxes on Cannabis Products," that notes our AMA's encouragement of states and territories to allocate a substantial portion of their cannabis tax revenue for public health purposes, including substance [use] prevention and treatment programs, cannabis-related educational campaigns, scientifically rigorous research on the health effects of cannabis, and public health surveillance efforts. (Reaffirm HOD Policy)

Fiscal Note: Minimal – less than $1,000

TABLE 1. Colorado and Kentucky Hemp Grower Marketing Channels

Hill R, Jablonski BBR, Van L, et al. Producers marketing a novel crop: a field-level view of hemp market channels. *Renewable Agriculture and Food Systems*. 2023;38. doi:10.1017/S1742170523000145



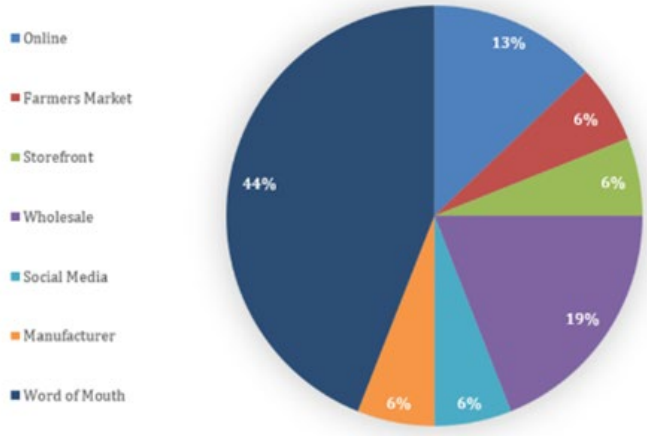


TABLE 2. Summary of Social Media Platform Policies Regarding Cannabis Promotion, as of October-November 2022

Berg CJ, LoParco CR, Cui Y, et al. A review of social media platform policies that address cannabis promotion, marketing and sales. *Subst Abuse Treat Prev Policy*. 2023;18(1):35. doi:10.1186/s13011-023-00546-x

	Specifies cannabis	Recognizes jurisdictional differences	Paid advertising		Unpaid promotion		Cannabis sales		Underage restrictions			
			Completely prohibited	Allowed but restricted	Completely prohibited	Allowed but restricted	Completely prohibited	Allowed but restricted	Age unspecified	< 18 years old	< 21 years old	Addresses cannabis
Discord	X	-	X	-	X	-	X	-	-	X	-	-
Facebook	X*	-	X	-	-	X	X	-	-	X	-	-
Instagram	X	-	X	-	-	X	X	-	X	-	-	-
Pinterest	X*	-	X	-	-	X	X	-	-	X	-	-
Reddit	X*	X	X	-	X	-	X	-	-	X	-	-
Snapchat	X*	X	-	X	X	-	X	-	X	-	-	-
TikTok	-	X	X	-	X	-	X	-	-	X	-	X
Tumblr	X*	X	-	X	-	X	X	-	-	-	X	X
Twitch	X*	-	X	-	-	X	X	-	X	-	-	-
Twitter	X*	X	X	-	-	X	X	-	-	X	-	X
YouTube	X	-	X	-	-	X	X	-	-	X	-	X

Notes: See also Supplementary Table 1 for more details. * Differentiates CBD from cannabis containing THC.

TABLE 3: State Regulation of Adult-Use Cannabis Legal Research Table

The Network for Public Health Law. State Regulation of Adult-Use Cannabis Advertising.; 2022. Accessed July 18, 2023. https://www.networkforphl.org/wp-content/uploads/2022/11/State-Regulation-of-Adult-Use-Cannabis-Advertising.pdf

STATE	SOURCE	REQUIRING COMMISSION APPROVAL	Medium Restrictions					CONTENT RESTRICTIONS						PHYSICAL RESTRICTIONS				
			Radio/Television (restriction- audience share over min. age)	Print (restriction- audience share over min. age)	Internet (restriction- audience share over min. age)	Event Sponsorship (restriction- audience share over min. age)	Location-Based Marketing Restrictions	Curative/Therapeutic Claims	Safety Claims	Content Targeting Children	Validity of Statements	Gifts/Prizes/Other Inducements	Product Warnings	Signs within Close Proximity to Schools	Signs on Public Property/Transp ortation	Signs Visible to General Public	Size/Other Features	Illuminated Signs
Alaska	Alaska Admin. Code tit. 3 § 306.770	N	N	N	Y	Y (70%)	N	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	N
Arizona	Ariz. Rev. Stat. Ann. § 36-2859	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
California	Cal. Bus. & Prof. Code § 26150-26156 (2017)	N	Y (71.6%)	Y (71.6%)	Y (71.6%)	Y (71.6%)	Y	Y	N	Y	Y	Y	N	Y	N	N	N	N
Colorado	Colo. Code Regs §212-3-3 R.700 Series	N	Y (71.6%)	Y (71.6%)	Y (71.6%)	Y (71.6%)	N	N	Y	Y	Y	N	N	Y	N	N	Y	N
Connecticut	Conn. Gen. Stat. §21a-421bb (Public Act No. 22-103) (2022)	N	Y (90%)	Y (90%)	Y (90%)	Y (90%)	Y	Y	N	Y	Y	N	Y	Y	Y	Y	N	Y
District of Columbia	No Advertising Provisions	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Illinois	410 Ill. Comp. Stat. 705/55-20 (2019)	N	N	N	N	N	N	Y	N	Y	Y	Y	N	Y	Y	N	N	N
Maine	18-691-1 Me. Code R. § 52	N	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y	Y	N	N	N	N
Maryland	Md. Code Ann.,Health-Gen. § 13-3313.1 (2019)	N	N	N	Y	N	Y	Y	Y	Y	Y	N	Y	Y	Y	N	N	N
Massachusetts	935 Mass. Code Regs. 500.105(4)	N	Y (85%)	Y (85%)	Y (85%)	Y	N	Y	Y	Y	Y	Y	Y	N	Y	N	N	Y
Michigan	Mich. Admin. Code r. 420.507 (2020)	N	Y (70%)	Y (70%)	Y (70%)	Y	N	Y	N	Y	Y	N	N	N	N	N	N	N
Montana	Mont. Admin. R. 42.39.123 (2021)	N	Y	Y	Y	N	Y	N	Y	Y	N	N	N	N	N	N	N	N
Nevada	Nev. Rev. Stat. § 678B.520 (2021)	N	Y (70%)	Y (70%)	Y (70%)	Y (70%)	N	N	N	Y	Y	Y	Y	Y	Y	N	N	N
New Jersey	N.J. Admin. Code § 17:30-14.2	N	Y (71.6%)	Y (71.6%)	Y* (71.6%)	Y (80.6%)	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N
New Mexico	N.M. Code R. § 16.8.3.8 (2022)	N	Y	Y (70%)	Y (70%)	N	Y	Y	N	Y	Y	N	Y	Y	Y	N	N	N
New York	N.Y. Can. § 86 (2022)	N	Y	Y	Y	N	N	Y	N	Y	Y	Y	N	Y	Y	Y	N	N
Oregon	Or. Admin. R. 845-025-8040 to 845-025-8060	N	Y (70%)	Y (70%)	Y (70%)	N	Y	Y	Y	Y	Y	N	Y	N	Y	N	N	N
Rhode Island	Rhode Island Gen.Laws § 21-28.11-5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Vt. Stat. Ann. Tit. 7 § 864 (2021)																	

Vermont	25-002 Vt. Code R. § 2.2.11 (2022)	Y	Y (85%)	Y (85%)	Y (85%)	Y (85%)	N	Y	N	Y	Y	Y	Y	N	N	N	N	N
Virginia	No Advertising Provisions	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Washington	Wash Admin. Code § 314-55-155 (2013)	N	N	N	N	N	N	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
1	RCW 69.50.369																		

TABLE 4: Cannabis Products that Appeal to Youth[56]

Fair L. THC edibles that look like snacks popular with kids? FTC and FDA have something to say about that. Federal Trade Commission. Published July 3, 2023. Accessed August 7, 2023. https://www.ftc.gov/business-guidance/blog/2023/07/thc-edibles-look-snacks-popular-kids-ftc-fda-have-something-say-about

Some of the products cited in FDA-FTC cease and desist letters to companies selling THC products copying the look of snacks popular with children

TABLE 5. Massachussets Cannabis Warning Label[57]

Line Packaging Supplies. Warning Label Massachusetts. Line Packaging Supplies. Accessed August 30, 2023. https://www.linepackagingsupplies.com/warning-label-massachusetts/

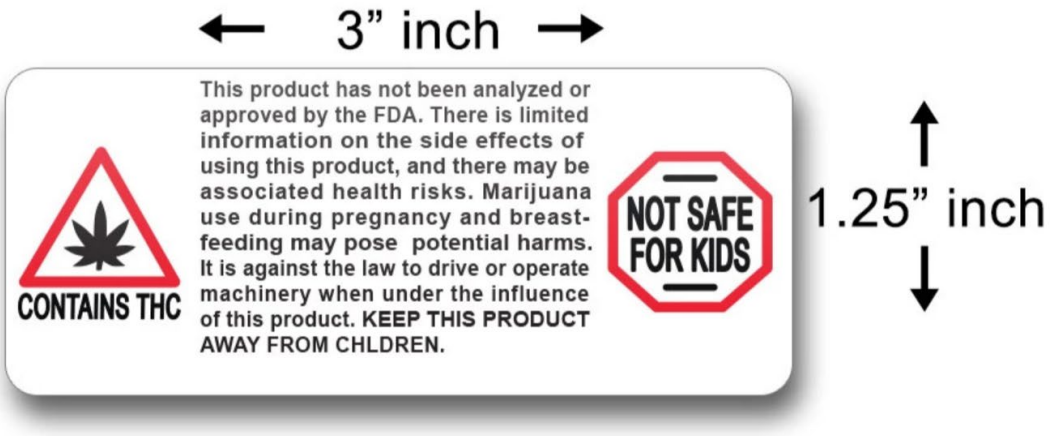


TABLE 6. Current Usage of the International Intoxicating Cannabis Products Symbol (IICPS) and Other Symbols

Doctors for Cannabis Regulation. Universal Cannabis Symbol. Accessed August 30, 2023. https://www.dfcr.org/universal-cannabis-symbol

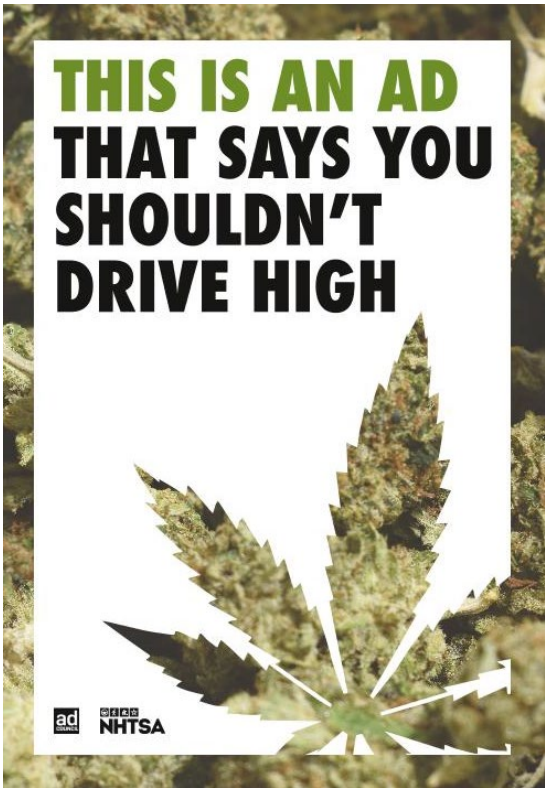
Symbol design	Authorities having jurisdiction (AHJs) using the symbol	Shape of outline (conventional meaning)	Emphasized color (conventional meaning)	Number of colors (including white)	Graphical element (cannabis leaf)	Large graphical element for the visually impaired	Text excluded from interior of symbol	ISO & ANSI compliant
	**IICPS:** MT, NJ, SD, & VT	Triangle (warning)	Yellow (caution)	2	Yes	Yes	Yes	Yes
	AR	None	None	2	No	No	No	No
	AZ, CO, FL, & OH	Diamond (none)	Red (prohibition)	2	No	No	No	No
	CA	Triangle (warning)	None	2	Yes	No	No	No
	CT, MA, ME, & RI	Triangle (warning)	Red (prohibition)	3	Yes	Yes	Yes	No
	MD	Triangle (warning)	Red (prohibition)	2	Yes	No	No	No
	MI	Inverted triangle (none)	Green (safe condition)	2	Yes	Yes	No	No
	NM	Diamond (none)	Red (prohibition)	2	No	No	No	No
	NV	Triangle (warning)	None	2	No	No	No	No
	NY	Square (none)	Yellow, red (caution, prohibition)	4	Yes	No	No	No
	OK	Rectangle (none)	Red (prohibition)	3	Yes	No	No	No
	OR	Rectangle (none)	Red (prohibition)	3	Yes	Yes	No	No
	WA	Diamond (none)	Yellow, green (caution, safe condition)	4	Yes	Yes	No	No
	Canada	Octagon (stop)	Red (prohibition)	3	Yes	Yes	No	No

TABLE 7. Cannabis Billboards[58]

Stanford University. Marijuana Billboards. Research into the Impact of Tobacco Advertising. Accessed August 30, 2023. https://tobacco.stanford.edu/marijuanas/billboards/

TABLE 8. Ad Council Drug-Impaired Driving Print Assets

Ad Council. Drug-Impaired Driving Campaign & Media Assets. Drug-Impaired Driving Prevention. Accessed August 21, 2023. https://www.adcouncil.org/campaign/drug-impaired-driving-prevention#print



REFERENCES

1. National Conference of State Legislatures. *State Medical Cannabis Laws*.; 2023. Accessed August 21, 2023. https://www.ncsl.org/health/state-medical-cannabis-laws

2. Pacula RL, Smart R. Medical Marijuana and Marijuana Legalization. *Annu Rev Clin Psychol*. 2017;13:397-419. doi:10.1146/annurev-clinpsy-032816-045128

3. NIDA. What is the scope of cannabis (marijuana) use in the United States? National Institute on Drug Abuse. Published January 23, 2023. Accessed July 25, 2023. https://nida.nih.gov/publications/research-reports/marijuana/what-scope-marijuana-use-in-united-states

4. Nagarkatti PN Mitzi. Cannabis-derived products like delta-8 THC and delta-10 THC have flooded the US market. University of South Carolina. Published April 28, 2023. Accessed July 28, 2023. https://www.sc.edu/uofsc/posts/2023/04/conversation_cannabis_derived_products.php

5. Wiley JL, Gourdet CK, Thomas BF. *Cannabidiol: Science, Marketing, and Legal Perspectives*. RTI Press; 2020. doi:10.3768/rtipress.2020.op.0065.2004

6. Kees J, Fitzgerald P, Dorsey JD, Hill RP. Evidence-Based Cannabis Policy: A Framework to Guide Marketing and Public Policy Research. *Journal of Public Policy & Marketing*. 2020;39(1):76-92. doi:10.1177/0743915619848422

7. Centers for Disease Control and Prevention. Marijuana and Public Health Data and Statistics. CDC.gov. Published June 8, 2021. Accessed August 7, 2023. https://www.cdc.gov/marijuana/data-statistics.htm

8. Urits I, Gress K, Charipova K, et al. Cannabis Use and its Association with Psychological Disorders. *Psychopharmacol Bull*. 2020;50(2):56-67.

9. Brown QL, Shmulewitz D, Sarvet AL, Young-Wolff KC, Howard T, Hasin DS. Cannabis use, cannabis use disorder and mental health disorders among pregnant and postpartum women in the US: A nationally representative study. *Drug Alcohol Depend*. 2023;248. doi:10.1016/j.drugalcdep.2023.109940

10. Whitehill JM, Trangenstein PJ, Jenkins MC, Jernigan DH, Moreno MA. Exposure to Cannabis Marketing in Social and Traditional Media and Past-Year Use Among Adolescents in States With Legal Retail Cannabis. *Journal of Adolescent Health*. 2020;66(2):247-254. doi:10.1016/j.jadohealth.2019.08.024

11. Evans JM, Kelly RF. Self-Regulation in the Alcohol Industry: A Federal Trade Commission Report to Congress. Federal Trade Commission. Published September 1, 1999. Accessed August 30, 2023. https://www.ftc.gov/reports/self-regulation-alcohol-industry-federal-trade-commission-report-congress

12. *21 U.S. Code § 843*.; 1970. Accessed August 21, 2023. https://www.law.cornell.edu/uscode/text/21/843

13. Allard NC, Kruger JS, Kruger DJ. Cannabis Advertising Policies in the United States: State-Level Variation and Comparison with Canada. *Cannabis and Cannabinoid Research*. 2023;8(3):505-509. doi:10.1089/can.2022.0068

14. U.S Food and Drug Administration. FDA Warns Companies Illegally Selling Over-the-Counter CBD Products for Pain Relief. FDA. Published March 22, 2021. Accessed August 15, 2023. https://www.fda.gov/news-events/press-announcements/fda-warns-companies-illegally-selling-over-counter-cbd-products-pain-relief

15. U.S Food and Drug Administration. FDA Warns Companies Illegally Selling CBD Products to Treat Medical Conditions, Opioid Addiction. FDA. Published March 22, 2021. Accessed August 15, 2023. https://www.fda.gov/news-events/press-announcements/fda-warns-companies-illegally-selling-cbd-products-treat-medical-conditions-opioid-addiction

16. Berg CJ, LoParco CR, Cui Y, et al. A review of social media platform policies that address cannabis promotion, marketing and sales. *Subst Abuse Treat Prev Policy*. 2023;18(1):35. doi:10.1186/s13011-023-00546-x

17. Federal Trade Commission. *How to Make Effective Disclosures in Digital Advertising*.; 2013. Accessed July 27, 2023. https://www.ftc.gov/sites/default/files/attachments/press-releases/ftc-staff-revises-online-advertising-disclosure-guidelines/130312dotcomdisclosures.pdf

18. U.S Food & Drug Administration. FDA and Cannabis: Research and Drug Approval Process. FDA. Published February 24, 2023. Accessed July 27, 2023. https://www.fda.gov/news-events/public-health-focus/fda-and-cannabis-research-and-drug-approval-process

19. D'hooghe M, Willekens B, Delvaux V, et al. Sativex® (nabiximols) cannabinoid oromucosal spray in patients with resistant multiple sclerosis spasticity: the Belgian experience. *BMC Neurology*. 2021;21(1):227. doi:10.1186/s12883-021-02246-0

20. Johnson R. *2018 Farm Bill Primer: Hemp Cultivation and Processing*. Congressional Research Service; 2019. Accessed August 9, 2023. https://crsreports.congress.gov/product/pdf/IF/IF11088

21. Hill R, Jablonski BBR, Van L, et al. Producers marketing a novel crop: a field-level view of hemp market channels. *Renewable Agriculture and Food Systems*. 2023;38. doi:10.1017/S1742170523000145

22. Schuster WM. Cannabis Derivatives and Trademark Registration: The Case of Delta-8-THC. *98 Indiana Law Journal 177 (2022)*. 2022;98(1). https://www.repository.law.indiana.edu/ilj/vol98/iss1/4

23. U.S Food and Drug Administration. FDA, FTC Warn Six Companies for Illegally Selling Copycat Food Products Containing Delta-8 THC. FDA. Published July 6, 2023. Accessed September 1, 2023. https://www.fda.gov/news-events/press-announcements/fda-ftc-warn-six-companies-illegally-selling-copycat-food-products-containing-delta-8-thc

24. Gottlieb S. Statement from FDA Commissioner Scott Gottlieb, M.D., on signing of the Agriculture Improvement Act and the agency's regulation of products containing cannabis and cannabis-derived compounds. FDA. Published March 24, 2020. Accessed July 30, 2023. https://www.fda.gov/news-events/press-announcements/statement-fda-commissioner-scott-gottlieb-md-signing-agriculture-improvement-act-and-agencys

25. U.S Food and Drug Administration. FDA Warns Companies for Illegally Selling Food and Beverage Products that Contain CBD. *FDA*. Published online November 21, 2022. Accessed

July 30, 2023. https://www.fda.gov/food/cfsan-constituent-updates/fda-warns-companies-illegally-selling-food-and-beverage-products-contain-cbd

26. U.S Food & Drug Administration. FDA Concludes that Existing Regulatory Frameworks for Foods and Supplements are Not Appropriate for Cannabidiol, Will Work with Congress on a New Way Forward. FDA. Published January 26, 2023. Accessed August 7, 2023. https://www.fda.gov/news-events/press-announcements/fda-concludes-existing-regulatory-frameworks-foods-and-supplements-are-not-appropriate-cannabidiol

27. Hammond CJ, Chaney A, Hendrickson B, Sharma P. Cannabis use among U.S. adolescents in the Era of Marijuana Legalization: a review of changing use patterns, comorbidity, and health correlates. *Int Rev Psychiatry*. 2020;32(3):221-234. doi:10.1080/09540261.2020.1713056

28. University of South Carolina Tobacco Center of Regulatory Science. CTP should actively integrate the relationship between cannabis and tobacco use into its tobacco regulation and proactively identify regulatory approaches from tobacco product regulation that can be applied to cannabis. Published online August 29, 2023. Accessed August 29, 2023. https://profglantz.files.wordpress.com/2023/08/6.-ucsf-comment-cannabis-and-tobacco-082523.pdf

29. Cavazos-Rehg PA, Krauss MJ, Cahn E, et al. Marijuana Promotion Online: an Investigation of Dispensary Practices. *Prev Sci*. 2019;20(2):280-290. doi:10.1007/s11121-018-0889-2

30. Anderson P, de Bruijn A, Angus K, Gordon R, Hastings G. Impact of alcohol advertising and media exposure on adolescent alcohol use: a systematic review of longitudinal studies. *Alcohol Alcohol*. 2009;44(3):229-243. doi:10.1093/alcalc/agn115

31. D'Amico EJ, Miles JNV, Tucker JS. Gateway to curiosity: Medical marijuana ads and intention and use during middle school. *Psychol Addict Behav*. 2015;29(3):613-619. doi:10.1037/adb0000094

32. Statista. Legal recreational cannabis sales U.S. 2021-2026. Statista. Published April 6, 2023. Accessed July 25, 2023. https://www.statista.com/statistics/933384/legal-cannabis-sales-forecast-us/

33. Navarro JG. Cannabis ad spend in North America 2030. Statista. Published January 6, 2023. Accessed August 9, 2023. https://www.statista.com/statistics/879805/cannabis-ad-spend-north-america/

34. Doctors for Cannabis Regulation. Universal Cannabis Symbol. Accessed August 30, 2023. https://www.dfcr.org/universal-cannabis-symbol

35. Trangenstein PJ, Whitehill JM, Jenkins MC, Jernigan DH, Moreno MA. Cannabis Marketing and Problematic Cannabis Use Among Adolescents. *J Stud Alcohol Drugs*. 2021;82(2):288-296. doi:10.15288/jsad.2021.82.288

36. Dilley JA, Graves JM, Brooks-Russell A, Whitehill JM, Liebelt EL. Trends and Characteristics of Manufactured Cannabis Product and Cannabis Plant Product Exposures Reported to US Poison Control Centers, 2017-2019. *JAMA Network Open*. 2021;4(5). doi:10.1001/jamanetworkopen.2021.10925

37. Swinburne M. *Cannabis Regulation Fact Sheet*. The Network for Public Health Law; 2022. Accessed August 21, 2023. https://www.networkforphl.org/wp-content/uploads/2022/11/Packaging-Regulation.pdf

38. Ishida JH, Zhang AJ, Steigerwald S, Cohen BE, Vali M, Keyhani S. Sources of Information and Beliefs About the Health Effects of Marijuana. *J Gen Intern Med*. 2020;35(1):153-159. doi:10.1007/s11606-019-05335-6

39. Moreno MA, Gower AD, Jenkins MC, Kerr B, Gritton J. Marijuana promotions on social media: adolescents' views on prevention strategies. *Substance Abuse Treatment, Prevention, and Policy*. 2018;13(1):23. doi:10.1186/s13011-018-0152-7

40. Spillane TE, Wong BA, Giovenco DP. Content analysis of instagram posts by leading cannabis vaporizer brands. *Drug Alcohol Depend*. 2021;218:108353. doi:10.1016/j.drugalcdep.2020.108353

41. Vogels EA, Gelles-Watnick R, Massarat N. *Teens, Social Media and Technology 2022*. Pew Research Center; 2022. Accessed July 27, 2023. https://www.pewresearch.org/internet/2022/08/10/teens-social-media-and-technology-2022/

42. Trangenstein PJ, Whitehill JM, Jenkins MC, Jernigan DH, Moreno MA. Active cannabis marketing and adolescent past-year cannabis use. *Drug Alcohol Depend*. 2019;204:107548. doi:10.1016/j.drugalcdep.2019.107548

43. Krauss MJ, Sowles SJ, Sehi A, et al. Marijuana advertising exposure among current marijuana users in the U.S. *Drug Alcohol Depend*. 2017;174:192-200. doi:10.1016/j.drugalcdep.2017.01.017

44. Kim Y, Vera L, Huang PhD J, Emery S. Marijuana Content on Digital Media and Marijuana Use among Young People in the United States. *Cannabis*. 5(2):16-29. doi:10.26828/cannabis/2022.02.007

45. Feeney KE, Kampman KM. Adverse effects of marijuana use. *Linacre Q*. 2016;83(2):174-178. doi:10.1080/00243639.2016.1175707

46. Purtle J, Brinson K, Stadnick NA. Earmarking Excise Taxes on Recreational Cannabis for Investments in Mental Health: An Underused Financing Strategy. *JAMA Health Forum*. 2022;3(4). doi:10.1001/jamahealthforum.2022.0292

47. Warnick A. Protecting public health key as marijuana legalization grows: Colorado leading the way among states. *The Nation's Health*. 2019;49(6):1-10.

48. Palmedo PC, Dorfman L, Garza S, Murphy E, Freudenberg N. Countermarketing Alcohol and Unhealthy Food: An Effective Strategy for Preventing Noncommunicable Diseases? Lessons from Tobacco. *Annual Review of Public Health*. 2017;38(1):119-144. doi:10.1146/annurev-publhealth-031816-044303

49. Ad Council. Drug-Impaired Driving Campaign & Media Assets. Drug-Impaired Driving Prevention. Accessed August 21, 2023. https://www.adcouncil.org/campaign/drug-impaired-driving-prevention#print

50. Centers for Disease Control and Prevention. Marijuana and Public Health. Health Effects - Driving. Published October 19, 2020. Accessed August 21, 2023. https://www.cdc.gov/marijuana/health-effects/driving.html

51. Hartman RL, Huestis MA. Cannabis effects on driving skills. *Clin Chem*. 2013;59(3):478-492. doi:10.1373/clinchem.2012.194381

52. Desrosiers NA, Ramaekers JG, Chauchard E, Gorelick DA, Huestis MA. Smoked Cannabis' Psychomotor and Neurocognitive Effects in Occasional and Frequent Smokers. *Journal of Analytical Toxicology*. 2015;39(4):251-261. doi:10.1093/jat/bkv012

53. National Highway Traffic Safety Administration. Drug-Impaired Driving. Accessed August 21, 2023. https://www.nhtsa.gov/risky-driving/drug-impaired-driving

54. Lacey JH, Kelley-Baker T, Berning A, et al. *Drug and Alcohol Crash Risk: A Case-Control Study*. National Highway Traffic Safety Administration; 2016. Accessed August 21, 2023. https://www.nhtsa.gov/sites/nhtsa.gov/files/documents/812355_drugalcoholcrashrisk.pdf

55. U.S Department of Transportation. National Highway Traffic Safety Administration. Office of Behavioral Safety Research. *Update to Special Reports on Traffic Safety during the COVID-19 Public Health Emergency: Fourth Quarter Data [Traffic Safety Facts]*.; 2021. doi:10.21949/1526015

56. Fair L. THC edibles that look like snacks popular with kids? FTC and FDA have something to say about that. Federal Trade Commission. Published July 3, 2023. Accessed August 7, 2023. https://www.ftc.gov/business-guidance/blog/2023/07/thc-edibles-look-snacks-popular-kids-ftc-fda-have-something-say-about

57. Line Packaging Supplies. Warning Label Massachusetts. Line Packaging Supplies. Accessed August 30, 2023. https://www.linepackagingsupplies.com/warning-label-massachusetts/

58. Stanford University. Marijuana Billboards. Research into the Impact of Tabacco Advertising. Accessed August 30, 2023. https://tobacco.stanford.edu/marijuanas/billboards/

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 7-I-23

Subject: Efficacy of Requirements for Metal Detection/Weapons Interdiction Systems in Health Care Facilities

Presented by: David J. Welsh, MD, MBA, Chair

Referred to: Reference Committee K

Resolution 938-I-22, asked that our American Medical Association Council on Science and Public Health study the issues of (1) workplace violence as it impacts health care workers, patients, and visitors, and (2) anticipated positive impacts of weapons detection and interdiction systems toward reduction of workplace violence, so that our AMA can develop learned and data-based recommendations and accompanying advocacy regarding proposed new requirements for the deployment of these systems in health care settings, and share these recommendations with accrediting bodies such as The Joint Commission, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other relevant stakeholders, including the American Hospital Association.

This report updates information contained in CSAPH 2-I-10, "Violence in the Emergency Department," and Board of Trustees Report 2-I-12, "Surveying Violence in the Non-hospital Work Environment," and CSAPH 7-A-16, "Preventing Violent Acts Against Health Care Providers." There is a significant amount of background information on this issue contained within these previous reports, including information on the types of workplace violence, prevalence of workplace violence in health care settings, risk factors, high-risk practice areas, hospital-based shootings, reporting of workplace violence, the current requirements to prevent violence against health care workers, and a review of interventions and evidence on their effectiveness. Our intention with this report is not to repeat that information, but to share relevant updates. We also recognize that the threat of violence against health care professionals does not only exist within health care facilities, but threats of violence outside of health care facilities is beyond the scope of this report.

METHODS

English language reports were selected from a search of the PubMed and Google Scholar databases using the search terms "health care" and "violence," "workplace violence" and "prevention," and "firearms" and "hospitals," "weapon" and "health care," and "metal detector" and "health care." Searches were time-limited to articles published since the last report on this topic in 2016. Additional articles were identified by manual review of the references cited in these publications. Further information was gathered from internet sites managed by relevant federal agencies and health care organizations.

BACKGROUND

The health care and social service industries experience the highest rates of injuries caused by workplace violence.[1] Workers in these industries are 5 times as likely to suffer a workplace violence injury than workers overall.[1] Health care workers accounted for 73 percent of all nonfatal workplace injuries and illnesses due to violence in 2018.[1] From 2011 to 2018, there were 156 workplace homicides to private health care workers, averaging about 20 each year. The most common assailant in workplace homicides to health care workers was a relative or domestic partner of the injured worker.[1]

The COVID-19 pandemic seemingly worsened violence against health care professionals. A survey by the International Council of Nurses, the International Committee of the Red Cross, the International Hospital Federation, and the World Medical Association conducted from May to July 2021 sought to understand the perceptions of violence against health care professionals during the first year of the COVID-19 pandemic.[2] The report found that of those organizations that had received reports of violence, 58 percent of the respondents perceived an increase and 9 percent of those who reported violence said it had not occurred before the pandemic.[3] All respondents reported verbal aggression; 82 percent mentioned threats and physical aggression while 27 percent reported staff being threatened by weapons.[4] Twenty-one percent reported the death or severe wounding of a health-care worker or patient.[4]

While fatal shootings, such as those at Legacy Good Samaritan Medical Center in Portland, Methodist Dallas Medical Center, Northside Medical building in Atlanta, and on the campus of Saint Francis Health System in Tulsa, Oklahoma receive media attention, there are many other non-fatal acts of violence in health care workplaces that are either not reported or get little attention.[5] Evidence indicates that workplace violence might lead to various negative impacts on health care professionals' psychological and physical health, such as increase in stress and anxiety levels and feelings of anger, guilt, insecurity, and burnout.[6] Furthermore, the general sentiment of health care professionals attacked in the workplace is that hospital administrators and the judicial system accept this violence occurs and do not do enough to protect health care professionals.[7]

DISCUSSION

Emergency departments, mental health, and long-term care providers are among the most frequent victims of patient and visitor attacks. Perpetrator characteristics or circumstances that influence this pattern of violent events include altered mental status, dementia and behavioral issues, substance use disorders, pain/medication withdrawal, and dissatisfaction with care.[8,9] Regulatory agencies have taken the following actions since 2016 to address violence in health care facilities.

Occupational Safety and Health Administration (OSHA)

In the Council's 2016 report, it was noted that OSHA does not have specific standards for workplace violence.[22] However, the courts have interpreted Section 5(a)(1) of the Occupational Safety and Health Act of 1970 (the General Duty Clause), to mean that:

> an employer has a legal obligation to provide a workplace free of conditions or activities that either the employer or industry recognizes as hazardous and that cause, or are likely to cause, death or serious physical harm to employees when there is a feasible method to abate the hazard.[22]

This means that workplace violence must have taken place, or the employer must be aware of threats or other signs that the potential for violence exists, to be held accountable under the General Duty Clause.

In 2017, OSHA published an updated compliance directive to provide OSHA compliance officers with guidance on responding to complaints of workplace violence in the health care setting.[10] In 2019, the Occupational Safety and Health Review Commission (OSHRC) upheld a citation issued to a health care employer after an employee was fatally stabbed by a mentally ill patient.[11] OSHRC held that incidents of workplace violence fall within an employer's obligation under the General Duty Clause.

In March of 2023, OSHA announced that it is in the early stages of developing a potential standard, Prevention of Workplace Violence in Healthcare and Social Assistance. OSHA convened a Small Business Advocacy Review (SBAR) Panel and heard from representatives from small businesses and who served as small entity representatives who could potentially be affected by the draft rule.[12]

The Joint Commission

Effective January 1, 2022, revised workplace violence prevention standards apply to the Joint Commission-accredited hospitals and critical access hospitals.[13] The Joint Commission cited the high incidence of workplace violence and the rationale for the creation of new accreditation requirements. The revised standards provide a framework to guide hospitals in developing effective workplace violence prevention systems, including leadership oversight, policies and procedures, reporting systems, data collection and analysis, post-incident strategies, training, and education to decrease workplace violence.[13] Effective workplace violence prevention programs require a worksite analysis with environmental modifications implemented based on findings from the analysis. Best practices and applicable laws and regulations are constantly evolving, so hospitals are required to review the program's policies and procedures, training, and education for consistency with the latest recommendations.[13]

FGI Guidelines

FGI is an independent, not-for-profit organization dedicated to developing guidance for the planning, design, and construction of hospitals, outpatient facilities, and residential health, care, and support facilities. FGI's "Draft Guidelines for Emergency Conditions in Health and Residential Care Facilities," provides that emergency departments shall be designed to ensure that access control can be maintained at all times.[14] Furthermore, the draft guidelines note that the exterior perimeter of the emergency department should have the capability to be secured to control access and provide safety in the event of a disaster or situations requiring a higher level of security.[14] Means to detect weapons, such as a metal detector, shall be provided at each point of entry to the emergency department.[5] A video surveillance system shall be provided for each emergency department entrance and where entrances may be locked, a visible duress alarm system shall be provided.[14] At the time of this report, the final guidelines were not yet available.

MAGNETOMETERS IN HEALTH CARE SETTINGS

Most studies on workplace violence have been designed to quantify the problem, but few have described methods to prevent such violence.[15] At the time of our last report, it was noted that some hospitals have installed magnetometers (metal detectors) at their entrances to prevent individuals from bringing weapons into facilities. Henry Ford Hospital in Detroit confiscated 33 handguns, 1,324 knives, and 97 chemical sprays within the first six months of screening. Other hospitals, including Johns Hopkins Hospital in Baltimore, suggested that widespread use of magnetometers is impractical given the many entrances most hospitals have. There were also concerns that armed

guards manning magnetometers could be the source of weapons used in hospital-based shootings. Since that time, there have been limited studies evaluating the effectiveness of magnetometers in reducing violence in health care facilities.

Perceptions of magnetometers in health care

Surveys have examined patient and employee attitudes towards the use of metal detectors specific to emergency departments. A survey of patrons in pediatric emergency departments found that the public has a strong perception that a metal detector protects both patrons and employees.[16] This finding is consistent with a prior survey of 176 patrons and 95 employees in an urban emergency department, which found that most patrons and staff liked the metal detector and said it created a safer environment.[17] Eighty-nine percent of the patrons and 73 percent of the employees said the metal detector made them feel safer.[17] Only 12 percent of the patrons and 10 percent of the employees said the metal detector invaded their privacy or the privacy of others.[17]

The International Association for Healthcare Security and Safety's 2020 Healthcare Crime Survey, asked participants if they used walk-through metal detectors to screen visitors and patients as they entered the hospital 24 hours a day, 7 days a week.[18] Eight percent (n = 19) of participant hospitals used walk-through metal detectors 24/7 in 2019. Three hospitals reported no impact on crime, security incidents, or workplace violence.[18] The remaining hospitals reported a positive impact on crime, security incidents, and workplace violence.[18]

Weapons retrieved after initiation of magnetometers

A 2021 cross-sectional survey of hospital security directors found that using a metal detector facilitates the discovery and awareness of weapons entering the health care facility.[19] Hospitals with metal detectors were more than 5 times as likely to frequently confiscate weapons.[19] The study also found that hospitals with psychiatric units were more likely to have frequent confiscation of weapons, likely due to the standard procedure of searching patients before admission.[19]

These findings are consistent with a previous study that found a metal detector installed at the entrance of an urban, high-volume teaching hospital emergency department resulted in the retrieval of firearms, knives, chemical sprays, and other weapons. A total of 5877 weapons were retrieved, an average of 218 per month: 268 firearms, 4842 knives, 512 chemical sprays, and 275 other weapons, such as brass knuckles, stun guns, and box cutters.[20]

However, it cannot be determined from data related to confiscation of weapons whether metal detectors reduce workplace violence in health care facilities.

Costs of magnetometers in health care facilities

One article notes that adding metal detectors is not as easy as it sounds. In addition to the cost of the equipment and personnel (at least two per metal detector), space is needed for the machine and for patients and visitors to wait in line.[21] Private search rooms may also be needed "for more intensive searching of people who set off the metal detector even after removing items most likely to cause problems."[21] X-ray machinery may also be needed to scan bags, requiring additional budget and space. Emergency departments may also station security guards at ambulance entrances to "wand" patients as they arrive to detect weapons.[21]
The process of going through the detectors can be time-consuming and frustrating when patients are seeking care. There may be the need for a nurse or paramedic to help with patient queuing so clinical staff have visibility of patients.[21] There have been instances, though not specific to

magnetometers, of patients going to the emergency department for treatment who have been unable to get in quickly enough for treatment. For example, Massachusetts passed "Laura's Law" after Laura Levis, who died in 2016 at the age of 34 outside CHA Somerville Hospital.[22] Having gone to the emergency department for an asthma attack, she found a well-lit entrance door to the emergency department locked. She called 911 for help, but by the time firefighters located her, she had suffered a cardiac arrest and died several days later.

There is little information in the published literature on equity considerations around the use of metal detectors in health care facilities, though we know they may interfere with implantable cardioverter defibrillators and pacemakers as well as pose challenges for those with limited mobility.

EXISTING AMA POLICY

Policy D-515.983, "Preventing Violent Acts Against Health Care Providers," notes that our AMA will continue to work with other appropriate organizations to prevent acts of violence against health care providers and improve the safety and security of providers while engaged in caring for patients, as well as widely disseminate information on effective workplace violence prevention interventions in the health care setting.

Policy H-515.966, "Violence and Abuse Prevention in the Health Care Workplace," encourages all health care facilities to: adopt policies to reduce and prevent all forms of workplace violence and abuse; develop a reporting tool that is easy for workers to find and complete; develop policies to assess and manage reported occurrences of workplace violence and abuse; make training courses on workplace violence prevention available to employees and consultants; and include physicians in safety and health committees.

H-515.957, "Preventing Violent Acts Against Health Care Providers," encourages OSHA to develop and enforce a standard addressing workplace violence prevention in health care and social service industries; encourages Congress to provide additional funding to the National Institute for Occupational Safety and Health (NIOSH) to further evaluate programs and policies to prevent violence against health care workers; and encourages NIOSH to adapt the content of their online continuing education course on workplace violence for nurses into a continuing medical education course for physicians.

Policy H-215.977, "Guns in Hospitals," encourage hospitals to incorporate, within their security policies, specific provisions on the presence of firearms in the hospital. Given that security needs stem from local conditions, firearm policies must be developed with the cooperation and collaboration of the medical staff, the hospital security staff, the hospital administration, other hospital staff representatives, legal counsel, and local law enforcement officials. Consultation with outside experts, including state and federal law enforcement agencies, or patient advocates may be warranted. The development of these policies should begin with a careful needs assessment that addresses past issues as well as future needs. Policies should, at minimum, address the following issues: a means of identification for all staff and visitors; restrictions on access to the hospital or units within the hospital, including the means of ingress and egress; changes in the physical layout of the facility that would improve security; the possible use of metal detectors; the use of monitoring equipment such as closed circuit television; the development of an emergency signaling system; signage for the facility regarding the possession of weapons; procedures to be followed when a weapon is discovered; and the means for securing or controlling weapons that may be brought into the facility, particularly those considered contraband but also those carried in by law enforcement personnel.

CONCLUSION

Health care personnel represent a significant portion of the victims of workplace violence and workplace violence can result in negative outcomes for health care personnel. In addition to physical injuries, it can result in low morale, decreased productivity, increased stress, and turnover. Citing the high incidence of workplace violence, the Joint Commission has revised workplace violence prevention standards for hospitals and critical access hospitals. The revised standards provide a framework to guide hospitals in developing effective workplace violence prevention systems. OSHA has also signaled that they are in the early stages of developing a potential standard on the Prevention of Workplace Violence in Healthcare and Social Assistance.

However, more research is needed regarding the effectiveness of interventions to prevent workplace violence in the health care setting, including the use of magnetometers and other weapons interdiction systems. While data suggests that magnetometers make patients and staff feel safer and they are effective in retrieving weapons, it is not clear to what extent they reduce workplace violence in health care settings and if the benefits outweigh the costs. As exiting AMA policy notes, security needs stem from local conditions and the development of health facility security policies should begin with a careful needs assessment that addresses past issues as well as future needs.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following recommendations be adopted, and the remainder of the report be filed.

1. That existing AMA policies on preventing violence against health care professionals be reaffirmed:

   D-515.983, "Preventing Violent Acts Against Health Care Providers," H-515.966, "Violence and Abuse Prevention in the Health Care Workplace," H-515.957, "Preventing Violent Acts Against Health Care Providers," H-215.977, "Guns in Hospitals," and H-515.950, "Protecting Physicians and Other Healthcare Workers in Society." (Reaffirm Existing Policy)

2. That our AMA encourages: (1) additional funding and research to evaluate effective interventions to prevent workplace violence against physicians and other health care professionals, including the effectiveness of magnetometers and other weapons interdiction systems in health care facilities; (2) health care facilities that have implemented magnetometers and other weapons interdiction systems to evaluate the impact on workplace violence and share best practices, including equity considerations; (3) the dissemination and awareness of guidance by OSHA and other organizations on the prevention of violence in health care facilities, including hospitals, ambulatory centers, and other clinical settings. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

REFERENCES

1. Workplace Violence in Healthcare, 2018 : U.S. Bureau of Labor Statistics. Accessed August 21, 2023. https://www.bls.gov/iif/factsheets/workplace-violence-healthcare-2018.htm
2. Impact of COVID on violence against healthcare – report published by ICN, ICRC, IHF and WMA. ICN - International Council of Nurses. Accessed August 21, 2023. https://www.icn.ch/news/impact-covid-violence-against-healthcare-report-published-icn-icrc-ihf-and-wma
3. Thornton J. Violence against health workers rises during COVID-19. *The Lancet*. 2022;400(10349):348. doi:10.1016/S0140-6736(22)01420-9
4. Thornton J. Violence against health workers rises during COVID-19. *The Lancet*. 2022;400(10349):348. doi:10.1016/S0140-6736(22)01420-9
5. Attacks at US medical centers show why health care is one of the nation's most violent fields. AP News. Published August 7, 2023. Accessed August 21, 2023. https://apnews.com/article/hospitals-workplace-violence-shootings-aa6918569ff8f76ff8a15b9813e31686
6. Mento C, Silvestri MC, Bruno A, et al. Workplace violence against healthcare professionals: A systematic review. *Aggress Violent Behav*. 2020;51:101381. doi:10.1016/j.avb.2020.101381
7. Jacobson R. Epidemic of Violence against Health Care Workers Plagues Hospitals. Scientific American. Accessed September 22, 2023. https://www.scientificamerican.com/article/epidemic-of-violence-against-health-care-workers-plagues-hospitals/
8. Pompeii LA, Schoenfisch AL, Lipscomb HJ, Dement JM, Smith CD, Upadhyaya M. Physical assault, physical threat, and verbal abuse perpetrated against hospital workers by patients or visitors in six U.S. hospitals. *Am J Ind Med*. 2015;58(11):1194-1204. doi:10.1002/ajim.22489
9. Ashleigh Watson MD, Mohammad Jafari Hbs, Ali Seifi MD. The Persistent Pandemic of Violence Against Health Care Workers. 2020;26. Accessed September 22, 2023. https://www.ajmc.com/view/the-persistent-pandemic-of-violence-against-health-care-workers
10. Holmes M. Enforcement Procedures and Scheduling for Occupational Exposure to Workplace Violence.
11. Integra_Health_Management,_Inc._Docket_13-1124_Combined_post.pdf. Accessed August 21, 2023. https://www.oshrc.gov/assets/1/18/Integra_Health_Management,_Inc._Docket_13-1124_Combined_post.pdf?8328
12. Workplace Violence SBREFA | Occupational Safety and Health Administration. Accessed August 21, 2023. https://www.osha.gov/workplace-violence/sbrefa
13. Workplace Violence Prevention Standards. R3 Report|Requirement, Rationale, Reference. A c publication of TheJoint Commission Issue 30, June 18, 2021. Available at https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/wpvp-r3_20210618.pdf.
14. FGI-Emergency-Conditions-Guidelines-DRAFT_21-04-01-1.pdf. Accessed August 21, 2023. https://fgiguidelines.org/wp-content/uploads/2021/04/FGI-Emergency-Conditions-Guidelines-DRAFT_21-04-01-1.pdf
15. Phillips JP. Workplace Violence against Health Care Workers in the United States. https://doi.org/10.1056/NEJMra1501998. doi:10.1056/NEJMra1501998
16. Mattox EA, Wright SW, Bracikowski AC. Metal detectors in the pediatric emergency department: patron attitudes and national prevalence. *Pediatr Emerg Care*. 2000;16(3):163-165. doi:10.1097/00006565-200006000-00006
17. Meyer T, Wrenn K, Wright SW, Glaser J, Slovis CM. Attitudes toward the use of a metal detector in an urban emergency department. *Ann Emerg Med*. 1997;29(5):621-624. doi:10.1016/s0196-0644(97)70250-6
18. Cs - 2020 Healthcare Crime Survey.pdf. Accessed August 21, 2023. https://iahssf.org/assets/2020-Healthcare-Crime-Survey-IAHSS-Foundation.pdf

19. Blando JD, Paul C, Szklo-Coxe M. Risk factors for workplace encounters with weapons by hospital employees. *Public Health Pract*. 2021;2:100105. doi:10.1016/j.puhip.2021.100105
20. Malka ST, Chisholm R, Doehring M, Chisholm C. Weapons Retrieved After the Implementation of Emergency Department Metal Detection. *J Emerg Med*. 2015;49(3):355-358. doi:10.1016/j.jemermed.2015.04.020
21. Are the Benefits of Metal Detectors Worth the Costs? ACEP Now. Accessed August 21, 2023. https://www.acepnow.com/article/are-the-benefits-of-metal-detectors-worth-the-costs/
22. Services AC. After Asthma Tragedy, Laura's Law Requires Better Access to Emergency Rooms in Massachusetts. Asthma and Allergy Foundation of America. Published March 25, 2021. Accessed August 21, 2023. https://community.aafa.org/blog/after-asthma-tragedy-laura-s-law-requires-better-access-to-emergency-rooms-in-massachusetts

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 901
(I-23)

Introduced by: Arizona Medical Association, American College of Occupational and Environmental Medicine, Aerospace Medicine Association

Subject: Silicosis from Work with Engineered Stone

Referred to: Reference Committee K

Whereas, Exposure to silica dust is a health hazard for workers who manufacture, finish, and install natural and engineered stone countertop products, causing silicosis, which is a progressive, debilitating, incurable, and sometimes fatal occupational disease[1]; and

Whereas, Close to 100,000 workers are employed in the manufacture, finishing, and installation of natural and engineered stone countertop products in the United States[2]; and

Whereas, Clusters of silicosis cases have been reported nationally and internationally among stone countertop fabrication workers, including cases in California[3] and Texas; and

Whereas, Silicosis is a disease related to long-term exposure, usually appearing after many years of exposure, unlike workplace injuries; and

Whereas, Implementing effective exposure controls is integral to the business of operating an engineered stone fabrication shop[5]; and

Whereas, The State of California has developed silica safety resources for stone fabricators and physicians that can guide other states in developing local resources[6]; therefore be it

RESOLVED, That our American Medical Association should encourage physicians, including occupational health physicians, pulmonologists, radiologists, pathologists, and other health-care professionals, to report all diagnosed or suspected cases of silicosis in accordance with National Institute for Occupational Safety and Health (NIOSH) guidance (New HOD Policy); and be it further

RESOLVED, That our AMA should advocate for the establishment of preventive measures to reduce exposure of workers to silica levels above the OSHA permissible exposure level (PEL) for respirable crystalline silica, which is a time-weighted average (TWA) of 50 micrograms per cubic meter ($\mu g/m^3$) of air (Directive to Take Action); and be it further

RESOLVED, That our AMA should advocate for the establishment of a registry of cases of silicosis to be maintained for workers diagnosed with silicosis resulting from engineered stonework or from other causes, either by state Departments of Public Health or their Division of Occupational Safety and Health (Directive to Take Action); and be it further

RESOLVED, That our AMA should advocate for the establishment of state funds to compensate workers who have been diagnosed with silicosis resulting from their work with silica, to recognize the progression and the need for increasing levels of compensation over time (Directive to Take Action); and be it further

RESOLVED, That our AMA recommends that State Medical Associations should take action with respect to the prevention of silicosis and to the recognition and compensation of affected workers in their states. (New HOD Policy)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 9/18/2023

REFERENCES:

1. Leso V, Fontana L, Romano R, Gervetti P, Iavicoli I. Artificial Stone Associated Silicosis: A Systematic Review. Int J Environ Res Public Health. 2019 Feb 16;16(4):568. doi: 10.3390/ijerph16040568.
2. Hua JT, Rose CS, Redlich CA. Engineered Stone-Associated Silicosis-A Lethal Variant of an Ancient Disease. JAMA Intern Med. 2023 Sep 1;183(9):908-910.
3. Fazio JC, Gandhi SA, Flattery J, Heinzerling A, Kamangar N, Afif N, Cummings KJ, Harrison RJ. Silicosis Among Immigrant Engineered Stone (Quartz) Countertop Fabrication Workers in California. JAMA Intern Med. 2023 Sep 1;183(9):991-998.
4. Related JAMA Network (Author Interviews) podcast: Silicosis Among Immigrant Engineered Stone (Quartz) Countertop Fabrication Workers in California. https://podcasts.apple.com/podcast/463469292?i=1000622158820
5. Proposed Petition Decision Of The Occupational Safety And Health Standards Board (Petition File No. 597) https://www.dir.ca.gov/oshsb/documents/petition-597-amended-adopteddecision.pdf
6. California Department of Public Health, Occupational Health Branch. Silica Safety Resources for Stone Fabricators https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/Pages/SilicaStoneFabricators.aspx

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 902
(I-23)

Introduced by: Integrated Physician Practice Section

Subject: Post Market Research Trials

Referred to: Reference Committee K

Whereas, patient safety necessitates that physicians have access to sound, unbiased information about the safety and effectiveness of drugs; and

Whereas, physicians rely on data and evidence provided by the Food and Drug Administration (FDA) to guide patients in sound clinical decision-making; and

Whereas, recent trends in FDA approvals have resulted in pharmaceuticals coming to market and gaining FDA approval faster and with less evidence of their efficacy; and

Whereas, clinical trial data for new pharmaceuticals increasingly relies on surrogate endpoints rather than direct measure of clinical benefit, as seen by an increase from 44 percent of pivotal trials based on surrogate endpoints between 2005 and 2012, to 60 percent based on surrogate endpoints between 2015 and 2017; and

Whereas, medications such as the FDA-approved Aducanumab demonstrate that surrogate endpoints that are “reasonably likely” to predict clinical benefit do not always result in actual clinical efficacy; and

Whereas, approximately three quarters of all new drugs in recent years were approved using an expedited regulatory pathway, making it more challenging to assess longer-term benefits and risks; and

Whereas, lack of sufficient data has significant implications for patients, medical professional, and health care spending; and

Whereas, Researchers have found that over half of post-market commitment studies and post-market requirement studies have produced novel information for clinical practice or have led to regulatory action, such as confirmation of benefit or a labeling change; and

Whereas, insufficient data can lead to concerns regarding patient safety and potential negative side effects; and

Whereas, drug manufacturers sometimes fail to complete “post-marketing” follow up trials in a timely manner, if at all; and

Whereas, studies have found that among more than 600 post-marketing studies imposed in 2009 and 2010, 20 percent were never started after five to six years, while others were significantly delayed; and

Whereas, the FDA Amendments Act of 2007 gave the FDA more authority to ensure timely completion of post-marketing requirements, however the FDA has yet to impose a civil monetary penalty for a delay; therefore be it

RESOLVED, that our American Medical Association advocate that the Food and Drug Administration use its authority to require and enforce timely completion of post-marketing trials or studies whenever sponsors rely on surrogate endpoints to support approval (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that the Food and Drug Administration use its authority to require that pharmaceuticals that received approval using surrogate endpoints demonstrate direct clinical benefit in post-market trials as a condition of continued approval (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that the Food and Drug Administration require drug manufacturers to make the findings of their post-market trials publicly available. (Directive to Take Action)

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

Received: 8/31/23

RELEVANT AMA POLICY

Reforming the FDA Accelerated Approval Process H-100.944
Our AMA supports: (1) mechanisms to address issues in the Food and Drug Administration (FDA)'s Accelerated Approval process, including but not limited to: efforts to ameliorate delays in post-marketing confirmatory study timelines and protocols for the withdrawal of approvals when post-marketing studies fail; and (2) specific solutions to issues in the FDA's Accelerated Approval process if backed by evidence that such solutions would not adversely impact the likelihood of investment in novel drug development.
Citation: Res. 525, A-22

Real-World Data and Real-World Evidence in Medical Product Decision Making H-480.938
1. Our AMA supports the generation and use of real-world data (RWD) and real-world evidence (RWE) fit for regulatory purpose to: (a) evaluate effectiveness and safety of medical products, while assuring patient privacy and confidentiality; (b) improve regulatory decision-making; (c) decrease medical product costs; (d) increase research efficiency; (e) advance innovative and new models of drug development; and (f) improve clinical care and patient outcomes.
2. Our AMA supports the aim of the U.S. Food and Drug Administration (FDA) to expand and clarify the use RWD and RWE in regulatory decision-making including in: (a) understanding the potential of RWE to meet the established standards for adequate and well-controlled clinical investigations; (b) pursuing the integration of RWE into medical product development and regulatory review; and (c) utilizing RWE to support new indications for approved medical products, and its ability to satisfy post-approval study requirements.
3. Our AMA supports that there be adequate funding of data infrastructure to allow for transparent data management capabilities, improved access to data by clinicians, especially physicians, as well as researchers and other stakeholders, and improved reliability and relevance of data.
4. Our AMA supports cooperation and collaboration of stakeholders to facilitate the collection and use of RWD and RWE that is deemed fit for regulatory purpose.
5. Our AMA will evaluate and develop a response to the educational needs of physicians seeking to understand the use of fit for purpose RWD and RWE in clinical practice.
Citation: CSAPH Rep. 2, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 903)
(I-23)

Introduced by: Medical Student Section

Subject: Supporting Emergency Anti-Seizure Interventions

Referred to: Reference Committee K

Whereas, over 3 million Americans live with active epilepsy, placing them at risk for status epilepticus and sequelae such as cognitive and psychiatric impairment or even death[1-2]; and

Whereas, lack of recognition of and rapid intervention for status epilepticus as a neurological emergency outside the hospital delays treatment and increases morbidity and mortality[2-6]; and

Whereas, the Food and Drug Administration approved intranasal midazolam and intranasal diazepam in 2019 and 2020 as effective emergency interventions for status epilepticus, which may improve care due to their easy administration by nonmedical caregivers (especially when patients cannot swallow or when rectal administration is difficult in public), rapid onset compared to oral medication, high bioavailability, safety, and reduction of stigma[7-8]; therefore be it

RESOLVED, that our American Medical Association support efforts in the recognition of status epilepticus and bystander intervention trainings (New HOD Policy); and be it further

RESOLVED, that our AMA encourage physicians to educate patients and families affected by epilepsy on status epilepticus and work with patients and families to develop an individualized action plan for possible status epilepticus, which may include distribution of home pharmacotherapy for status epilepticus, in accordance with the physician's best clinical judgment. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 09/11/2023

REFERENCES

1. Zack, M. et al. National and State Estimates of the Number of Adults and Children with Active Epilepsy - United State, 2015. Centers for Disease Control and Prevention. 2017 Aug.; 66(31):821–5.
2. Sairanen, J. et al. Treatment delay in status epilepticus – more effective prehospital symptom recognition warranted. Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine. 2019 Mar.; 27(28).
3. Maier, S. et al. Recognition and treatment of status epilepticus in the prehospital setting. Seizure: European Journal of Epilepsy. 2021 Jan.; 86: 1-5.
4. Josephson, S. et al. Quality improvement in neurology: Inpatient and emergency care quality measure set. Neurology. 2017 Aug.; 89 (7).
5. Hoerth M. et al. Seizure Rescue Therapies. Epilepsy Foundation. April 14, 2019.
6. Cruickshank Moira. Et al. Pre-hospital and emergency department treatment of convulsive status epilepticus in adults: an evidence synthesis. Health Technol Assess. 2022 Mar.; 26(20):1-76.
7. Cloyd J. et al. Overcoming the challenges of developing an intranasal diazepam rescue therapy for the treatment of seizure clusters. Epilepsia. 2021 Apr.; 62(4): 846-856.
8. Hoerth M. et al. Nasal Rescue Medicines. Epilepsy Foundation. April 18, 2020.

RELEVANT AMA POLICY

H-130.938 Cardiopulmonary Resuscitation (CPR) and Defibrillators
Our AMA: (1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation; (2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs; (3) encourages the American public to become trained in CPR and the use of automated external defibrillators; (4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held; (5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events; (6) supports increasing government and industry funding for the purchase of automated external defibrillator devices; (7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel; (8) supports the development and use of universal connectivity for all defibrillators; (9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use; (10) will update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications; (11) urges AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators; and (12) supports consistent and uniform legislation across states for the legal protection of those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim. [CCB/CLRPD Rep. 3, A-14; Appended: Res. 211, I-14; Modified: Res. 919, I-15; Appended: Res. 211, I-18; Modified: Res. 418, A-23]

D-60.976 Childhood Anaphylactic Reactions
Our AMA will: (1) urge all schools, from preschool through 12th grade, to: (a) develop Medical Emergency Response Plans (MERP); (b) practice these plans in order to identify potential barriers and strategies for improvement; (c) ensure that school campuses have a direct communication link with an emergency medical system (EMS); (d) identify students at risk for life-threatening emergencies and ensure these children have an individual emergency care plan that is formulated with input by a physician; (e) designate roles and responsibilities among school staff for handling potential life-threatening emergencies, including administering medications, working with EMS and local emergency departments, and contacting families; (f) train school personnel in cardiopulmonary resuscitation; (g) adopt the School Guidelines for Managing Students with Food Allergies distributed by FARE (Food Allergy Research & Education); and (h) ensure that appropriate emergency equipment to deal with anaphylaxis and acute asthmatic reactions is available and that assigned staff are familiar with using this equipment; (2) work to expand to all states laws permitting students to carry prescribed epinephrine or other medications prescribed by their physician for asthma or anaphylaxis; (3) support increased research to better understand the causes, epidemiology, and effective treatment of anaphylaxis; (4) urge the Centers for Disease Control and Prevention to study the adequacy of school personnel and services to address asthma and anaphylactic emergencies; (5) urge physicians to work with parents and schools to ensure that all their patients with a food allergy have an individualized emergency plan; and (6) work to allow all first responders to carry and administer epinephrine in suspected cases of anaphylaxis. [CSAPH Rep. 1, A-07; Modified: CCB/CLRPD Rep. 2, A-14]

H-440.884 Food Allergic Reactions in Schools and Airplanes
Our AMA recommends that all: (1) schools provide increased student and teacher education on the danger of food allergies; (2) schools have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the school administration be trained and certified in the indications for and techniques of their use; and (3) commercial airlines have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the flight staff, such as the head flight attendant, be trained and certified in the indications for and techniques of their use. [Res. 415, A-04; Reaffirmed: CSAPH Rep. 1, A-14]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 904
(I-23)

Introduced by: Medical Student Section

Subject: Universal Return-to-Play Protocols

Referred to: Reference Committee K

Whereas, sports injuries, including concussions and musculoskeletal injuries, are associated with various sequelae, including cognitive impairment, decreased physical activity, impaired mobility, obesity, cardiovascular disease, post-traumatic arthritis, depression, and anxiety[1-4]; and

Whereas, previous injury is a significant risk factor for subsequent injury, due to altered proprioception and range of motion and scar tissue[5]; and

Whereas, women athletes experience overuse injuries more often than men athletes[6]; and

Whereas, inconsistencies in return-to-play criteria lead to a wide range of rehabilitation programs of different timelines, including both accelerated and 9-12 month protocols[7-8]; and

Whereas, for athletes with concussions, only 45% of athletes recommended to return to play after 10 to 14 days actually experienced significant recovery, but this number rose to 96% after 8 weeks post-injury, indicating that wide discrepancies in timelines affect recovery rates[9]; and

Whereas, uniform return-to-play criteria has demonstrated efficacy for athletes with posterior cruciate ligament injury, resulting in 92% returning to baseline performance 2 years after injury and 70% continuing to perform at the same level 5 years after injury[10]; therefore be it

RESOLVED, that our American Medical Association encourage interested parties to: (a) establish a standard, universal protocol for return-to-play recovery for collegiate and professional athletes; (b) promote additional evidence-based studies on the effectiveness of a universal protocol for evaluation and post-injury management course at the collegiate and professional level; (c) support national and state efforts to minimize the consequences of inadequate recovery windows for collegiate and professional athletes. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 09/11/2023

REFERENCES

1. Schallmo, M. et. al. Return-to-Play and Performance Outcomes of Professional Athletes in North America After Hip Arthroscopy From 1999 to 2016. The American Journal of Sports Medicine. 2018 May; 46(8): 1959-1969.
2. Singla, A. et. al. The anatomy of concussion and chronic traumatic encephalopathy: A comprehensive review. Clinical Anatomy. 2018 Nov; 32(1): 310-318.
3. Lemoyne, J. et. al. Analyzing injuries among university-level athletes: prevalence, patterns and risk factors. Journal of Canadian Chiropractic Association. 2017 Aug; 61(2): 88-95.
4. Gennarelli, S.M. et. al. Psychosocial interventions help facilitate recovery following musculoskeletal sports injuries: a systematic review. The Physician and Sportsmedicine. 2020 Mar; 48(4): 370-377.

5. Fulton, J. et. al. Injury Risk is Altered by Previous Injury: A Systematic Review of the Literature and Presentation of Causative Neuromuscular Factors. International Journal of Sports Physical Therapy. 2014 Oct; 9(5): 583-595.
6. Carter, C. et. al. Sex-based Differences in Common Sports Injuries. Journal of the American Academy of Orthopaedic Surgeons. 2018 July; 26(13): 447-454.
7. Schrock, J. et. al. Evolving Treatment Patterns of NFL Players by Orthopaedic Team Physicians Over the Past Decade, 2008-2016. Sports Health: Sage Journals. 2018 Feb; 10(5): 453-461.
8. Flagg, K. et. al. Current criteria for return to play after anterior cruciate ligament reconstruction: an evidenced-based review. Annals of Translational Medicine. 2019 Oct; 7: S252.
9. Kara, S. et. al. Less Than Half of Patients Recover Within 2 Weeks of Injury After a Sports-Related Mild Traumatic Brain Injury: A 2-Year Prospective Study. Clinical Journal of Sport Medicine. 2020 March; 30(2): 96-101.
10. Agolley, D. et. al. Successful return to sports in athletes following non-operative management of acute isolated posterior cruciate ligament injuries. The Bone & Joint Journal. 2017 Jun; 99(6): 774-778.

RELEVANT AMA POLICY

H-470.971 Athletic Preparticipation Examinations for Adolescents
To promote the health and safety of adolescents, our AMA recommends that state medical societies work with appropriate state and local agencies to promote the following:
(1) The development of standards for preparticipation athletic examinations that are consistent with consensus recommendations of the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and the American Osteopathic Academy of Sports Medicine.
(2) Only licensed MDs, DOs, and licensed physician extenders practicing under the supervision of licensed MDs and DOs perform preparticipation examinations.
(3) The decision of whether or not an adolescent is healthy and physically mature enough to participate in a particular sport is made by a qualified physician.
(4) The decision of when an injured athlete resumes participation is made by a qualified physician.
(5) The most current guidelines established by the American Academy of Pediatrics, American College of Cardiology, American College of Sports Medicine, and other appropriate medical specialty societies are used to determine eligibility for sports participation. [BOT Rep. R, A-90; Amended: CSA Rep. 5, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: BOT Rep. 9, A-14; Reaffirmed: CSAPH Rep. 3, A-15]

H-470.954 Reduction of Sports-Related Injury and Concussion
1. Our AMA will: (a) work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports-related injuries across the lifespan; and (b) promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences.
2. Our AMA supports the adoption of evidence-based, age-specific guidelines on the evaluation and management of concussion in all athletes for use by physicians, other health professionals, and athletic organizations.
3. Our AMA will work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the ability of physicians to prevent, diagnose, and manage concussions and other sports-related injuries.
4. Our AMA urges appropriate agencies and organizations to support research to: (a) assess the short- and long-term cognitive, emotional, behavioral, neurobiological, and neuropathological consequences of concussions and repetitive head impacts over the life span; (b) identify determinants of concussion and other sports-related injuries in pediatric and adult athletes, including how injury thresholds are modified by the number of and time interval between head impacts and concussions; (c) develop and evaluate effective risk reduction measures to prevent or reduce sports-related injuries and concussions and their sequelae across the lifespan; and (d) develop objective biomarkers to improve the identification, management, and prognosis of athletes suffering from concussion to reduce the dependence on self-reporting and inform evidence-based, age-specific guidelines for these patients.
5. Our AMA supports research into the detection, causes, and prevention of injuries along the continuum from subconcussive head impacts to conditions such as chronic traumatic encephalopathy (CTE). [CSAPH Rep. 3, A-15; Appended: Res. 905, I-16]

H-470.959 Reducing Risk of Concussion and Other Injuries in Youth Sports
1. Our American Medical Association promotes the adoption of requirements that athletes participating in school or other organized youth sports and who are suspected by a coach, trainer, administrator, or other individual responsible for the health and well-being of athletes of having sustained a concussion be removed immediately from the activity in which they are engaged and not return to competitive play,

practice, or other sports-related activity without the written approval of a physician (MD or DO) or a designated member of the physician-led care team who has been properly trained in the evaluation and management of concussion. When evaluating individuals for return-to-play, physicians (MD or DO) or the designated member of the physician-led care team should be mindful of the potential for other occult injuries.

2. Our AMA encourages physicians to: (a) assess the developmental readiness and medical suitability of children and adolescents to participate in organized sports and assist in matching a child's physical, social, and cognitive maturity with appropriate sports activities; (b) counsel young patients and their parents or caregivers about the risks and potential consequences of sports-related injuries, including concussion and recurrent concussions; (c) assist in state and local efforts to evaluate, implement, and promote measures to prevent or reduce the consequences of concussions, repetitive head impacts, and other injuries in youth sports; and (d) support preseason testing to collect baseline data for each individual.

3. Our AMA will work with interested agencies and organizations to: (a) identify harmful practices in the sports training of children and adolescents; (b) support the establishment of appropriate health standards for sports training of children and adolescents; (c) promote evidenced-based educational efforts to improve knowledge and understanding of concussion and other sport injuries among youth athletes, their parents, coaches, sports officials, school personnel, health professionals, and athletic trainers; and (d) encourage further research to determine the most effective educational tools for the prevention and management of pediatric/adolescent concussions.

4. Our AMA supports (a) requiring states to develop and revise as necessary, evidenced-based concussion information sheets that include the following information: (1) current best practices in the prevention of concussions, (2) the signs and symptoms of concussions, (3) the short-and long-term impact of mild, moderate, and severe head injuries, and (4) the procedures for allowing a student athlete to return to athletic activity; and (b) requiring parents/guardians and students to sign concussion information sheets on an annual basis as a condition of their participation in sports. [Res. 910, I-10; Reaffirmed: BOT Rep. 9, A-14; Modified: CSAPH Rep. 3, A-15; Modified: BOT Action in response to referred for decision: Res. 409, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution:905
(I-23)

Introduced by: Medical Student Section

Subject: Support for Research on the Relationship Between Estrogen and Migraine

Referred to: Reference Committee K

Whereas, migraine is a leading cause of disability, lost productivity, and medical expenses for patients, with frequent late diagnosis and subsequent financial burden[1]; and

Whereas, migraine affects about 1 in 6 individuals, with women affected at 2 to 3 times the rate as men, and 25% of patients with migraine experience aura[2-6]; and

Whereas, migraine's effect on cerebral blood vessels can increase stroke risk, but migraine with aura is associated with double the stroke risk compared to migraine without aura[7-11]; and

Whereas, oral contraceptives (OCPs) are used by 25% of women of reproductive age, with the most common OCPs being combined estrogen-progestin OCPs[12-13]; and

Whereas, due to estrogen's association with cardiovascular risk, patients with migraine may avoid combined OCPs, but data on stroke risk for these patients is not always clearly delineated by presence of aura, impacting the use of individualized risk assessment[7-11]; and

Whereas, lack of specificity in data on the relationship between migraine with and without aura and combined OCPs may result in many patients being unable to use these medications for contraception, menstrual regulation, menstrual migraines, uterine bleeding, cancer prevention, acne, hirsutism, osteoporosis, menopausal symptoms, hormone replacement therapy (such as gender-affirming care), and various other hormonal indications[13-15]; and

Whereas, studies suggest that cardiovascular risk due to estrogen may vary based on dose, administration route, age, menstrual and menopausal status, and presence of aura[7-11,16-33]; and

RESOLVED, that our American Medical Association support further research regarding the role of estrogen as a risk factor for stroke and cardiovascular events at the dosages and routes found in, inclusive of but not limited to combined oral contraceptive pills, vaginal rings, transdermal patches, hormone replacement therapy, and gender affirming hormone therapy in individuals with migraine and migraine with aura (New HOD Policy); and be it further

RESOLVED, that our AMA work with relevant stakeholders to advocate for increased resources to allow for appropriate education and assessment, when indicated, of migraine and migraine with aura consistent with current diagnostic guidelines in medical practice sites inclusive of but not limited to primary care, obstetrics and gynecology, endocrinology, neurology, and cardiology clinics. (Directive to Take Action)

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

Received: 09/19/2023

REFERENCES

1. "The Facts about Migraine." *American Migraine Foundation*, 19 July 2022, https://americanmigrainefoundation.org/resource-library/migraine-facts/.
2. Burch, R., P. Rizzoli, and E. Loder, The Prevalence and Impact of Migraine and Severe Headache in the United States: Figures and Trends From Government Health Studies. Headache, 2018. 58(4): p. 496-505.
3. Shankar Kikkeri, N. and S. Nagalli, Migraine with Aura, in StatPearls. 2022, StatPearls Publishing: Treasure Island (FL).
4. Vetvik KG, MacGregor EA. Sex differences in the epidemiology, clinical features, and pathophysiology of migraine. Lancet Neurol. 2017 Jan;16(1):76-87.
5. "Headache Disorders." *World Health Organization*, World Health Organization, https://www.who.int/news-room/fact-sheets/detail/headache-disorders.
6. Rai, N.K., et al., Factors associated with delayed diagnosis of migraine: A hospital-based cross-sectional study. Journal of family medicine and primary care, 2019. 8(6): p. 1925-1930.
7. Carlton C, Banks C, Sundararajan S. Oral Contraceptives and Ischemic Stroke Risk. Stroke, 2018. 49(4): p. e157-e159.
8. Nettleton, William, and Valerie King. "The Risk of MI and Ischemic Stroke with Combined Oral Contraceptives." American Family Physician, 1 Nov. 2016, https://www.aafp.org/pubs/afp/issues/2016/1101/p691.html.
9. Gupta, D. R., et al. (2022). "Non-oral routes, novel formulations and devices of contraceptives: An update." Journal of Controlled Release 345: 798-810.
10. "Combined Hormonal Birth Control: Pill, Patch, and Ring." ACOG, 2018, https://www.acog.org/womens-health/faqs/combined-hormonal-birth-control-pill-patch-ring.
11. Calhoun, A.H. and P. Batur, Combined hormonal contraceptives and migraine: An update on the evidence. Cleveland Clinic journal of medicine, 2017. 84(8): p. 631.
12. Daniels K, Abma JC. Current Contraceptive Status Among Women Aged 15-49: United States, 2017-2019. NCHS Data Brief. 2020 Oct;(388):1-8. PMID: 33151146.
13. Cooper, D.B., P. Patel, and H. Mahdy, Oral Contraceptive Pills, in StatPearls. 2022, StatPearls Publishing: Treasure Island (FL).
14. Armstrong, C., ACOG Guidelines on Noncontraceptive Uses of Hormonal Contraceptives. American Family Physician, 2010. 82(3): p. 288-295.
15. Kamani Mustafa, Akgor Utku, Gültekin Murat (2022) Review of the literature on combined oral contraceptives and cancer cancer 16 1416
16. Gillum, L.A., S.K. Mamidipudi, and S.C. Johnston, Ischemic Stroke Risk With Oral Contraceptives A Meta-analysis. JAMA, 2000. 284(1): p. 72-78.
17. Sheikh, H.U., et al., Risk of Stroke Associated With Use of Estrogen Containing Contraceptives in Women With Migraine: A Systematic Review. Headache, 2018. 58(1): p. 5-21.
18. Xu, Z., et al., Current use of oral contraceptives and the risk of first-ever ischemic stroke: A meta-analysis of observational studies. Thrombosis research, 2015. 136(1): p. 52-60.
19. Kao, A., History of Oral Contraception. AMA Journal of Ethics, 2000. 2(6): p. 55-56.
20. Mukherjee, Debabrata, and Carlton C, Banks M, Sundararajan S. "Oral Contraceptives and Ischemic Stroke Risk." American College of Cardiology, 28 Mar. 2018, https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2018/03/28/14/02/oral-contraceptives-and-ischemic-stroke-risk.
21. Tepper, N.K., et al., Safety of hormonal contraceptives among women with migraine: A systematic review. Contraception, 2016. 94(6): p. 630-640.
22. Mary, L. and P. Jacqueline, Migraine and the Contraceptive Pill or the Contraceptive Patch | Health. 2017.
23. Tietjen, G.E. and Maly, E.F. (2020), Migraine and Ischemic Stroke in Women. A Narrative Review. Headache: The Journal of Head and Face Pain, 60: 843-863.
24. Allais, G., et al., Treating migraine with contraceptives. Neurological Sciences, 2017. 38(1): p. 85-89.
25. "Migraine with Aura, Contraceptives and Stroke Risk." American Headache Society, 24 Nov. 2020, https://americanheadachesociety.org/news/migraine-aura-contraceptives-stroke-risk/.
26. Carrasquilla, G.D., et al., Postmenopausal hormone therapy and risk of stroke: A pooled analysis of data from population-based cohort studies. PLoS medicine, 2017. 14(11): p. e1002445.
27. Løkkegaard, E., L.H. Nielsen, and N. Keiding, Risk of Stroke With Various Types of Menopausal Hormone Therapies. Stroke, 2017. 48(8): p. 2266-2269.
28. Boardman HM, Hartley L, Eisinga A, Main C, Roqué i Figuls M, Bonfill Cosp X, Gabriel Sanchez R, Knight B. Hormone therapy for preventing cardiovascular disease in post-menopausal women. Cochrane Database Syst Rev. 2015 Mar 10;(3):CD002229. doi: 10.1002/14651858.CD002229.pub4. PMID: 25754617.
29. Jelena Pavlovic, H.S., Migraine and Contraceptives. 2022.
30. Hutchinson, Susan, and Catherine Stika. "Contraceptive Options for Women with Migraine - American Headache Society." *American Headache Society*, Jan. 2022, https://americanheadachesociety.org/wp-content/uploads/2021/01/AHS-First-Contact-Hormones-Contrceptive-Options.pdf
31. Lucas, S., Migraine and Other Headache Disorders: ACOG Clinical Updates In Women's Health Care Primary and Preventive Care Review Summary Volume XVIII, Number 4. Obstetrics and gynecology, 2019. 134(1): p. 211.
32. Reddy, N., et al., The complex relationship between estrogen and migraines: a scoping review. Systematic reviews, 2021. 10(1): p. 72-4.
33. "Preconception Health and Health Care Is Important for All." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 20 Sept. 2022, https://www.cdc.gov/preconception/overview.html.

RELEVANT AMA POLICY

H-75.990 Development and Approval of New Contraceptives
Our AMA: (1) supports efforts to increase public funding of contraception and fertility research; (2) urges the FDA to consider the special health care needs of Americans who are not adequately served by existing contraceptive products when considering the safety, effectiveness, risk and benefits of new contraception drugs and devices; and (3) encourages contraceptive manufacturers to conduct post-marketing surveillance studies of contraceptive products to document the latter's long-term safety, effectiveness and acceptance, and to share that information with the FDA. [BOT Rep. O, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Modified: CSAPH Rep. 1, A-21]

H-75.995 Contraceptive Advertising
Our AMA supports the concept of providing accurate and balanced information on the effectiveness, safety and risks/benefits of contraception in all public media and urges that such advertisements include appropriate information on the effectiveness, safety and risk/benefits of various methods. [Res. 4, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17]

D-75.995 Over-the-Counter Access to Oral Contraceptives
Our AMA: (1) encourages the US Food and Drug Administration to approve a switch in status from prescription to over-the-counter for oral contraceptives, without age restriction; (2) encourages the continued study of issues relevant to over-the-counter access for oral contraceptives; and (3) will work with expert stakeholders to advocate for the availability of hormonal contraception as an over-the-counter medication. [Sub. Res. 507, A-13; Modified: BOT Rep. 10, A-18; Modified: Res. 518, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 906
(I-23)

Introduced by: Medical Student Section

Subject: Online Content Promoting LGBTQ+ Inclusive Safe Sex Practices

Referred to: Reference Committee K

Whereas, 80% of young adults and adolescents learn about sexual health and safe sex from television, with LGBTQ+ individuals especially turning to television to receive information that may otherwise be difficult to access depending on their community[1,2-3]; and

Whereas, a 2015 content analysis showed that 56% of visual cues and dialogues and 26% of major and minor storylines focused on sexual health, and while 8% of visual cues and dialogues and 20% of major and minor storylines focused on sexual orientation and gender identity, none presented information on sexual health and safe sex[1]; and

Whereas, a growing majority of young adults use online streaming services to consume television and media[4-5]; and

Whereas, stigma perpetuates harmful information in sexual education curricula, with many states negatively describing sex between LGBTQ+ individuals[6]; and

Whereas, online and social media education on safe sex (inclusive of LGBTQ+ individuals) can be an inexpensive and effective way to reach the LGBTQ+ community, including youth[7-8]; and

Whereas, existing AMA policy already urges television broadcasters, producers, and sponsors to encourage education about safe sex practices; therefore be it

RESOLVED, that our American Medical Association amend policy H-485.994, "Television Broadcast of Sexual Encounters and Public Health Awareness" by addition and deletion, to read as follows:

> Television Broadcast and Online Streaming of Sexual Encounters and Public Health Awareness on Social Media Platforms, H-485.994
> The AMA urges television broadcasters and online streaming services, producers, ~~and~~ sponsors, and any associated social media outlets to encourage education about heterosexual and LGBTQ+ inclusive safe sexual practices, including but not limited to condom use and abstinence, in television or online programming of sexual encounters, and to accurately represent the consequences of unsafe sex. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 09/19/2023

REFERENCES

1. Janni J. Kinsler, Deborah Glik, Sandra de Castro Buffington, Hannah Malan, Carsten Nadjat-Haiem, Nicole Wainwright & Melissa Papp-Green (2019) A Content Analysis of How Sexual Behavior and Reproductive Health are Being Portrayed on Primetime Television Shows Being Watched by Teens and Young Adults, Health Communication, 34:6, 644-651, DOI: 10.1080/10410236.2018.1431020
2. Currin JM, Hubach RD, Durham AR, Kavanaugh KE, Vineyard Z, Croff JM. How gay and bisexual men compensate for the lack of meaningful sex education in a socially conservative state. Sex Education. 2017;17(6):667-681. doi:10.1080/14681811.2017.1355298
3. Hobaica S, Kwon P. "This Is How You Hetero:" Sexual Minorities in Heteronormative Sex Education. American Journal of Sexuality Education. 2017;12(4):423-450. doi:10.1080/15546128.2017.1399491
4. 61% of young adults in U.S. watch mainly streaming TV. Pew Research Center. https://www.pewresearch.org/fact-tank/2017/09/13/about-6-in-10-young-adults-in-u-s-primarily-use-online-streaming-to-watch-tv/. Published May 30, 2020. Accessed September 18, 2020.
5. Trendera LLC. All About Gen Z. The Trendera Files Report. 2017;8(3). https://static1.squarespace.com/static/56a6d045df40f3cc4889f22f/t/59765342db29d6d9c74fe21b/1500926813297/All+About+Gen+Z_CNE.pdf. Accessed September 18, 2020.
6. Sex and HIV Education. Guttmacher Institute. https://www.guttmacher.org/state-policy/explore/sex-and-hiv-education. Updated August 1, 2023. Accessed September 15, 2023.
7. Patel VV, Masyukova M, Sutton D, Horvath KJ. Social Media Use and HIV-Related Risk Behaviors in Young Black and Latino Gay and Bi Men and Transgender Individuals in New York City: Implications for Online Interventions. J Urban Health. 2016;93(2):388-399. doi:10.1007/s11524-016-0025-1
8. Mustanski B, Greene GJ, Ryan D, Whitton SW. Feasibility, acceptability, and initial efficacy of an online sexual health promotion program for LGBT youth: the Queer Sex Ed intervention. J Sex Res. 2015;52(2):220-230. doi:10.1080/00224499.2013.867924

RELEVANT AMA POLICY

H-485.994 Television Broadcast of Sexual Encounters and Public Health Awareness

The AMA urges television broadcasters, producers, and sponsors to encourage education about safe sexual practices, including but not limited to condom use and abstinence, in television programming of sexual encounters, and to accurately represent the consequences of unsafe sex. [Res. 421, I-91; Reaffirmed: CSA Rep. 3, A-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15]

H-170.968 Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools

(1) Supports the concept of sexuality education in the home, when possible, as well as developmentally appropriate sexuality education programming in the schools at all levels, at local option and direction;
(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms and other effective barrier protection methods available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ+ youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;
(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;
(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;

(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
(7) Supports federal funding of comprehensive sex education programs that stress the importance of preventing unwanted teenage pregnancy and sexually transmitted infections via comprehensive education, including contraceptive choices, abstinence, and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and
(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and
(10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate. [CSA Rep. 7 and Reaffirmation I-99; Reaffirmed: Res. 403, A-01; Modified Res. 441, A-03; Appended: Res. 834, I-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: Res. 405, A-16; Appended: Res. 401, A-16; Appended: Res. 414, A-18; Appended: Res. 428, A-18; Modified: Res. 413, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 909
(I-23)

Introduced by: Medical Student Section

Subject: High Risk HPV Subtypes in Minoritized Populations

Referred to: Reference Committee K

Whereas, American Indian/Alaska Native (AI/AN) people continue to disproportionately suffer the highest rates of HPV-associated cervical cancer and are twice as likely to develop and four times as likely to die from cervical cancer as non-Hispanic whites[1,2]; and

Whereas, compared to other groups, AI/AN women are less likely to be screened for HPV, leading to inadequate high-risk HPV typing and surveillance in this population[3-4]; and

Whereas, despite greater HPV vaccine initiation, AI/AN patients were found to have higher rates of high-risk HPV (34.8%) compared to the national average (20.7%), including strains not included in the 9-valent HPV vaccine, such as HPV-51 in the Great Plains region[3]; and

Whereas, data is insufficient to account for significant variations in high-risk cervical cancer strains in AI/AN patients by geographic region (Northern Plains, Alaska, Southwest)[3,5-7]; and

Whereas, a study evaluating the number of racial and ethnic minoritized groups participating in clinical cancer trials found that only 0.048% of participants identified as AI/AN, despite comprising 2.9% of the US population[8-9]; and

Whereas, factors resulting in low research participation by members of minoritized groups include fear of discrimination by medical professionals, inability to access specialty care centers, a history of unethical medical testing, and insufficient time or financial resources[10]; and

Whereas, historical wrongs against AI/AN people, such as the unethical distribution of research samples of Havasupai tribal members and forced sterilization of AI/AN people across the nation, contribute to decreased participation by AI/AN people in research trials[11]; and

Whereas, AI/AN patients were insufficiently sampled for strains of high-risk HPV for vaccine development and vaccine impact studies, consistent with the overall underrepresentation of AI/AN individuals in vaccine clinical trials[3,6,12]; therefore be it

RESOLVED, that our American Medical Association amend H-440.872, “HPV Vaccine and Cervical and Oropharyngeal Cancer Prevention Worldwide,” by addition as follows:

> HPV Vaccine and Cervical and Oropharyngeal Cancer Prevention Worldwide H-440.872
> 1. Our AMA (a) urges physicians and other health care professionals to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine HPV related cancer screening; and (b) encourages the development and funding of programs

targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs.

2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public.

3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits; (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations; and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.

4. Our AMA encourages appropriate parties to investigate means to increase HPV vaccination rates by facilitating administration of HPV vaccinations in community-based settings including school settings.

5. Our AMA will study requiring HPV vaccination for school attendance.

6. Our AMA encourages collaboration with interested parties to make available human papillomavirus vaccination to people who are incarcerated for the prevention of HPV-associated cancers.

7. Our AMA supports further research by relevant parties of HPV self-sampling in the United States to determine whether it can decrease health care disparities in cervical cancer screening.

8. Our AMA advocate that racial, ethnic, socioeconomic, and geographic differences in high-risk HPV subtype prevalence be taken into account during the development, clinical testing, and strategic distribution of next-generation HPV vaccines. (Modify Current HOD Policy)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 09/27/2023

REFERENCES

1. Centers for Disease Control and Prevention. Cancers associated with human papillomavirus in the American Indian and Alaska Native Population, United States—1999–2015, Purchased/ Referred Care Delivery Areas-PRCDA. USCS data brief, no. 6. Atlanta, GA: Centers for Disease Control and Prevention. 2019
2. National Indian Council on Aging. American Indians Twice as Likely to Develop Cervical Cancer. NICOA. 2020. Accessed March 7, 2023. https://www.nicoa.org/american-indians-twice-as-likely-to-develop-cervical-cancer/
3. Lee NR, Winer RL, Cherne S, et al. Human Papillomavirus Prevalence Among American Indian Women of the Great Plains. Journal of Infectious Disease. 2019;219(6):908-915. doi:10.1093/infdis/jiy600
4. Bordeaux SJ, Baca AW, Begay RL, Gachupin FC, Caporaso JG, Herbst-Kralovetz MM, Lee NR. Designing Inclusive HPV Cancer Vaccines and Increasing Uptake among Native Americans—A Cultural Perspective Review. *Current Oncology*. 2021; 28(5):3705-3716. https://doi.org/10.3390/curroncol28050316
5. Senkomago V, Henley SJ, Thomas CC, Mix JM, Markowitz LE, Saraiya M. Human Papillomavirus–Attributable Cancers — United States, 2012–2016. MMWR Morb Mortal Wkly Rep 2019;68:724–728. DOI: http://dx.doi.org/10.15585/mmwr.mm6833a
6. White MC, Espey DK, Swan J, Wiggins CL, Eheman C, Kaur JS. Disparities in cancer mortality and incidence among American Indians and Alaska Natives in the United States. Am J Public Health. 2014;104 Suppl 3(Suppl 3):S377-S387. doi:10.2105/AJPH.2013.301673
7. Melkonian SC, Jim MA, Haverkamp D, et al. Disparities in Cancer Incidence and Trends among American Indians and Alaska Natives in the United States, 2010-2015. Cancer Epidemiol Biomarkers Prev. 2019;28(10):1604-1611. doi:10.1158/1055-9965.EPI-19-0288

8. Cayatineto H, Clyde C, Yazzie G, Selassie G, de Soto J. The Systemic Exclusion of Native Americans from Cancer Clinical Trials. Journal of Medical Research and Health Sciences. 2021;4. doi:https://doi.org/10.52845/JMRHS/2021-4-8-4
9. National Council on Aging. American Indians and Alaska Natives: Key Demographics and Characteristics. Published online January 10, 2023. https://www.ncoa.org/article/american-indians-and-alaska-natives-key-demographics-and-characteristics
10. Scientific American. Clinical Trials Have Far Too Little Racial and Ethnic Diversity. Published online September 1, 2018. https://www.scientificamerican.com/article/clinical-trials-have-far-too-little-racial-and-ethnic-diversity/
11. Tenzin Shakya and Allie Yang. Despite mistrust, Native Americans' participation in vaccine development proves vital. ABC News. Published online December 25, 2020. https://abcnews.go.com/US/mistrust-native-americans-participation-vaccine-development-proves-vital/story?id=74879531
12. Flores LE, Frontera WR, Andrasik MP, et al. Assessment of the Inclusion of Racial/Ethnic Minority, Female, and Older Individuals in Vaccine Clinical Trials. JAMA Netw Open. 2021;4(2):e2037640. doi:10.1001/jamanetworkopen.2020.37640

RELEVANT AMA POLICY

H-440.872 HPV Vaccine and Cervical and Oropharyngeal Cancer Prevention Worldwide
1. Our AMA (a) urges physicians and other health care professionals to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine HPV related cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs.
2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public.
3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits; (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations; and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.
4. Our AMA encourages appropriate parties to investigate means to increase HPV vaccination rates by facilitating administration of HPV vaccinations in community-based settings including school settings.
5. Our AMA will study requiring HPV vaccination for school attendance.
6. Our AMA encourages collaboration with interested parties to make available human papillomavirus vaccination to people who are incarcerated for the prevention of HPV-associated cancers.
7. Our AMA supports further research by relevant parties of HPV self-sampling in the United States to determine whether it can decrease health care disparities in cervical cancer screening.
[Res. 503, A-07; Appended: Res. 6, A-12; Reaffirmed: CSAPH Rep. 1, A-22; Reaffirmation: A-22; Modified: Res. 916, I-22; Modified: Res. 404, A-23; Appended: Res. 404, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 910
(I-23)

Introduced by: Medical Student Section

Subject: Sickle Cell Disease Workforce

Referred to: Reference Committee K

Whereas, patients with sickle cell disease (SCD) face barriers such as lack of specialized care, transportation issues, and geographic limitations[1-18]; and

Whereas, interdisciplinary services for patients with SCD may include primary care, specialty care (hematologists and physicians who specialize in SCD, cardiologists, pulmonologists, nephrologists, vascular neurologists, and surgeons), behavioral healthcare to help manage acute and chronic pain and psychiatric comorbidities, and educational and employment services to support patients whose school or work is often interrupted[19–21]; and

Whereas, comprehensive interdisciplinary care models for SCD gain direct expertise working with the multifaceted issues of SCD and demonstrated improved outcomes in symptom control, fewer acute hospitalizations, decreased overall costs, and reduced rates of life-threatening complications such as acute chest syndrome[19-26]; and

Whereas, increased access to specialized and interdisciplinary care can also reduce medical mistrust and reports of discrimination among patients with SCD, improve adherence to treatment plans, and increase patient satisfaction scores[27–36]; and

Whereas, multiple Congressional bills, including the Sickle Cell Disease Comprehensive Care Act and the Sickle Cell Disease Treatment Centers Act of 2022, aim to improve care for patients with SCD[37]; therefore be it

RESOLVED, that our American Medical Association amend H-350.973, “Sickle Cell Disease,” by addition to read as follows:

> Sickle Cell Disease H-350.973
> Our AMA:
> (1) recognizes sickle cell disease (SCD) as a chronic illness;
> (2) encourages educational efforts directed to health care providers and the public regarding the treatment and prevention of SCD;
> (3) supports the inclusion of SCD in newborn screening programs and encourages genetic counseling for parents of SCD patients and for young adults who are affected, carriers, or at risk of being carriers;
> (4) supports ongoing and new research designed to speed the clinical implementation of new SCD treatments;
> (5) recommends that SCD research programs have input in the planning stage from the local African American community, SCD patient advocacy

groups, and others affected by SCD;
(6) supports the development of an individualized sickle cell emergency care plan by physicians for in-school use, especially during sickle cell crises;
(7) supports the education of teachers and school officials on policies and protocols, encouraging best practices for children with sickle cell disease, such as adequate access to the restroom and water, physical education modifications, seat accommodations during extreme temperature conditions, access to medications, and policies to support continuity of education during prolonged absences from school, in order to ensure that they receive the best in-school care, and are not discriminated against, based on current federal and state protections; ~~and~~
(8) encourages the development of model school policy for best in-school care for children with sickle cell disease.
(9) supports expanding the health care and research workforce taking care of patients with sickle cell disease; and
(10) collaborates with relevant parties to advocate for improving access to comprehensive, quality, and preventive care for individuals with sickle cell disease, to address crucial care gaps that patients with sickle cell disease face and improve both the quality of care and life for patients affected by sickle cell disease. (Modify Current HOD Policy)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 09/27/2023

REFERENCES

1. Lee L, Smith-Whitley K, Banks S, Puckrein G. Reducing Health Care Disparities in Sickle Cell Disease: A Review. Public Health Rep. 134(6):599-607. doi:10.1177/0033354919881438
2. Sedrak A, Kondamudi NP. Sickle Cell Disease. https://www.ncbi.nlm.nih.gov/books/NBK482384/
3. Osunkwo I, Andemariam B, Minniti CP, Inusa BP, El Rassi F, Francis-Gibson B. Impact of sickle cell disease on patients' daily lives, symptoms reported, and disease management strategies: results from the international Sickle Cell World Assessment Survey (SWAY. Am J Hematol. 96(4):404-417.
4. Lubeck D, Agodoa I, Bhakta N. Estimated Life Expectancy and Income of Patients With Sickle Cell Disease Compared With Those Without Sickle Cell Disease. JAMA Netw Open. 2019;2(11):e1915374(v 1). doi:10.1001/jamanetworkopen.2019.15374
5. Peterson EE, Salemi JL, Dongarwar D, Salihu HM. Acute care utilization in pediatric sickle cell disease and sickle cell trait in the USA: prevalence, temporal trends, and cost. Eur J Pediatr. (v;179(11):1701-1710). doi:10.1007/s00431-020-03656-x.
6. Brousseau DC, Owens PL, Mosso AL, Panepinto JA, Steiner CA. Acute care utilization and rehospitalizations for sickle cell disease. JAMA. 303(13):1288-1294. doi:10.1001/jama.2010.378
7. Brennan-Cook J, Bonnabeau E, Aponte R, Augustin C, Tanabe P. Barriers to Care for Persons With Sickle Cell Disease: The Case Manager's Opportunity to Improve Patient Outcomes. Prof Case Manag. 23(4):213-219. doi:10.1097/NCM.0000000000000260
8. Mainous AG, Tanner RJ, Harle CA, Baker R, Shokar NK, Hulihan MM. Attitudes toward Management of Sickle Cell Disease and Its Complications: A National Survey of Academic Family Physicians. Anemia. 2015;2015:1-6. doi:10.1155/2015/853835
9. Sinha CB, Bakshi N, Ross D, Krishnamurti L. Management of Chronic Pain in Adults Living With Sickle Cell Disease in the Era of the Opioid Epidemic. JAMA Netw Open. 2019;2(5):e194410. doi:10.1001/jamanetworkopen.2019.4410
10. Fearon A, Marsh A, Kim J, Treadwell M. Pediatric residents' perceived barriers to opioid use in sickle cell disease pain management. Pediatr Blood Cancer. 2019;66(2):e27535. doi:10.1002/pbc.27535
11. Martin OY, Thompson SM, Carroll AE, Jacob SA. Emergency department provider survey regarding acute sickle cell pain management. J Pediatr Hematol Oncol. 2020;42(6):375-380. doi:10.1097/MPH.0000000000001843
12. Brown SE, Weisberg DF, Balf-Soran G, Sledge WH. Sickle cell disease patients with and without extremely high hospital use: pain, opioids, and coping. J Pain Symptom Manage. 49(3):539-547. doi:10.1016/j.jpainsymman.2014.06.007.
13. Elander J, Beach MC, C Jr H. Respect, trust, and the management of sickle cell disease pain in hospital: comparative analysis of concern-raising behaviors, preliminary model, and agenda for international collaborative research to inform practice. Ethn Health. 16(4-5):405-421. doi:10.1080/13557858.2011.555520

14. Crego N, Masese R, Bonnabeau E. Patient Perspectives of Sickle Cell Management in the Emergency Department. Crit Care Nurs Q. 44(2):160-174. doi:10.1097/CNQ.0000000000000350
15. Stanton M V, Jonassaint CR, Bartholomew FB, et al. The association of optimism and perceived discrimination with health care utilization in adults with sickle cell disease. Journal of National Medical Association. 102(11):1056-1063. doi:10.1016/S0027-9684(15)30733-1.
16. Bulgin D, Tanabe P, Jenerette C. Stigma of Sickle Cell Disease: A Systematic Review. Issues Ment Health Nurs. 39(8):675-686. doi:10.1080/01612840.2018.1443530
17. Mulchan SS, Valenzuela JM, Crosby LE, Sang CDP. Applicability of the SMART model of transition readiness for sickle-cell disease. J Pediatr Psychol. 41(5):543-554. doi:10.1093/jpepsy/jsv120.
18. Jenerette CM, Brewer CA, Ataga KI. Care seeking for pain in young adults with sickle cell disease. Pain Manag Nurs. 15(1):324-330. doi:10.1016/j.pmn.2012.10.007
19. Sciences NA, Engineering, Medicine H, Division M. Board on Population Health and Public Health Practice; Committee on Addressing Sickle Cell Disease: A Strategic Plan and Blueprint for Action. In: Martinez RM, Osei-Anto HA, McCormick M, eds. Addressing Sickle Cell Disease: A Strategic Plan and Blueprint for Action. National Academies Press (US. https://www.ncbi.nlm.nih.gov/books/NBK566477/
20. Kanter J, Smith WR, Desai PC. Building access to care in adult sickle cell disease: defining models of care, essential components, and economic aspects. Blood Adv. 4(16):3804-3813. doi:10.1182/bloodadvances.2020001743
21. Pires RP, Oliveira MC, Araújo LB, Oliveira JC, Alcântara TM. Impact of sickle cell disease on work activity. Rev Bras Med Trab. 20(2):272-278. doi:10.47626/1679-4435-2022-641
22. Lavu S, Szuber N, Mudireddy M, et al. Comprehensive management reduces incidence and mortality of acute chest syndrome in patients with sickle cell disease. Am J Hematol. 2018;93(3):E64-E67. doi:10.1002/AJH.24994
23. Basishvili G, Gotesman J, Vandervoort K, Jacobs C, Vattappally L, Minniti CP. Comprehensive management reduces incidence and mortality of acute chest syndrome in patients with sickle cell disease. Am J Hematol. 93(3).
24. Koch KL, Karafin MS, Simpson P, Field JJ. Intensive management of high-utilizing adults with sickle cell disease lowers admissions. Am J Hematol. 90(3):215-219.
25. Lanzkron S, Carroll CP, Hill P, David M, Paul N, Haywood C. Impact of a Dedicated Infusion Clinic for Acute Management of Adults with Sickle Cell Pain Crisis. Am J Hematol. 2015;90(5):376. doi:10.1002/AJH.23961
26. Kanter J, Gibson R, Lawrence RH, et al. Perceptions of US Adolescents and Adults with Sickle Cell Disease on Their Quality of Care. JAMA Netw Open. 2020;3(5). doi:10.1001/JAMANETWORKOPEN.2020.6016
27. Haywood C, Lanzkron S, Bediako S, et al. Perceived discrimination, patient trust, and adherence to medical recommendations among persons with sickle cell disease. J Gen Intern Med. 2014;29(12):1657-1662. doi:10.1007/S11606-014-2986-7
28. Haywood C, Diener-West M, Strouse J, et al. Perceived discrimination in health care is associated with a greater burden of pain in sickle cell disease. J Pain Symptom Manage. 2014;48(5):934-943. doi:10.1016/j.jpainsymman.2014.02.002
29. Haywood C, Lanzkron S, Ratanawongsa N, et al. The association of provider communication with trust among adults with sickle cell disease. J Gen Intern Med. 2010;25(6):543-548. doi:10.1007/s11606-009-1247-7
30. Oyedeji C, Strouse JJ. Improving the Quality of Care for Adolescents and Adults With Sickle Cell Disease—It's a Long Road. JAMA Netw Open. 2020;3(5):e206377-e206377. doi:10.1001/JAMANETWORKOPEN.2020.6377
31. Hoegy D, Guilloux R, Bleyzac N, et al. Pediatric-Adult Care Transition: Perceptions of Adolescent and Young Adult Patients with Sickle Cell Disease and Their Healthcare Providers. Patient Prefer Adherence. 2022;16:2727. doi:10.2147/PPA.S377236
32. Howell KE, Saulsberry-Abate AC, Mathias JG, et al. TRANSITION CARE CONTINUITY PROMOTES LONG-TERM RETENTION IN ADULT CARE AMONG YOUNG ADULTS WITH SICKLE CELL DISEASE. Pediatr Blood Cancer. 2021;68(10):e29209. doi:10.1002/PBC.29209
33. Rubin D, Smith-Whitley K, Jan S. Identifying Best Practices for Transitioning Youth with Sickle Cell from Pediatric to Adult Care. Policy Lab at Children's Hospital of Philadelphia.
34. Oyeku SO, Faro EZ. Rigorous and practical quality indicators in sickle cell disease care. Hematology Am Soc Hematol Educ Program. 2017(1):418-422. doi:10.1182/asheducation-2017.1.418
35. Farooq F, Mogayzel PJ, Lanzkron S, Haywood C, Strouse JJ. Comparison of US Federal and Foundation Funding of Research for Sickle Cell Disease and Cystic Fibrosis and Factors Associated With Research Productivity. JAMA Netw Open. 3(3). doi:10.1001/jamanetworkopen.2020.1737
36. Farooq F, Mogayzel PJ, Lanzkron S, Haywood C, Strouse JJ. Comparison of US Federal and Foundation Funding of Research for Sickle Cell Disease and Cystic Fibrosis and Factors Associated With Research Productivity. JAMA Netw Open. 2020;3(3):201737. doi:10.1001/jamanetworkopen.2020.1737
37. Sickle Cell Disease Treatment Centers Act of. S.4866.

RELEVANT AMA POLICY

H-350.973 Sickle Cell Disease

(1) recognizes sickle cell disease (SCD) as a chronic illness;
(2) encourages educational efforts directed to health care providers and the public regarding the treatment and prevention of SCD;
(3) supports the inclusion of SCD in newborn screening programs and encourages genetic counseling for

parents of SCD patients and for young adults who are affected, carriers, or at risk of being carriers;
(4) supports ongoing and new research designed to speed the clinical implementation of new SCD treatments;
(5) recommends that SCD research programs have input in the planning stage from the local African American community, SCD patient advocacy groups, and others affected by SCD;
(6) supports the development of an individualized sickle cell emergency care plan by physicians for in-school use, especially during sickle cell crises;
(7) supports the education of teachers and school officials on policies and protocols, encouraging best practices for children with sickle cell disease, such as adequate access to the restroom and water, physical education modifications, seat accommodations during extreme temperature conditions, access to medications, and policies to support continuity of education during prolonged absences from school, in order to ensure that they receive the best in-school care, and are not discriminated against, based on current federal and state protections; and
(8) encourages the development of model school policy for best in-school care for children with sickle cell disease. [CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Modified: BOT Rep. 12, A-11; Appended: Res. 906, I-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 913
(I-23)

Introduced by: Medical Student Section

Subject: Public Health Impacts of Industrialized Farms

Referred to: Reference Committee K

Whereas, an industrialized farm, also known as Concentrated Animal Feeding Operation (CAFO), refers to a facility that keeps a large number of animals confined for more than 45 days in any 12-month period[1]; and

Whereas, CAFOs are well-known sources of water and air pollution and are associated with numerous environmental and population health risks[2-7]; and

Whereas, residing in proximity to CAFOs is associated with increased transmission of zoonotic pathogens, development of antibiotic resistance, and increased risk of respiratory disease, acute gastrointestinal illness, urinary tract infections, autoimmune disease, adverse birth outcomes, anemia, kidney disease, and cardiovascular mortality[8-17]; and

Whereas, the adverse health effects of CAFOs tend to disproportionately affect communities of color, low-income communities, and rural communities[18-20]; and

Whereas, pollution from CAFOs is regulated by the Environmental Protection Agency (EPA) under the 1972 Clean Water Act and Clean Air Act[1]; and

Whereas, in 2019, the EPA signed an amendment stating CAFOs are exempt from the Emergency Planning and Community Right to Know Act (EPCRA) and the Comprehensive Environmental Response Compensation, and Liability Act (CERCLA), which are statutes requiring industries to report when high levels toxic chemicals are released into the environment[21]; and

Whereas, in 2022, the EPA denied two petitions from groups asking it to revise its CAFO regulations and instead announced it will undertake a comprehensive evaluation of its guidelines and will incorporate feedback from stakeholders to inform its regulatory revisions[22]; therefore be it

RESOLVED, that our American Medical Association recognize Concentrated Animal Feeding Operations (CAFOs) as a public health hazard (New HOD Policy); and be it further

RESOLVED, that our AMA encourage the Environmental Protection Agency and appropriate parties to remove the regulatory exemptions for CAFOs under the Emergency Planning and Community Right-to-Know Act and the Comprehensive Environmental Response, Compensation, and Liability Act and tighten restrictions on pollution from CAFOs. (New HOD Policy)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 09/27/2023

REFERENCES

1. US EPA O. Animal Feeding Operations (AFOs). Published August 24, 2015. Accessed September 16, 2023. https://www.epa.gov/npdes/animal-feeding-operations-afos
2. Brown CN, Mallin MA, Loh AN. Tracing nutrient pollution from industrialized animal production in a large coastal watershed. Environ Monit Assess. 2020;192(8):515. doi:10.1007/s10661-020-08433-9
3. Domingo NGG, Balasubramanian S, Thakrar SK, et al. Air quality–related health damages of food. Proc Natl Acad Sci. 2021;118(20):e2013637118. doi:10.1073/pnas.2013637118
4. Glibert PM. From hogs to HABs: impacts of industrial farming in the US on nitrogen and phosphorus and greenhouse gas pollution. Biogeochemistry. 2020;150(2):139-180. doi:10.1007/s10533-020-00691-6
5. Kravchenko J, Rhew SH, Akushevich I, Agarwal P, Lyerly HK. Mortality and Health Outcomes in North Carolina Communities Located in Close Proximity to Hog Concentrated Animal Feeding Operations. N C Med J. 2018;79(5):278-288. doi:10.18043/ncm.79.5.278
6. Lewis BM, Battye WH, Aneja VP, Kim H, Bell ML. Modeling and Analysis of Air Pollution and Environmental Justice: The Case for North Carolina's Hog Concentrated Animal Feeding Operations. Environ Health Perspect. 2023;131(8):87018. doi:10.1289/EHP11344
7. Loftus C, Afsharinejad Z, Sampson P, et al. Estimated time-varying exposures to air emissions from animal feeding operations and childhood asthma. Int J Hyg Environ Health. 2020;223(1):187-198. doi:10.1016/j.ijheh.2019.09.003
8. Wei X, Aggrawal A, Bond RF, Latack BC, Atwill ER. Dispersal and Risk Factors for Airborne Escherichia coli in the Proximity to Beef Cattle Feedlots. J Food Prot. 2023;86(6):100099. doi:10.1016/j.jfp.2023.100099
9. Amato HK, Wong NM, Pelc C, et al. Effects of concentrated poultry operations and cropland manure application on antibiotic resistant Escherichia coli and nutrient pollution in Chesapeake Bay watersheds. Sci Total Environ. 2020;735:139401. doi:10.1016/j.scitotenv.2020.139401
10. Casanova LM, Hill VR, Sobsey MD. Antibiotic-resistant Salmonella in swine wastes and farm surface waters. Lett Appl Microbiol. 2020;71(1):117-123. doi:10.1111/lam.13242
11. Schultz AA, Peppard P, Gangnon RE, Malecki KMC. Residential proximity to concentrated animal feeding operations and allergic and respiratory disease. Environ Int. 2019;130:104911. doi:10.1016/j.envint.2019.104911
12. Guo Y, Ryan U, Feng Y, Xiao L. Association of Common Zoonotic Pathogens With Concentrated Animal Feeding Operations. Front Microbiol. 2021;12:810142. doi:10.3389/fmicb.2021.810142
13. Quist AJL, Holcomb DA, Fliss MD, Delamater PL, Richardson DB, Engel LS. Exposure to industrial hog operations and gastrointestinal illness in North Carolina, USA. Sci Total Environ. 2022;830:154823. doi:10.1016/j.scitotenv.2022.154823
14. Holcomb DA, Quist AJL, Engel LS. Exposure to industrial hog and poultry operations and urinary tract infections in North Carolina, USA. Sci Total Environ. 2022;853:158749. doi:10.1016/j.scitotenv.2022.158749
15. Ayala-Ramirez M, MacNell N, McNamee LE, et al. Association of distance to swine concentrated animal feeding operations with immune-mediated diseases: An exploratory gene-environment study. Environ Int. 2023;171:107687. doi:10.1016/j.envint.2022.107687
16. Mendrinos A, Ramesh B, Ruktanonchai CW, Gohlke JM. Poultry Concentrated Animal-Feeding Operations on the Eastern Shore, Virginia, and Geospatial Associations with Adverse Birth Outcomes. Healthc Basel Switz. 2022;10(10):2016. doi:10.3390/healthcare10102016
17. Son JY, Miranda ML, Bell ML. Exposure to concentrated animal feeding operations (CAFOs) and risk of mortality in North Carolina, USA. Sci Total Environ. 2021;799:149407. doi:10.1016/j.scitotenv.2021.149407
18. Son JY, Bell ML. Concentrated animal feeding operations (CAFOs) in relation to environmental justice related variables in Wisconsin, United States. J Expo Sci Environ Epidemiol. Published online September 9, 2023. doi:10.1038/s41370-023-00598-y
19. Hall J, Galarraga J, Berman I, et al. Environmental Injustice and Industrial Chicken Farming in Maryland. Int J Environ Res Public Health. 2021;18(21):11039. doi:10.3390/ijerph182111039
20. Galarraga J, Khanjar N, Berman I, et al. Environmental Injustice and Industrial Chicken Farming in Delaware. New Solut J Environ Occup Health Policy NS. 2022;31(4):441-451. doi:10.1177/10482911211052944
21. Environmental Protection Agency. Amendment to Emergency Release Notification Regulations on Reporting Exemption for Air Emissions From Animal Waste at Farms; Emergency Planning and Community Right-to- Know Act. Published online June 13, 2019. Accessed September 16, 2023. https://www.govinfo.gov/content/pkg/FR-2019-06-13/pdf/2019-12411.pdf
22. US EPA O. Animal Agriculture Water Quality Subcommittee. Published August 14, 2023. Accessed September 16, 2023. https://www.epa.gov/npdes/animal-agriculture-water-quality-subcommittee

RELEVANT AMA POLICY

H-135.911 Environmental Health Equity in Federally Subsidized Housing

1. Our American Medical Association acknowledges the potential adverse health impacts of living in close proximity to Superfund sites or other contaminated lands.
2. Our AMA advocates for mandated disclosure of Superfund sites or other contaminated lands proximity to those purchasing, leasing, or currently residing in housing in close proximity to Superfund sites or other contaminated lands.

3. Our AMA supports efforts of public agencies to study the safety of proposed public housing expansions with respect to pollutant exposure and to expand construction of new public and publicly subsidized housing properties on lands without demonstrated unsafe levels of hazardous pollutants. [Res. 415, A-23]

H-135.998 AMA Position on Air Pollution
Our AMA urges that: (1) Maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties.
(2) Community control programs should be implemented wherever air pollution produces widespread environmental effects or physiological responses, particularly if these are accompanied by a significant incidence of chronic respiratory diseases in the affected community.
(3) Prevention programs should be implemented in areas where the above conditions can be predicted from population and industrial trends.
(4) Governmental control programs should be implemented primarily at those local, regional, or state levels which have jurisdiction over the respective sources of air pollution and the population and areas immediately affected, and which possess the resources to bring about equitable and effective control. [BOT Rep. L, A-65; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-14; Reaffirmation A-16; Reaffirmed: BOT Rep. 29, A-19]

H-135.996 Pollution Control and Environmental Health
Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in pollution control and improvement of environmental health. [Sub. Res. 40, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 914
(I-23)

Introduced by: American Academy of Pediatrics
American Academy of Child & Adolescent Psychiatry

Subject: Adverse Childhood Experiences

Referred to: Reference Committee K

Whereas, Adverse Childhood Experiences (ACEs) are currently defined by a 1998 Kaiser Permanente and CDC study as stressful, traumatic events that occur during childhood which currently include episodes of physical, sexual or emotional abuse, physical and emotional neglect, familial mental illness, incarceration, substance use, having separated parents, and witnessing violence against the child's mother; and

Whereas, Current evidence shows 63.9% of adults in the US have experienced one or more ACEs; and

Whereas, Experiencing four or more ACEs significantly increases the risk of morbidity and mortality from chronic diseases including cardiovascular disease, depression, cancer, diabetes, obesity, and suicide; and

Whereas, Current research demonstrates preventing ACEs can reduce heart disease by 1.9 million cases and depression by 21 million cases; and

Whereas, Research on interventions aimed at children who experience ACEs can diminish the impact of these events on child behavioral and mental health problems by lowering metabolic, immunologic, neuroendocrine, and inflammatory activation while also enhancing the parent-child relationship, trust in clinicians, and utilization of healthcare; and

Whereas, The expanded categories of ACEs identified in The Philadelphia ACE Project are: witnessed violence, felt discrimination, unsafe neighborhood, experienced bullying, lived in foster care; and

Whereas, The World Health Organization's ACE International Questionnaire (ACE-IQ) recognizes additional ACEs including migration trauma; and

Whereas, The expanded categories of ACEs are more inclusive of historically marginalized communities better identifying at risk groups for chronic morbidity and mortality; and

Whereas, Studies have shown more than 50% of Black and Hispanic children have experienced at least one ACE; and

Whereas, The current limited definition of ACEs does not allow expansion based upon more current research identifying poverty, food insecurity, migration, foster care and bullying as additional ACEs; and

Whereas, Recent bicameral, bipartisan legislation was introduced in Congress to establish a national ACEs response team grant dedicating $40 million in federal resources towards prevention and early intervention efforts aimed at diminishing the impacts ACEs have upon the developing child; and

Whereas, The Mental Health Liaison Group, comprised by over 70 national organizations including the American Academy of Pediatrics, and American Psychiatric Association, and the American Academy of Child and Adolescent Psychiatry, wrote letters of support for the filed legislation while our AMA had not done so at the time of this resolution; and

Whereas, Preventing damage to the developing brain of a child, or at a minimum ameliorating the toxic stress which occurs during these Adverse Childhood Experiences saves lives and money; therefore be it

RESOLVED, That our American Medical Association collaborate with the Centers for Disease Control and Prevention (CDC) and other relevant interested parties to advocate for the addition of witnessing violence, experiencing discrimination, living in an unsafe neighborhood, experiencing bullying, placement in foster care, migration-related trauma, and living in poverty, and any additional categories as needed and justified by scientific evidence to the currently existing Adverse Childhood Experiences (ACEs) categories for the purposes of continuing to improve research into the health impacts of ACEs and how to mitigate them (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the CDC and other relevant interested parties to advocate for resources to expand research into ACEs and efforts to operationalize those findings into effective and evidence-based clinical and public health interventions (Directive to Take Action); and be it further

RESOLVED, that our AMA support the establishment of a national ACEs response team grant to dedicate federal resources towards supporting prevention and early intervention efforts aimed at diminishing the impacts ACEs have on the developing child. (New HOD Policy)

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

Received: 9/27/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 915
(I-23)

Introduced by: American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Psychiatric Association

Subject: Social Media Impact on Youth Mental Health

Referred to: Reference Committee K

Whereas, over the past decade, there has been a substantial increase in social media engagement among children and adolescents; and

Whereas, this trend has been further amplified during the COVID-19 pandemic, as digital connection became the default method of socialization for many across the country; and

Whereas, social media use is nearly universal among young people with up to 95% of teenagers are active online; and

Whereas, despite a minimum age requirement of 13 years on most U.S. platforms, nearly 40% of children aged 8-12 are on social media as well; and

Whereas, concurrently, rates of depression and anxiety among youth have surged; and

Whereas, data has shown that those who spend more than 3 hours per day on social media have double the risk of poor mental health and that the average teenager spends about 3.5 hours per day using social media platforms; and

Whereas, 46% of teens reported that social media contributes to negative feelings about their body image; and

Whereas, there is currently not enough evidence to conclude that social media use is sufficiently safe in this population; and

Whereas, the adolescent brain is at a vulnerable stage of development that can make adolescents and young adults prone to experiencing adverse effects from social media use, including disruptions in sleep patterns, fostering unrealistic self-comparisons, adopting avoidant coping strategies, engaging in cyberbullying, and encountering predatory behaviors; and

Whereas, our American Medical Association advocates that children’s mental health and barriers to mental health care access for children represent a national emergency that requires urgent attention from all interested parties; therefore be it

RESOLVED, that our American Medical Association work with relevant parties to develop guidelines for age-appropriate content and access and to develop age-appropriate digital literacy training to precede social media engagement among children and adolescents (Directive to Take Action); and be it further

RESOLVED, that our AMA amend policy D-478.965 by insertion as follows: (4) advocates for and support media and social networking services addressing and developing safeguards for users, including protections for youth online privacy, effective controls allowing youth and caregivers to manage screentime content and access, and to develop age-appropriate digital literacy training (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA advocate that the federal government requires social media companies to share relevant data for further independent research on social media's effect on youth mental health and fund future federal research on the potential benefits and harms of social media use on youth mental health. (Directive to Take Action)

Fiscal Note: $251,462 Convene expert panel, develop & disseminate educational materials

Received: 9/27/23

Currently under study by CSAPH with a report due at the June 2024 HOD Annual Meeting.

REFERENCES

1. Weigle P, Hurst-Della Pietra P, Peeples D., TikTok Teens: New Research Reveals How Social Media Affects Mental Health. JAACAP. Published online October 2022. https://doi.org/10.1016/j.jaac.2022.07.744
2. "Social Media and Youth Mental Health: The U.S. Surgeon General's ..." Social Media and Youth Mental Health: The U.S. Surgeon General's Advisory (Executive Summary) , Office of the U.S. Surgeon General, 2023, www.hhs.gov/sites/default/files/sg-youth-mental-health-social-media-summary.pdf.
3. "APA Panel Issues Recommendations for Adolescent Social Media Use." American Psychological Association, American Psychological Association, 9 May 2023, www.apa.org/news/press/releases/2023/05/adolescent-social-media-use-recommendations.

RELEVANT AMA POLICY

D-345.972 Mental Health Crisis
1. Our AMA will work expediently with all interested national medical organizations, national mental health organizations, and appropriate federal government entities to convene a federally-sponsored blue ribbon panel and develop a widely disseminated report on mental health treatment availability and suicide prevention in order to:
a) Improve suicide prevention efforts, through support, payment and insurance coverage for mental and behavioral health and suicide prevention services, including, but not limited to, the National Suicide Prevention Lifeline;
b) Increase access to affordable and effective mental health care through expanding and diversifying the mental and behavioral health workforce;
c) Expand research into the disparities in youth suicide prevention;
d) Address inequities in suicide risk and rate through education, policies and development of suicide prevention programs that are culturally and linguistically appropriate;
e) Develop and support resources and programs that foster and strengthen healthy mental health development; and
f) Develop best practices for minimizing emergency department delays in obtaining appropriate mental health care for patients who are in mental health crisis.
2. Our AMA supports physician acquisition of emergency mental health response skills by promoting education courses for physicians, fellows, residents, and medical students including, but not limited to, mental health first aid training.
3. Our AMA along with other interested parties will advocate that children's mental health and barriers to mental health care access for children represent a national emergency that requires urgent attention from all interested parties.
4. Our AMA will join with other interested parties to advocate for efforts to increase the mental health workforce to address the increasing shortfall in access to appropriate mental health care for children. [Res. 425, A-22; Appended: Res. 422, A-23]

D-478.965 Addressing Social Media and Social Networking Usage and its Impacts on Mental Health
Our AMA: (1) will collaborate with relevant professional organizations to: (a) support the development of continuing education programs to enhance physicians' knowledge of the health impacts of social media and social networking usage; and (b) support the development of effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing health sequelae of social media and social networking usage; (2) advocates for schools to provide safe and effective educational programs by which students can learn to identify and mitigate the onset of mental health sequelae of social media and social networking usage; (3) affirms that use of social media and social networking has the potential to positively or negatively impact the physical and mental health of individuals, especially adolescents and those with preexisting psychosocial conditions; (4) advocates for and support media and social networking services addressing and developing safeguards for users; and (5) advocates for the study of the positive and negative biological, psychological, and social effects of social media and social networking services use. [Res. 905, I-17; Modified: Res. 420, A-21; Reaffirmation: A-23]

H-478.976 Teens and Social Media
Our American Medical Association will study and make recommendations for teenage use of social media, including proposing model state and federal legislation as needed, with a report back at the 2024 Annual Meeting. [Res. 430, A-23]

H-60.934 Internet Pornography: Protecting Children and Youth Who Use the Internet and Social Media
Our AMA: (1) Recognizes the positive role of the Internet in providing health information to children and youth. (2) Recognizes the negative role of the Internet in connecting children and youth to predators and exposing them to pornography. (3) Supports federal legislation that restricts Internet access to pornographic materials in designated public institutions where children and youth may use the Internet. (4) Encourages physicians to continue efforts to raise parent/guardian awareness about the importance of educating their children about safe Internet and social media use. (5) Supports school-based media literacy programs that teach effective thinking, learning, and safety skills related to Internet and social media use. (6) Actively support legislation that would strengthen child-centric content protection by internet service providers and/or search engines in order to limit the access of pornography to minors on the internet and mobile applications. [BOT Rep. 10, I-06; Modified: CSAPH Rep. 01, A-16; Appended: Rep. 926, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 916
(I-23)

Introduced by: Washington, American Association of Public Health Physicians

Subject: Elimination of Buprenorphine Dose Limits

Referred to: Reference Committee K

Whereas, Washington state lost 2,910 citizens to death from drug overdoses, primarily fentanyl, in the year ending February 2023, a 23.9% increase over the previous year, far more than any other state[1]; and

Whereas, buprenorphine use reduces risk of opioid overdose death by at least 50%,[2] making it one of the two most effective treatments available for opioid use disorder (OUD); and

Whereas, keeping patients in treatment requires an effective dose that protects them from withdrawal symptoms and craving; and

Whereas, patients and prescribers encounter strict dose limits set by clinics, health systems, pharmacies and insurers based on guidelines set by the United States Food and Drug Administration (FDA) in 2021; and

Whereas, fentanyl currently in widespread use is 100 times more potent and far more lethal than the prescription pain medications that were the prevalent illicit opioids when the FDA's dosing guideline was set; and

Whereas, extensive research published over decades[4] shows that 1) buprenorphine's life-saving benefits are dose-dependent well above the FDA's guideline and 2) individualized dosing is most effective for keeping patients in treatment; therefore be it

RESOLVED, that our American Medical Association support flexibility in dosing of buprenorphine by elimination of non-evidence-based dose limits imposed by clinics, health systems, pharmacies and insurance carriers (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for the elimination of non-evidence-based buprenorphine dose limits imposed by the United States Food and Drug Administration, clinics, health systems, pharmacies, and insurance carriers. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 9/27/23

REFERENCES

1. Ahmad FB, Cisewski JA, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2023.
2. Sordo L, Barrio G, Bravo MJ, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. BMJ. 2017;357:j1550.
3. Buprenorphine Prescribing Information. US Food and Drug Administration. Access at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/020732s024lbl.pdf.
4. Grande LA, Cundiff D, Murray M, Greenwald MK, Wright TE, Martin SA. Evidence on Buprenorphine Dose Limits: A Review, published online by Journal of Addiction Medicine, J Addict Med 2023; Jun 16. doi: 10.1097/ADM.0000000000001189.

RELEVANT AMA POLICY

D-95.972 Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder
1. Our AMA's Opioid Task Force will publicize existing resources that provide advice on overcoming barriers and implementing solutions for prescribing buprenorphine for treatment of Opioid Use Disorder.

2. Our AMA supports eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 917
(I-23)

Introduced by: New England

Subject: Advocating for Education and Action Regarding the Health Hazards of PFAS Chemicals

Referred to: Reference Committee K

Whereas, in 2019 the American Medical Association resolved to support research and policy to address the effects of PFAS exposure[1] and supported legislation and regulation seeking to address contamination, exposure, classification, and clean-up of per- and polyfluoroalkyl substances as follows:[2] “our AMA: (1) supports continued research on the impact of perfluoroalkyl and polyfluoroalkyl chemicals on human health; (2) supports legislation and regulation seeking to address contamination, exposure, classification, and clean-up of PFAS substances; and (3) will advocate for states, at minimum, to follow guidelines presented in the Environmental Protection Agency’s Drinking Water Health Advisories for perfluorooctanoic acid (PFOA) and perfluorooctane sulfonic acid (PFOS), with consideration of the appropriate use of Minimal Risk Levels (MRLs) presented in the CDC/ATSDR Toxicological Profile for PFAS”; and

Whereas, Per- and polyfluoroalkyl substances (PFAS), are a large class of chemicals with at least one aliphatic perfluorocarbon moiety; this carbon - fluorine bond is exceptionally strong and therefore highly resistant to degradation; thus the moniker “forever chemicals” because these chemicals persist, have the potential to bioaccumulate and become more concentrated in the environment with the passage of time;[3] and

Whereas, PFAS are ubiquitous: they are found in “non-stick” products that resist stains, oil, grease, and water including cookware,[4] artificial turf, clothing, leather, carpets, food packaging, firefighting foam, cosmetics, shampoos, sunscreens, pesticides; medical equipment such as PPE, masks, gowns, IV tubing, and medications;[5] and petroleum extraction (“fracking”) fluids;[6] the latter are sometimes repurposed as road salt or as “biosolids” that are then spread on crops[7]; and

Whereas, the PFAS chemicals PFOA and PFOS have recently been designated by the US EPA as hazardous substances that can be responded to via Superfund;[8] and while the EPA has set health advisory levels at between 0.002 and 0.004 ng/L, health effects, according to the EPA, can occur at any level;[9] and

Whereas, PFAS exposure has been associated with endocrine disruption, immune suppression, impaired organogenesis, damage to reproductive organs, and hepatotoxicity; low infant birth weight, preeclampsia,[10] impaired fertility, obesity, Type 2 diabetes, harms to neurocognitive and behavioral development in children, and malignancies, including prostate, kidney, and testicular cancer;[11] and

Whereas, PFAS exposure occurs via food, air, and water, including drinking water and rain;[12] water can become contaminated when PFAS leaches into water supplies from plastic containers, landfills, industrial and agricultural runoff, or following pesticide spraying (PFOS has been detected in 6/10 tested pesticides at levels between 3.92 to 19.2 mg/kg);[13] other common

sources of exposure include: ingestion of contaminated dust (from carpets, upholstery, etc.) as well as migration into food or beverages from boxes/packaging/plastic bottles); in infants, toddlers, and children, hand-to-mouth behavior is a significant source of exposure; and

Whereas, PFAS has direct impacts on the practice of medicine since they are used extensively in medical products, including medications, IV tubing, and PPE;[14] pharmaceuticals often include a fluorine molecule to increase cell permeability to Increase uptake;[15] and persons with high PFAS levels may be less responsive to certain medications, like vaccines;[16] and

Whereas, like lead, exposure to PFAS is widespread, but like lead, mitigating exposure and focusing on children and adults who are highly exposed is helpful since these persons can then be identified and helped (ie, parents can be cautioned to use a different, PFAS-free water source to use to make up baby formula, etc); like lead, limiting length and extent of high exposure could potentially improve health outcomes; and

Whereas, PFAS chemicals disproportionately pose challenges to low income and minority communities: some of the highest levels found across the country exist in lower income communities, even when the exposure hazard is not disproportionate between low and high income communities, the ability to respond with adequate filtration and monitoring efforts is unequal; and

Whereas, the National Academy of Science, Engineering and Medicine has recommended[17] that individuals with significant exposure to PFAS (including those who live near commercial airports, military bases and farms where sewage sludge may have been used) be tested and receive ongoing medical monitoring; PFAS blood testing in the population based C8 Dupont study in 69,030 participants was essential in determining associated health conditions with PFAS chemicals;[18,19] and PFAS blood tests are currently available through Quest and other providers;[20] and

Whereas, 99% of United States residents have various PFAS detectable in their blood[21]; and

Whereas, Newly developed educational resources on PFAS are available and include a free CME course on PFAS and comprehensive medical information and guidance on PFAS-REACH project's website (funded by the NIH's National Institute of Environmental Health Sciences (NIEHS))[22] and the July 2022 National Academy of Science, Engineering and Medicine report on PFAS;[23] therefore be it

RESOLVED, that our American Medical Association improve physician and public education around the adverse health effects of PFAS and potential mitigation and prevention efforts. (Directive to Take Action)

Fiscal Note: $51,420 Develop continuing medical education module

Received: 10/3/23

REFERENCES

[1] https://pfas-exchange.org/wp-content/uploads/PFAS-REACH-Medical-screening-guidance_clinicians.pdf
[2] https://www.ama-assn.org/system/files/2019-09/i19-901.pdf
[3] Carol F. Kwiatkowski et al., "Scientific Basis for Managing PFAS as a Chemical Class", Environ. Sci. Technol. Lett. 2020, 7, 8, 532–543, June 30, 2020 https://doi.org/10.1021/acs.estlett.0c00255
[4] Ramírez Carnero A, Lestido-Cardama A, Vazquez Loureiro P, Barbosa-Pereira L, Rodríguez Bernaldo de Quirós A, Sendón R. Presence of Perfluoroalkyl and Polyfluoroalkyl Substances (PFAS) in Food Contact Materials (FCM) and Its Migration to Food. Foods. 2021 Jun 22;10(7):1443. doi: 10.3390/foods10071443. PMID: 34206351; PMCID: PMC8306913. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8306913/
[5] Gluge J et al. An overview of the uses of per and polyfluoroalkyl substances (PFAS). Environ. Sci.: Processes Impacts, 2020, **22**, 2345-2373 DOI: 10.1039/D0EM00291G. https://pubs.rsc.org/en/content/articlehtml/2020/em/d0em00291g
[6]Hiroko T. EPA approved toxic chemicals for fracking a decade ago, new files shoe. NYT. 07.12.2021. https://www.nytimes.com/2021/07/12/climate/epa-pfas-fracking-forever-chemicals.html#:~:text=For%20much%20of%20the%20past,to%20internal%20documents%20from%20the
[7]https://extension.umaine.edu/agriculture/guide-to-investigating-pfas-risk-on-your-farm/
[8] https://www.epa.gov/pfas
[9] https://www.epa.gov/sdwa/drinking-water-health-advisories-pfoa-and-pfos
[10] Blake BE, Fenton SE. Early life exposure to per- and polyfluoroalkyl substances (PFAS) and latent health outcomes: A review including the placenta as a target tissue and possible driver of peri- and postnatal effects. Toxicology. 2020 Oct;443:152565.https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7530144/
[11] https://www.atsdr.cdc.gov/pfas/health-effects/index.html
[12]Cousins I, Johansson J et al. Outside the safe operating space of a new boundary for per and polyfluoroalkyl substances (PFAS), *Environ. Sci. Technol.* 2022, 56, 16, 11172–11179
Publication Date:August 2, 2022
https://doi.org/10.1021/acs.est.2c02765
https://pubs.acs.org/doi/10.1021/acs.est.2c02765
[13] https://www.sciencedirect.com/science/article/pii/S266691102200020X
[14] Gluge J et al. An overview of the uses of per and polyfluoroalkyl substances (PFAS). Environ. Sci.: Processes Impacts, 2020, **22**, 2345-2373 DOI: 10.1039/D0EM00291G. https://pubs.rsc.org/en/content/articlehtml/2020/em/d0em00291g
[15] Velcicky J, Schlapbach A, Heng R, Revesz L, Pflieger D, Blum E, Hawtin S, Huppertz C, Feifel R, Hersperger R. Modulating ADME Properties by Fluorination: MK2 Inhibitors with Improved Oral Exposure. ACS Med Chem Lett. 2018 Mar 20;9(4):392-396. doi: 10.1021/acsmedchemlett.8b00098.. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5900337/
[16] Grandjean P et al., Serum vaccine antibody concentrations in children exposed to perfluorinated compounds. JAMA 307, 391–397 (2012)
[17]National Academies of Sciences, Engineering, and Medicine. 2022. *Guidance on PFAS Exposure, Testing, and Clinical Follow-Up*. Washington, DC: The National Academies Press.
[17] https://doi.org/10.17226/26156.
[18] http://www.c8sciencepanel.org/
[19] Frisbee SJ, Brooks AP Jr, Maher A, Flensborg P, Arnold S, Fletcher T, Steenland K, Shankar A, Knox SS, Pollard C, Halverson JA, Vieira VM, Jin C, Leyden KM, Ducatman AM. The C8 health project: design, methods, and participants. Environ Health Perspect. 2009 Dec;117(12):1873-82. doi: 10.1289/ehp.0800379.
[20] https://pfas-exchange.org/wp-content/uploads/PFAS-Blood-Testing-Document-May-2022.pdf
[21] Kato K, Wong LY, Jia LT, Kuklenyik Z, Calafat AM. Trends in exposure to polyfluoroalkyl chemicals in the U.S. Population: 1999–2008. Environ Sci Technol 2011;45(19):8037–45.
[22] https://pfas-exchange.org/
[23] https://nap.nationalacademies.org/catalog/26156/guidance-on-pfas-exposure-testing-and-clinical-follow-up

RELEVANT AMA POLICY

Per- and Polyfluoroalkyl Substances (PFAS) and Human Health H-135.916

Our AMA: (1) supports continued research on the impact of perfluoroalkyl and polyfluoroalkyl chemicals on human health; (2) supports legislation and regulation seeking to address contamination, exposure, classification, and clean-up of (PFAS) substances; and (3) will advocate for states, at minimum, to follow guidelines presented in the Environmental Protection Agencys Drinking Water Health Advisories for perfluorooctanoic acid (PFOA) and perfluorooctane sulfonic acid (PFOS), with consideration of the appropriate use of Minimal Risk Levels (MRLs) presented in the CDC/ATSDR Toxicological Profile for (PFAS).

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 918
(I-23)

Introduced by: New England

Subject: Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals

Referred to: Reference Committee K

Whereas, as of February 1, 2022, there are 6,033 total male individuals, of whom 5,440 are criminally sentenced, 24 are pre-trial detainees, and 569 face civil commitments, and 199 total female individuals, of whom 155 are criminally sentenced, 40 are pre-trial detainees, and 4 face civil commitments, who are in the jurisdiction of the Massachusetts Department of Corrections;[i] and

Whereas, in 2021, the average male justice-involved individual was 44 years old and the average female justice-involved individual was 42 years old in Massachusetts, with 951 individuals 60 years of age and over as of January 1, 2021,[ii] and average age of individuals who are incarcerated rising concurrently with their health needs;[iii] and

Whereas, in 2016, about 43% of federal justice-involved individuals reported ever having a chronic condition, 33% reported currently having a chronic condition, and 31% had medical visits outside of carceral facilities;[iv] and

Whereas, people of color are overrepresented in prisons and jails in Massachusetts, with Whites accounting for 76% of the state population but 49% of prison or jail population, Blacks accounting for 7% of the state population but 26% of prison or jail population, and Latinos accounting for 10% of the state population but 24% of prison or jail population;[v] and

Whereas, US carceral facilities provide health care for justice-involved individuals in both on-site and off-site facilities depending on the type of service, with emergency, obstetrics, gynecology, and cardiology procedural services more commonly provided at non-carceral hospital facilities;[vi] and

Whereas, universal shackling in a hospital refers to the placement of metal restraints around the legs, wrists, or waist of justice-involved patients, regardless of age, illness, mobility, or criminal record disposition,[vii] with the recent exception of perinatal patients in Massachusetts; and

Whereas, Massachusetts enacted legislation in 2014 to prevent perinatal shackling, or the use of shackles for patients who are incarcerated and pregnant, in labor, or in postpartum recovery, by correction officers while the attending physician or nurse treating the perinatal patient may request immediate removal of restraints;[viii] and

Whereas, our American Medical Association has model state legislation to prohibit the practice of shackling pregnant prisoners;[ix] and

Whereas, US Senators Elizabeth Warren and Corey Booker introduced the Dignity for Incarcerated Women Act in 2017,[x] and the First Step Act of 2018 placed a federal prohibition on

the use of restraints on individuals who are pregnant and in the custody of the federal Bureau of Prisons or the US Marshals Service;[xi,xii] and Whereas, Thirty-two states have implemented some form of restriction on perinatal shackling, with 13 states banning shackling throughout pregnancy, labor, postpartum, and during transport between carceral and health care facilities;[xiii] and

Whereas, physicians and nurses in hospitals routinely assess the necessity of physical or pharmacological restraints on non justice–involved patients who may harm themselves or others, as well as document their use in the electronic medical record with descriptions of the reason for restraint, form of restraint, and periodic re-evaluations of continued need for restraint and any consequence on patient health;[xiv,xv] and

Whereas, the use of restraints on non justice–involved patients in the hospital setting is regulated by the Centers for Medicare and Medicaid Services, which mandate that the least restrictive form of restraint that protects the safety of the patient, health care staff, and others is used;[xvi,xvii] and

Whereas, shackling patients under special circumstances including, but not limited to, old age, loss of consciousness, terminal illness, or limited mobility, is unnecessary and excessive restraint, thus cruel, inhuman, and degrading as defined by the Universal Declaration of Human Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, and the International Covenant on Civil and Political Rights [xviii,xix,xx] and in violation of the medical ethics principle of nonmaleficence; and

Whereas, physical restraint use on patients is associated with delays in necessary emergency operations, increased falls and deliriums, as well as elevated risks of in-hospital deaths and venous thrombosis;[xxi,xxii] and

Whereas, in psychiatric settings, restraints have led to inappropriate actions by staff, invoking a fear response in patients and a loss of trust in the psychiatric staff,[xxiii] ultimately causing patients to be less likely to follow their treatment plan, use medical care, or consent to a surgical procedure;[xxiv] and

Whereas, formerly justice-involved individuals of color who experienced discrimination in healthcare settings due to their criminal records are less likely to use primary care resources upon release,[xxv] report worse mental and physical health following their release,[xxvi] and are more likely to report increased psychological distress;[xxvii] and

Whereas, physicians have written about the moral injury and contribution to physician burnout due to practicing in hospitals that routinely shackle every justice-involved patient;[xxviii,xxix] and

Whereas, violence against health care workers is of critical importance that should be addressed through effective hospital security protocols and staff training;[xxx] and

Whereas, current hospital policies for shackling in Massachusetts align with policies governing the shackling of non-justice-involved patients only in regard to justice-involved pregnant individuals, yet permit the universal shackling of all non-pregnant justice-involved patients, regardless of other special circumstances including, but not limited to, old age, loss of consciousness, terminal illness, or limited mobility; therefore be it

RESOLVED, that our American Medical Association condemns the practice of universally shackling every patient who is involved with the justice system while they receive care in

hospitals and outpatient health care settings (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for the universal assessment of every individual who is involved with the justice system who presents for care, by medical and security staff in collaboration with correctional officers, to determine whether shackles are necessary or may be harmful, and, if restraint is deemed necessary, that the least restrictive alternative to shackling with metal cuffs is used when appropriate (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate nationally for the end of universal shackling, to protect human and patient rights, improve patient health outcomes, and reduce moral injury among physicians. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 10/3/23

REFERENCES

[i] Massachusetts Department of Corrections, Research Division. Quick Statistics. Mass.gov. https://www.mass.gov/service-details/quick-statistics. Accessed March 8, 2022.
[ii] Cannata N, McDonald S, Desrochers B, et al.; 2021. https://www.mass.gov/doc/prison-population-trends-2020/download. Accessed March 8, 2022.
[iii] Maruschak LM, Berzofsky M, Unangst J. (Young M, Cooperman I, Thomas J, eds.). Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice; 2015. https://bjs.ojp.gov/content/pub/pdf/mpsfpji1112.pdf. Accessed March 8, 2022.
[iv] Maruschak LM, Bronson J, Alper M. Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice; 2021. https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/mprpspi16st.pdf. Accessed March 8, 2022.
[v] Prison Policy Initiative. Massachusetts profile. https://www.prisonpolicy.org/profiles/MA.html. Published 2022. Accessed March 8, 2022.
[vi] Chari KA, Simon AE, DeFrances CJ, Maruschak L. National Center for Health Statistics, Centers for Disease Control and Prevention; 2016. https://www.cdc.gov/nchs/data/nhsr/nhsr096.pdf. Accessed March 8, 2022.
[vii] Feinauer E, Lee A, Park J, Walker T, Smith G. (Citro B, Dakwar J, Fettig A, Kalantry S, eds.). International Human Rights Clinic University of Chicago Law School, CLAIM, ACLU National Prison Project; 2013. https://tbinternet.ohchr.org/Treaties/CCPR/Shared%20Documents/USA/INT_CCPR_NGO_USA_15235_E.pdf. Accessed March 8, 2022.
[viii] An Act to Prevent Shackling and Promote Safe Pregnancies for Female Inmates. Session Laws Chapter 103 (2014). https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter103. Accessed March 8, 2022.
[ix] An “Act to prohibit the shackling of pregnant prisoners” model state legislation. 2015. https://www.ama-assn.org/media/9791/download#:~:text=The%20AMA%20model%20state%20legislation%20is%20a%20straightforward%20prohibition%20on,personnel%20or%20substantial%20flight%20risk. Accessed March 8, 2022.
[x] S.1524 - 115th Congress (2017-2018): Dignity Act. (2017, July 11). https://www.congress.gov/bill/115th-congress/senate-bill/1524. Accessed March 8, 2022.
[xi] S.756 - 115th Congress (2017-2018): First Step Act of 2018. (2018, December 21). https://www.congress.gov/bill/115th-congress/senate-bill/756. Accessed March 8, 2022
[xii] James N. Congressional Research Service; 2019. https://crsreports.congress.gov/product/pdf/R/R45558. Accessed March 8, 2022.
[xiii] Richardson A. Shackling of Pregnant Prisoners Is Ongoing. Bill of Health. March 2020. https://blog.petrieflom.law.harvard.edu/2020/03/04/shackling-of-pregnant-prisoners-is-ongoing/. Accessed March 8, 2022.
[xiv] Thomann S, Zwakhalen S, Richter D, Bauer S, Hahn S. Restraint use in the acute-care hospital setting: A cross-sectional multi-centre study. International Journal of Nursing Studies. 2021;114:103807. doi:10.1016/j.ijnurstu.2020.103807
[xv] de Bruijn W, Daams JG, van Hunnik FJG, et al. Physical and Pharmacological Restraints in Hospital Care: Protocol for a Systematic Review. Front Psychiatry. 2020;10:921. Published 2020 Feb 28. doi:10.3389/fpsyt.2019.00921
[xvi] Centers for M& MS. Vol 71. Woodlawn, MD: Department of Health and Human Services; 2006:71380. https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/downloads/finalpatientrightsrule.pdf
[xvii] Mental Health Legal Advisors C. Rights of Adults in Massachusetts Hospitals and Emergency Rooms Regarding Restraint and Seclusion. 2021. http://mhlac.org/wp-content/uploads/2018/10/Rights_in_hospitals_including_hospital_emergency_rooms_regarding_restraint_and_seclusion.pdf
[xviii] Universal Declaration of Human Rights. United Nations. https://www.un.org/en/about-us/universal-declaration-of-human-rights. Accessed March 8, 2022. Article 5
[xix] International Convention on the Elimination of All Forms of Racial Discrimination. United Nations Human Rights. https://www.ohchr.org/en/professionalinterest/pages/cerd.aspx. Published 1969. Accessed March 8, 2022.
[xx] International Covenant on Civil and Political Rights. United Nations Human Rights. https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx. Published 1976. Accessed March 8, 2022. Article 10
[xxi] Bureau of Justice Assistance U.S. Department of Justice; 2014. https://cjinvolvedwomen.org/wp-content/uploads/2015/09/Best-Practices-Use-of-Restraints-Pregnant.pdf. Accessed March 8, 2022.

[xxii] Robinson M, Lavere K, Porsa E. End the routine shackling of incarcerated inpatients. Journal of Hospital Medicine. 2021;16(6):376-377. doi:10.12788/jhm.3581
[xxiii] Klein J. A Theory of Punishment: The Use of Mechanical Restraints in Psychiatric Care. University of Southern California Review of Law and Social Justice. 2011;21(1):47-72. https://gould.usc.edu/students/journals/rlsj/issues/assets/docs/volume21/Fall2011/3.Klein.pdf. Accessed March 8, 2022.
[xxiv] Thom DH, Hall MA, Pawlson LG. Measuring patients' trust in physicians when assessing quality of care. Health Affairs. 2004;23(4):124-132. doi:10.1377/hlthaff.23.4.124
[xxv] Frank JW, Wang EA, Nunez-Smith M, Lee H, Comfort M. Discrimination based on criminal record and healthcare utilization among men recently released from prison: a descriptive study. Health Justice. 2014;2:6. doi:10.1186/2194-7899-2-6
[xxvi] Redmond N, Aminawung JA, Morse DS, Zaller N, Shavit S, Wang EA. Perceived Discrimination Based on Criminal Record in Healthcare Settings and Self-Reported Health Status among Formerly Incarcerated Individuals. J Urban Health. 2020;97(1):105-111. doi:10.1007/s11524-019-00382-0
[xxvii] Turney K, Lee H, Comfort M. Discrimination and Psychological Distress Among Recently Released Male Prisoners. American Journal of Men's Health. November 2013:482-493. doi:10.1177/1557988313484056
[xxviii] Lescure T. Opinion: No patient should have to die in shackles. The Washington Post. October 5, 2021. https://www.washingtonpost.com/opinions/2021/10/05/no-patient-should-have-die-shackles/
[xxix] Replace the 'cold steel' of hospital-bed shackles with the warmth of compassion. STAT. December 4, 2020. https://www.statnews.com/2020/12/04/replace-cold-steel-of-hospital-bed-shackles-with-warmth-of-compassion/
[xxx] Preventing violence against health workers. World Health Organization. https://www.who.int/activities/preventing-violence-against-health-workers. Accessed March 8, 2022.

RELEVANT AMA POLICY

Shackling of Pregnant Women in Labor H-420.957

1. Our AMA supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents:

- An immediate and serious threat of harm to herself, staff or others; or
- A substantial flight risk and cannot be reasonably contained by other means.

If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used."

2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 919
(I-23)

Introduced by: Indiana

Subject: Lithium Battery Safety

Referred to: Reference Committee K

Whereas, more pieces of equipment utilize lithium batteries; and

Whereas, lithium batteries have limited useful lifetime use; and

Whereas, disposal and recycling of lithium batteries is not a well-established system; and

Whereas, improper storage of lithium batteries can lead to fires; and

Whereas, putting out lithium battery fires can be difficult and requires robust resources; and

Whereas, rural communities' fire department coverage resources can be less robust and less able to handle lithium battery fires; and

Whereas, local agencies often are not aware of lithium battery storage in their area; therefore be it

RESOLVED, that our American Medical Association seek legislation to increase environmental and public safety oversight of lithium batteries and businesses that store and dispose of lithium batteries. (Directive to Take Action)

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

Received: 10/4/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 920
(I-23)

Introduced by: Indiana

Subject: Antipsychotic Medication Use for Hospice Patients

Referred to: Reference Committee K

Whereas, antipsychotic medications are associated with increased morbidity and mortality in the geriatric population; and

Whereas, antipsychotic medication use is often prohibited in skilled facilities, so many hospice patients do not experience relief of their distress with the use of medications that are acceptable at nursing facilities; and

Whereas, hospice patients are a unique population that often remain in their current living environment during their end-of-life journey, particularly in patients with dementia who often struggle with behavioral issues; and

Whereas, hospice patients have different goals for their care than other residents of skilled facilities, and one common goal of caring for hospice patients is to allow them to remain in their preferred environment to avoid further distress; and

Whereas, hospice patients develop behaviors that are often difficult to manage in response to their terminal state, but they do respond to anti-psychotic medications; therefore be it

RESOLVED, that our American Medical Association seek legislation or regulatory changes that exempt hospice patients from limitations on the use of antipsychotic medications for behavioral changes. (Directive to Take Action)

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

Received: 10/4/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 921
(I-23)

Introduced by: Women Physicians Section

Subject: Addressing Disparities and Lack of Research for Endometriosis

Referred to: Reference Committee K

Whereas, endometriosis is defined as a medical condition in which endometrial-like tissue from the uterus grows in a location outside of the uterus[1]; and

Whereas, an estimated 11% of women in the United States have endometriosis, though this was noted to be a conservative estimate, as the actual percentage of patients with this condition would likely increase when considering individuals with symptoms below the clinical threshold or a patient population containing of all individuals with uteruses[2]; and

Whereas, endometriosis is the third most common cause of gynecological-related hospitalization and when patient populations are stratified by diagnostic indicators, the incidence of endometriosis were found to be as high as 71.4%[4,3]; and

Whereas, endometriosis is one of the most common reproductive conditions among women compared to 11% of women of reproductive age experience infertility, 5-10% experiencing Polycystic Ovarian Syndrome (PCOS), and 0.7% experiencing cervical cancer[5-7]; and

Whereas, although novel mechanisms contributing to the development of endometriosis have been suggested, there is currently no single, widely accepted etiology for endometriosis[8-10]; and

Whereas, symptoms of endometriosis vary from asymptomatic to severe pelvic pain, and bleeding, many symptoms of endometriosis can have multiple causes, making endometriosis difficult to diagnose[11]; and

Whereas, the most common classification system of endometriosis, the revised American Society of Reproductive Medicine (rASRM) classification system, was created in 1968 and considers endometriosis involvement of the peritoneum, fallopian tubes, ovaries, and cul-de-sac, but has been found to have numerous disadvantages, indicating the need for additional research to improve this system[12,13]; and

Whereas, the length of time for a patient to receive an endometriosis diagnosis appears to have decreased in recent years, a diagnosis of endometriosis typically takes an average of 4-11 years, and the amount of time for diagnosis in Black and Hispanic women is considerably higher [14,15, 31]; and

Whereas, multiple studies have suggested that diet may play an important role in alleviating endometriosis symptoms, however, the studies are limited with small sample sizes, which further points to the growing need for additional endometriosis research and awareness[16-18]; and

Whereas, in the current endometriosis research that does exist, small sample sizes are common, which prevents the creation of evidence-based guidelines for practitioners[16-18]; and

Whereas, endometriosis has been found to have a significant negative impact on the quality of life of those diagnosed, including increased cost of healthcare, higher healthcare resource utilization, and decreased productivity at both home and workplace[19-21]; and

Whereas, black and Hispanic patients are less likely to receive a diagnosis of endometriosis than their White or Asian counterparts, further contributing to a delay in diagnosis and placing a disproportionate healthcare burden on these patients[22]; and

Whereas, the American Journal of Obstetrics and Gynecology has previously noted the prolonged period between presentation of endometriosis symptoms and treatment for or diagnosis of endometriosis, as well as the health disparities this may cause[15]; and

Whereas, a majority of recommendations for practice regarding endometriosis from the American Academy of Family Physicians are based on consensus, expert opinion, and disease-oriented evidence rather than research, indicating the need for additional endometriosis research to improve endometriosis guidelines for physician practice[23]; and

Whereas, the American College of Obstetricians and Gynecologists has multiple practice guidelines based on scientific evidence that outline different combinations of medication and surgical intervention as treatment options for endometriosis, but many are dependent on a prior diagnosis of endometriosis[24]; and

Whereas, the American Society of Reproductive Medicine has multiple fact sheets on endometriosis available for patients, but no practice documents for practitioners specifically dedicated to endometriosis[25]; and

Whereas, it is clear that additional research is needed to understand symptoms, causes, and treatment of endometriosis, however the National Institute of Health (NIH) dedicates only 0.038% of the overall NIH budget to endometriosis research[26]; and

Whereas, endometriosis research continues to remain an extremely underfunded area of women's health research, even after recent legislation increased endometriosis research funding from $13 million to $26 million in 2020[27]; and

Whereas, in 2022, endometriosis, a condition affecting approximately 11% of women, is allocated only $27 million of the $45 billion NIH research budget, while inflammatory bowel disease, a condition affecting 1.3% of all patients, is allocated $195 million dollars for research[28-30]; and

Whereas, current AMA Policy H-525.988 currently supports increased funding for women's health research, but fails to specifically highlight the dire need for endometriosis research and does not take measurable action or advocacy to achieve these increases in research; and

Whereas, endometriosis research continues to remain significantly underfunded since the passage of this H-525.988 and its subsequent modification in 2010, indicating a persistent policy gap and the need for an additional resolution to specifically address this gap for patients with endometriosis; therefore be it

RESOLVED, that our American Medical Association collaborate with stakeholders to recognize endometriosis as an area for health disparities research that continues to remain critically

underfunded, resulting in a lack of evidence-based guidelines for diagnosis and treatment of this condition amongst people of color (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with stakeholders to promote awareness of the negative effects of a delayed diagnosis of endometriosis and the healthcare burden this places on patients, including health disparities among patients from communities of color who have been historically marginalized (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for increased endometriosis research addressing health disparities in the diagnosis, evaluation, and management of endometriosis (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for increased funding allocation to endometriosis-related research for patients of color, especially from federal organizations such as the National Institutes of Health. (Directive to Take Action)

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

Received: 10/5/23

REFERENCES

1. World Health Organization. Endometriosis. www.who.int. Updated March 24, 2023. Accessed August 21, 2023. https://www.who.int/news-room/fact-sheets/detail/endometriosis#:~:text=Overview,period%20and%20last%20until%20menopause
2. Buck Louis GM, Hediger ML, Peterson CM, et al. Incidence of endometriosis by study population and diagnostic method: the ENDO study. Fertil Steril. 2011;96(2):360-365. doi:10.1016/j.fertnstert.2011.05.087
3. Ghiasi M, Kulkarni MT, Missmer SA. Is Endometriosis More Common and More Severe Than It Was 30 Years Ago? Journal of Minimally Invasive Gynecology. 2020 Feb;27(2):452-461. DOI: 10.1016/j.jmig.2019.11.018. PMID: 31816389.
4. Whiteman MK, Kuklina E, Jamieson DJ, Hillis SD, Marchbanks PA. Inpatient hospitalization for gynecologic disorders in the United States. Am J Obstet Gynecol. 2010;202(6):541.e1-541.e5416. doi:10.1016/j.ajog.2009.12.013
5. Eunice Kennedy Shriver National of Institute of Child Health and Human Development. www.nichd.nih.gov. How Common is Infertility? Last reviewed February 8, 2018. Accessed August 21, 2023. https://www.nichd.nih.gov/health/topics/infertility/conditioninfo/common.
6. Yale Medicine. www.yalemedicine.org. Polycystic Ovarian Syndrome. Accessed August 21, 2023. https://www.yalemedicine.org/conditions/polycystic-ovary-syndrome.
7. National Cancer Institute. seer.cancer.gov. Cancer Stat Facts: Cervical Cancer. Accessed August 21, 2023. https://seer.cancer.gov/statfacts/html/cervix.html.
8. Rahmioglu, N., Mortlock, S., Ghiasi, M. et al. The genetic basis of endometriosis and comorbidity with other pain and inflammatory conditions. Nat Genet 55, 423-436 (2023). https://doi.org/10.1038/s41588-023-01323-z.
9. Wessels, J.M., Domínguez, M.A., Leyland, N.A. et al. Endometrial microbiota is more diverse in people with endometriosis than symptomatic controls. Sci Rep 11, 18877 (2021). https://doi.org/10.1038/s41598-021-98380-3.
10. Mayo Clinic. www.mayoclinic.org. Endometriosis. Updated July 24, 2018. Accessed July 21, 2023. https://www.mayoclinic.org/diseases-conditions/endometriosis/symptoms-causes/syc-20354656.
11. Soliman AM, Fuldeore M, Snabes MC. Factors Associated with Time to Endometriosis Diagnosis in the United States. J Womens Health (Larchmt). 2017;26(7):788-797. doi:10.1089/jwh.2016.6003
12. Buttram VC Jr. An expanded classification of endometriosis. Fertil Steril. 1978;30(2):240-242. doi:10.1016/s0015-0282(16)43467-9
13. Haas D, Shebl O, Shamiyeh A, Oppelt P. The rASRM score and the Enzian classification for endometriosis: their strengths and weaknesses. Acta Obstet Gynecol Scand. 2013;92(1):3-7. doi:10.1111/aogs.12026
14. Soliman AM, Fuldeore M, Snabes MC. Factors Associated with Time to Endometriosis Diagnosis in the United States. J Womens Health (Larchmt). 2017;26(7):788-797. doi:10.1089/jwh.2016.6003
15. Agarwal SK, Chapron C, Giudice LC, et al. Clinical diagnosis of endometriosis: a call to action. Am J Obstet Gynecol. 2019;220(4):354.e1-354.e12. doi:10.1016/j.ajog.2018.12.039
16. Barnard ND, Holtz DN, Schmidt N, et al. Nutrition in the prevention and treatment of endometriosis: A review. Front Nutr. 2023;10:1089891. Published 2023 Feb 17. doi:10.3389/fnut.2023.1089891
17. Huijs E, Nap A. The effects of nutrients on symptoms in women with endometriosis: a systematic review. Reprod Biomed Online. 2020;41(2):317-328. doi:10.1016/j.rbmo.2020.04.014
18. Deepak Kumar K, Appleby-Gunnill B, Maslin K. Nutritional practices and dietetic provision in the endometriosis population, with a focus on functional gut symptoms. J Hum Nutr Diet. 2023;36(4):1529-1538. doi:10.1111/jhn.13158
19. Soliman AM, Surrey E, Bonafede M, Nelson JK, Castelli-Haley J. Real-World Evaluation of Direct and Indirect Economic Burden Among Endometriosis Patients in the United States. Adv Ther. 2018;35(3):408-423. doi:10.1007/s12325-018-0667-3

20. Soliman AM, Coyne KS, Gries KS, Castelli-Haley J, Snabes MC, Surrey ES. The Effect of Endometriosis Symptoms on Absenteeism and Presenteeism in the Workplace and at Home. J Manag Care Spec Pharm. 2017;23(7):745-754. doi:10.18553/jmcp.2017.23.7.745
21. Nnoaham KE, Hummelshoj L, Webster P, et al. Impact of endometriosis on quality of life and work productivity: a multicenter study across ten countries. Fertil Steril. 2011;96(2):366-373.e8. doi:10.1016/j.fertnstert.2011.05.090
22. Bougie O, Yap MI, Sikora L, Flaxman T, Singh S. Influence of race/ethnicity on prevalence and presentation of endometriosis: a systematic review and meta-analysis. BJOG. 2019;126(9):1104-1115. doi:10.1111/1471-0528.15692
23. Edi R, Cheng T. Endometriosis: Evaluation and Treatment. Am Fam Physician. 2022;106(4):397-404.
24. Practice bulletin no. 114: management of endometriosis. Obstet Gynecol. 2010;116(1):223-236. doi:10.1097/AOG.0b013e3181e8b073
25. American Society for Reproductive Medicine. Current Evaluation of Amenorrhea (2008). www.asrm.org. Accessed August 21, 2023. https://www.asrm.org/practice-guidance/practice-committee-documents/current-evaluation-of-amenorrhea/?_t_id=oWb-jHJn0ZwBsy2AG8yHnQ==&_t_uuid=s9ahrpCHSdKlktZPwCK6qA&_t_q=endometriosis&_t_tags=siteid:01216f06-3dc9-4ac9-96da-555740dd020c,language:en,andquerymatch&_t_hit.id=ASRM_Models_Pages_ContentPage/_dad965ac-78ec-4d64-8848-1b3c2584d9ae_en&_t_hit.pos=1
26. Ellis K, Munro D, Clarke J. Endometriosis Is Undervalued: A Call to Action. Front Glob Womens Health. 2022 May 10;3:902371. doi: 10.3389/fgwh.2022.902371. PMID: 35620300; PMCID: PMC9127440.
27. Endometriosis Foundation of America. U.S. House Approves Doubling Funding for Endometriosis Research to $26 Million Annually. www.endofund.org. Posted July 31, 2020. Accessed August 21, 2023. https://www.endofound.org/u.s.-house-approves-doubling-funding-for-endometriosis-research-to-26-million-annually
28. Centers for Disease Control and Prevention. Prevalence of IBD. www.cdc.gov. Reviewed April 14, 2022. Accessed August 21, 2023. https://www.cdc.gov/ibd/data-and-statistics/prevalence.html
29. NIH Report. Estimates of Funding for Various Research, Condition, and Disease Categories (RCDC). report.nih.gov. Published March 31, 2023. Accessed August 21, 2023. https://report.nih.gov/funding/categorical-spending#/
30. National Institutes of Health. Budget. www.nih.gov. Reviewed August 1, 2023. Accessed August 21, 2023. https://www.nih.gov/about-nih/what-we-do/budget
31. American Journal of Managed Care. Racial Disparities Associated With Endometriosis Diagnosis. Accessed September 20, 2023. https://www.ajmc.com/view/racial-disparities-associated-with-endometriosis-diagnosis

RELEVANT AMA POLICY

Sex and Gender Differences in Medical Research H-525.988
Our AMA:
(1) reaffirms that gender exclusion in broad medical studies questions the validity of the studies' impact on the health care of society at large;
(2) affirms the need to include all genders in studies that involve the health of society at large and publicize its policies;
(3) supports increased funding into areas of women's health and sexual and gender minority health research;
(4) supports increased research on women's health and sexual and gender minority health and the participation of women and sexual and gender minorities in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women and sexual and gender minorities from diverse cultural and ethnic groups, geographic locations, and socioeconomic status;
(5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based and gender-based analysis of data, even if such comparisons are negative; and
(6) recommends that medical and scientific journals diversify their review processes to better represent women and sexual and gender minorities. [Res. 80, A-91; Appended: CSA Rep. 4, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 05, A-16; Modified: Res. 004, A-23]

An Expanded Definition of Women's Health H-525.976
Our AMA recognizes the term "women's health" as inclusive of all health conditions for which there is evidence that women's risks, presentations, and/or responses to treatments are different from those of men, and encourages that evidence-based information regarding the impact of sex and gender be incorporated into medical practice, research, and training. [CSAPH Rep. 05, A-16]

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The

elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations. [CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21]

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities. [BOT Rep. 4, A-03; Reaffirmation A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19]

8.5 Disparities in Health Care
Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices physicians should:

(a) Provide care that meets patient needs and respects patient preferences.

(b) Avoid stereotyping patients.
(c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
(e) Encourage shared decision making.
(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

(g) Help increase awareness of health care disparities.
(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

AMA Principles of Medical Ethics: I,IV,VII,VIII,IX

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law. [Issued: 2016]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 922
(I-23)

Introduced by: American Association of Neurological Surgeons, Congress of Neurological Surgeons, California

Subject: Prescription Drug Shortages and Pharmacy Inventories

Referred to: Reference Committee K

Whereas, opioid and other drug shortages have become common; and

Whereas, physicians cannot know or predict inventories at any given pharmacy; and

Whereas, physicians are often asked to write new prescriptions to allow medications to be filled at an alternate pharmacy; and

Whereas, requests for new prescriptions often come days later when the original prescriber may not be available; and

Whereas, many states no longer accept paper prescriptions, which allowed prescriptions to be presented to more than one pharmacy when necessary; and

Whereas, requiring a new prescription can delay the availability of critical medications or critical prescription medications; therefore be it

RESOLVED, that our American Medical Association work with the pharmacy industry to develop and implement a mechanism to transfer prescriptions without requiring a new prescription (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for legislation and/or regulations permitting pharmacies to transfer prescriptions to other pharmacies when prescription medications are unavailable at the original pharmacy or the patient requests the prescription be transferred. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 10/11/23

RELEVANT AMA POLICY

Access to Medication H-120.920
Our AMA will advocate against pharmacy practices that interfere with patient access to medications by refusing or discouraging legitimate requests to transfer prescriptions to a new pharmacy, to include transfer of prescriptions from mail-order to local retail pharmacies.

Legalization of Interpharmacy Transfer of Electronic Controlled Substance Prescriptions H-120.923
Our AMA will advocate for the removal of state, federal and other barriers that impede interpharmacy transfers of valid electronic prescriptions for Schedule II-V medications.

Resolutions not for consideration

Resolutions

001 Physician-Patient Communications in the Digital Era
003 Guardianship and Conservatorship Reform
008 AMA Executive Vice President
209 Opposing Pay-to-Stay Incarceration Fees
211 Indian Water Rights
212 Medical-Legal Partnerships & Legal Aid Services
214 Humanitarian Efforts to Resettle Refugees
221 Support for Physicians Pursuing Collective Bargaining and Unionization
303 Fairness for International Medical Students
602 Inclusive Language for Immigrants in Relevant Past and Future AMA Policies
603 Improving the Efficiency of the House of Delegates Resolution Process
604 Updating Language Regarding Families and Pregnant Persons
605 Ranked Choice Voting
607 Equity-Focused Person-First Language in AMA Reports and Policies
810 Racial Misclassification
816 Reducing Barriers to Gender-Affirming Care through Improved Payment and Reimbursement
907 Occupational Screenings for Lung Disease
908 Sexuality and Reproductive Health Education
911 Support for Research on the Nutritional and Other Impacts of Plant-Based Meat
912 Fragrance Regulation

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(I-23)

Introduced by: American College of Cardiology, American Society of Echocardiography, American Society of Nuclear Cardiology, Heart Rhythm Society, Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Computed Tomography, Society for Cardiovascular Magnetic Resonance

Subject: Physician-Patient Communications in the Digital Era

Referred to: Reference Committee on Amendments to Constitution and Bylaws

---

Whereas, rapid advances in digital health care and information technology have compounded communication gaps already stressing our overloaded health care workforce; and

Whereas, physicians communicate results of tests, evaluate clinical progress, and answer individual patient's queries, often after usual business hours, utilizing the digital messaging capabilities of the electronic medical record; and

Whereas, physicians also evaluate electronically transmitted data and interact with other health care providers via the electronic medical record outside the time allotted for a traditional office visit; and

Whereas, several large U.S. health systems including the Mayo Clinic, the Cleveland Clinic, Northwestern Medicine, the University of California at San Francisco, the Ohio State University, Johns Hopkins Medicine, and others have started billing in the range of $50-160 for certain online messaging between doctors and their patients; and

Whereas, under some circumstances, these charges may be covered by Medicare and private insurance as general standard of care; and

Whereas, Medicare defines a billable exchange as a series of messages that requires at least five minutes of a clinician's time over seven days; and

Whereas, the federal Hospital Price Transparency Rule,1 which took effect on January 1, 2021, requires hospitals to post all prices online, easily accessible and searchable, in the form of (1) a single machine-readable standard charges file pricing for all items, services, and drugs by all payers and all plans, the de-identified minimum and maximum negotiated rates, and all discounted cash prices, as well as (2) prices for the 300 most common shoppable services either as a consumer friendly standard charges display listing actual prices or, alternatively, as a price estimator tool; and

Whereas, low-income patients may be less likely than high-income patients to have access to digital technology and to be able to afford these additional fees; and

Whereas, separate charges for communicating medical results and recommendations electronically to select patients could be considered a form of retainer or concierge medicine, raising ethical issues; and

Whereas, clinicians are already stressed by heavy workloads and need time-efficient, compensated alternatives to traditional in-person or real time video patient encounters; and

Whereas, requirements for documentation under the current fee-for-service payment system may be an obstacle to appropriate, efficient, desirable digital interaction between physicians and their patients; therefore be it

RESOLVED, that our American Medical Association conduct a comprehensive study defining the appropriate role of digital interaction between patients and their doctors, including models for compensation. (Directive to Take Action)

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

Received: 9/25/23

REFERENCES

1. CEJA Report 3-A-03 AMA Principles of Medical Ethics: I, II VI, VIII, IX

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(I-23)

Introduced by: Medical Student Section

Subject: Guardianship and Conservatorship Reform

Referred to: Reference Committee on Amendments to Constitution and Bylaws

---

Whereas, 1.3 million people (including their $50 billion in assets) are in court-appointed guardianships or conservatorships, the vast majority of which are permanent guardianships, the most restrictive form and the most difficult and expensive to amend[1]; and

Whereas, due to wide state variation, data on guardian abuse is limited, but reports indicate hundreds of cases of physical and financial abuse[1-4;] and

Whereas, a Senate Committee on Aging report noted the harm of our guardianship system on older and disabled patients, and emphasized the need for less restrictive alternatives[1]; and

Whereas, the elderly American population is projected to nearly double by 2060 and comprise over 20% of the total population[1,5-6]; and

Whereas, physicians play a major role in determining guardianships by providing medical evidence and expertise[7]; and

Whereas, individuals with intellectual and developmental disabilities (IDD) face barriers to adequate capacity determinations that increase their risk of overly restrictive guardianships[8]; and

Whereas, supported decision making (SDM) is a less restrictive alternative to guardianships already adopted by 12 states and several other countries that demonstrates preservation of decision-making capacity, cognitive function, and social support[9-11]; therefore be it

RESOLVED, that our American Medical Association support federal and state efforts to collect anonymized data on guardianships and conservatorships to assess the effects on medical decision making and rates of abuse (New HOD Policy); and be it further

RESOLVED, that our AMA study the impact of less restrictive alternatives to guardianships and conservatorships including supported decision making on medical decision making, health outcomes, and quality of life. (Directive to Take Action)

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

Received: 09/19/2023

REFERENCES

1. Senate Aging Committee Examines Ways to Strengthen Guardianship Programs. US Senate Committee on Aging. https://www.aging.senate.gov/press-releases/senate-aging-committee-examines-ways-to-strengthen-guardianship-programs. Published November 28, 2018. Accessed August 24, 2021.

2. Elder Abuse: The Extent of Abuse by Guardians is Unknown, but Some Measures Exist to Help Protect Older Adults. United States Government Accountability Office. November 2016, https://www.gao.gov/assets/690/681088.pdf.
3. Margaret "Jenny" Hatch, Samantha Alexandra Crane, Jonathan G. Martinis; Unjustified Isolation Is Discrimination: The *Olmstead* Case Against Overbroad and Undue Organizational and Public Guardianship. *Inclusion* 1 June 2015; 3 (2): 65–74. doi: https://doi.org/10.1352/2326-6988-3.2.65
4. Andreasian, Karen et al. Revisiting S.C.P.A. 17-A: Guardianship for people with Intellectual and Developmental Disabilities, CUNY Law review 18, no. 287 (2015): 335.
5. Projected Future Growth of Older Population. Administration for Community Living. https://acl.gov/aging-and-disability-in-america/data-and-research/projected-future-growth-older-population#:~:text=In%202019%2C%20there%20were%2054.1,and%2094.7%20million%20by%202060. Published May 4, 2022. Accessed August 29, 2023.
6. Teasdale B, Daigle LE, Gann T. The contingent effect of guardianship on victimization: An examination of people with and without mental health problems. *J Interpers Violence.* 2021;36(11-12):5186-5208. https://pubmed.ncbi.nlm.nih.gov/30303026. Accessed August 24, 2021.
7. Representation and Investigation in Guardianship Proceedings. American Bar Association Commission on Law and Aging, 2021. https://www.americanbar.org/content/dam/aba/administrative/law_aging/chartrepresentationandinvestigation.authcheckdam.pdf
8. Turning Rights Into Reality: How Guardianship and Alternatives Impact the Autonomy of People With Intellectual and Developmental Disabilities. National Council on Disability, 10 June 2019. https://ncd.gov/sites/default/files/NCD_Turning-Rights-into-Reality_508_0.pdf
9. Kristin, Glen B. Supported Decision-Making and the Human Right of Legal Capacity. *Inclusion* 1 March 2015; 3 (1): 2–16. doi: https://doi.org/10.1352/2326-6988-3.1.2
10. Peterson, Andrew et al. "Supported Decision Making With People at the Margins of Autonomy." *The American journal of bioethics : AJOB* vol. 21,11 (2021): 4-18. doi:10.1080/15265161.2020.1863507
11. National Resource Center for Supported Decision-Making, In Your State, accessed March 10, 2022. http://www.supporteddecisionmaking.org/states

RELEVANT AMA POLICY

H-140.845 Encouraging the Use of Advance Directives and Health Care Powers of Attorney
Our AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives. [CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 9, I-15; Reaffirmed: Res. 517, A-16; Reaffirmed: BOT Rep. 05, I-16; Reaffirmed in lieu of: Res. 121, A-17]

Code of Medical Ethics Opinion 2.1.2 Decisions for Adult Patients Who Lack Capacity
Respect for patient autonomy is central to professional ethics and physicians should involve patients in health care decisions commensurate with the patient's decision-making capacity. Even when a medical condition or disorder impairs a patient's decision-making capacity, the patient may still be able to participate in some aspects of decision making. Physicians should engage patients whose capacity is

impaired in decisions involving their own care to the greatest extent possible, including when the patient has previously designated a surrogate to make decisions on his or her behalf.
When a patient lacks decision-making capacity, the physician has an ethical responsibility to:
(a) Identify an appropriate surrogate to make decisions on the patient's behalf:
(i) the person the patient designated as surrogate through a durable power of attorney for health care or other mechanism; or
(ii) a family member or other intimate associate, in keeping with applicable law and policy if the patient has not previously designated a surrogate.
(b) Recognize that the patient's surrogate is entitled to the same respect as the patient.
(c) Provide advice, guidance, and support to the surrogate.
(d) Assist the surrogate to make decisions in keeping with the standard of substituted judgment, basing decisions on:
(i) the patient's preferences (if any) as expressed in an advance directive or as documented in the medical record;
(ii) the patient's views about life and how it should be lived;
(iii) how the patient constructed his or her life story; and
(iv) the patient's attitudes toward sickness, suffering, and certain medical procedures.
(e) Assist the surrogate to make decisions in keeping with the best interest standard when the patient's preferences and values are not known and cannot reasonably be inferred, such as when the patient has not previously expressed preferences or has never had decision-making capacity. Best interest decisions should be based on:
(i) the pain and suffering associated with the intervention;
(ii) the degree of and potential for benefit;
(iii) impairments that may result from the intervention;
(iv) quality of life as experienced by the patient.
(f) Consult an ethics committee or other institutional resource when:
(i) no surrogate is available or there is ongoing disagreement about who is the appropriate surrogate;
(ii) ongoing disagreement about a treatment decision cannot be resolved; or
(iii) the physician judges that the surrogate's decision:
a. is clearly not what the patient would have decided when the patient's preferences are known or can be inferred;
b. could not reasonably be judged to be in the patient's best interest; or
c. primarily serves the interests of the surrogate or other third party rather than the patient.
AMA Principles of Medical Ethics: I,III,VIII*;* Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(I-23)

Introduced by: California, Montana, Washington

Subject: AMA Executive Vice President

Referred to: Reference Committee on Amendments to Constitution and Bylaws

---

Whereas, our American Medical Association is the most powerful voice for physicians in the nation; and

Whereas, the Executive Vice President (EVP) of the AMA is thus a position of extreme importance to the physician community; and

Whereas, the tradition of our AMA has been to have a physician EVP; and

Whereas, our AMA should select the most qualified physician leader possible for the EVP position; and

Whereas, at any given time that best physician leader may be serving or have recently served in the AMA physician leadership; and

Whereas, physician leaders who are serving or recently served in AMA leadership are sometimes the most knowledgeable and experienced in addressing the current issues facing the House of Medicine; and

Whereas, many physician leaders serving in the AMA would be extremely qualified candidates for the AMA EVP based on their AMA leadership experience and their own medical practice and medical administration leadership experiences; and

Whereas, physicians who may be serving or have recently served in the AMA physician leadership as an officer or trustee are currently ineligible for consideration for the AMA EVP position under AMA Code Section B-5.3.6.4 until three years after their AMA service; and

Whereas, no comparable physician or health care organization has such a strict limitation on who can be considered for their EVP position; therefore be it

RESOLVED, that our American Medical Association delete the AMA Board of Trustees Duties and Privileges Code B-5.3.6.4: ~~No individual who has served as an AMA officer or trustee shall be selected or serve as Executive Vice President until three years following completion of the term of the AMA office.”~~ (Modify Bylaws)

Fiscal Note: Minimal - less than $1,000

Received: 9/27/23

RELEVANT AMA POLICY

Board of Trustees
Duties and Privileges. B-5.3
In addition to the rights and duties conferred or imposed upon the Board of Trustees by law and custom and elsewhere in the Constitution and Bylaws, the Board of Trustees shall:
5.3.1 Management. Manage or direct the management of the property and conduct the affairs, work and activities of the AMA consistent with the policy actions and directives adopted by the House of Delegates, except as may be otherwise provided in the Constitution or these Bylaws.
5.3.1.1 The Board is the principal governing body of the AMA and it exercises broad oversight and guidance for the AMA with respect to the management systems and risk management program of the AMA through its oversight of the AMA's Executive Vice President.
5.3.1.2 Board of Trustee actions should be based on policies and directives approved by the House of Delegates. In the absence of specifically applicable House policies or directives and to the extent feasible, the Board shall determine AMA positions based on the tenor of past policy and other actions that may be related in subject matter.
5.3.2 Planning. Serve as the principal planning agent for the AMA.
5.3.2.1 Planning focuses on the AMA's goals and objectives and involves decision-making over allocation of resources and strategy development. Planning is a collaborative process involving all of the AMA's Councils, Sections, and other appropriate AMA components.
5.3.2.2 The House of Delegates and the Council on Long Range Planning and Development have key roles in identifying and making recommendations to the Board regarding important strategic issues and directions related to the AMA's vision, goals, and priorities.
5.3.3 Fulfillment of House of Delegates Charge. Review all resolutions and recommendations adopted by the House of Delegates to determine how to fulfill the charge from the House. Resolutions and recommendations pertaining to the expenditure of funds also shall be reviewed. If it is decided that the expenditure is inadvisable, the Board shall report, at its earliest convenience, to the House the reasons for its decisions.
5.3.3.1 In determining expenditure advisability, the Board will consider the scope of the proposed expenditure and whether it is consistent with the AMA's vision, goals, and priorities. Where the Board recommends that a proposed expenditure is not prudent and is inadvisable,
the Board will present alternative actions, if feasible, in its report to the House.
5.3.4 Publication. Within the policies adopted by the House of Delegates, provide for the publication of The Journal of the American Medical Association and such specialty journals, periodicals, and other publications and electronic media information as it may deem to be desirable in the best interests of the public and the medical profession.
5.3.5 Election of Secretary. Select a Secretary from one of its members annually.
5.3.6 Selection of Executive Vice President. Select and evaluate an Executive Vice President.
5.3.6.1 The Executive Vice President is the chief executive officer of the AMA and as such is responsible for AMA management and performance in accordance with the vision, goals, and priorities of the AMA. The Executive Vice President is both a key leader for the organization and the bridge between AMA management and the Board of Trustees.
5.3.6.2 The Executive Vice President shall manage and direct the day-to-day duties of the AMA, including advocacy activities, and perform the duties commonly required of the chief executive officer of a corporation.
5.3.6.3 The Executive Vice President shall ensure that there is an active and effective risk management program.5.3.6.4 No individual who has served as an AMA Officer or Trustee shall be selected or serve as Executive Vice President until 3 years following completion of the term of the AMA office.
5.3.7 Finances. Maintain the financial health of the AMA. The Board shall:
5.3.7.1 Oversee the development and approve the annual budget for the AMA, consistent with the AMA's vision, goals, and priorities.
5.3.7.2 Ensure that the AMA's resource allocations are aligned with the AMA's plan and budget.
5.3.7.3 Evaluate membership dues levels and make related recommendations to the House of Delegates.
5.3.7.4 Review and approve financial and business decisions that significantly affect the AMA's revenues and expenses.
5.3.7.5 Have the accounts of the AMA audited at least annually.
5.3.8 Financial Reporting. Make proper financial reports concerning AMA affairs to the House of Delegates at its Annual Meeting.

5.3.9 Appointment of Committees. Appoint such committees as necessary to carry out the purposes of the AMA.
5.3.9.1 An advisory committee will be constituted for purposes of education and advocacy.
5.3.9.1.1 It will have a governing council and a direct reporting relationship to the Board.
5.3.9.1.2 An advisory committee will not have representation in the House of Delegates.
5.3.9.1.3 An advisory committee will operate under a charter that will be subject to review and renewal by the Board at least every four years.
5.3.9.2 An ad hoc committee will be constituted as a special committee, workgroup or taskforce.
5.3.9.2.1 It will operate for a specific purpose and for a prescribed period of time.
5.3.10 Committee Vacancies. Fill vacancies in any committee where such authority is not delegated elsewhere by these Bylaws.
5.3.11 Litigation. Initiate, defend, settle, or otherwise dispose of litigation involving the interests of the AMA.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(I-23)

Introduced by: Medical Student Section

Subject: Opposing Pay-to-Stay Incarceration Fees

Referred to: Reference Committee B

Whereas, "pay-to-stay" fees require individuals to pay for their own imprisonment to cover housing and food costs and are used in 49 states, including $249 daily in Connecticut, $80 daily in Maine and Kentucky, $66 daily in Ohio, and $20 daily in Alabama[1-5]; and

Whereas, average hourly wages during incarceration are $0.13 to $1.30 per hour, and in the first year after release, 49% earn $500 or less and 80% earn less than $15,000[6-7]; and

Whereas, because only 10-15% are ever collected, pay-to-stay fees do not significantly contribute to prison budgets, but permanently damage the credit records of individuals leaving incarceration if not paid within 180 days after release andharm future prospects for stable employment and housing[5,8,9]; and

Whereas, pay-to-stay fees keep formerly incarcerated individuals trapped in a cycle of poverty and imprisonment, as debts hinder re-entry, contribute to recidivism, and force individuals to forgo basic necessities in order to make payments[10-12]; and

RESOLVED, that our American Medical Association collaborate with relevant parties, oppose fees charged to incarcerated individuals for room and board, and advocate for federal and state efforts to repeal statutes and ordinances which permit inmates to be charged for room and board. (Directive to Take Action)

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

Received: 09/27/2023

REFERENCES

1. Friedman B. Unveiling the Necrocapitalist Dimensions of the Shadow Carceral State: On Pay-to-Stay to Recoup the Cost of Incarceration. Journal of Contemporary Criminal Justice. 2021 Feb.; 37(1):66-87.
2. Fernandes, A. et al. The “Damaged” State vs. the “Willful” Nonpayer: Pay-to-Stay and the Social Construction of Damage, Harm, and Moral Responsibility in a Rent-Seeking Society. The Russell Sage Foundation Journal of the Social Sciences. 2022 Jan.; 8(1) 82-105.
3. Teresa Beatty and Michael Llorens v Ned Lamont and William Tong. 3:22-cv-00380 (2022).
4. Is Charging Inmates to Stay in Prison Smart Policy? Brennan Center for Justice. September 9, 2019.
5. Link, C. et al. In Jail & In Debt: Ohio’s Pay-to-Stay Fees. American Civil Liberties Union of Ohio. Fall 2015.
6. Captive Labor: Exploitation of Incarcerated Workers. American Civil Liberties Union and Global Human Rights Clinic. June 15, 2022.
7. Haight, K. Paying for the Privilege of Punishment: Reinterpreting Excessive Fines Clause Doctrine to Allow State Prisoners to Seek Relief from Pay-to-Stay Fees. William & Mary Law Review. 2020; 62(1):287.
8. Lehr, S. The Vast Majority of States Allow People to be Charged for Time Behind Bars. National Public Radio. March 4, 2022.
9. Fines, Fees, and Bail: Payments in the Criminal Justice System that Disproportionately Impact the Poor. Council of Economic Advisers. December 2015.

10. Ortiz, J. M., & Jackey, H. (2019). The System Is Not Broken, It Is Intentional: The Prisoner Reentry Industry as Deliberate Structural Violence. The Prison Journal. 2019; 99(4): 484–503.
11. Link, N. Is There a Link Between Criminal Debt and Recidivism in Reentry?. Federal Sentencing Reporter 2022; 34(2-3):188–192.
12. Harper A, Ginapp C, Bardelli T, Grimshaw A, Justen M, Mohamedali A, Thomas I, Puglisi L. Debt, Incarceration, and Re-entry: a Scoping Review. American Journal of Criminal Justice. 2021; 46(2):250-278.

RELEVANT AMA POLICY

D-430.992 Reducing the Burden of Incarceration on Public Health

1. Our AMA will support efforts to reduce the negative health impacts of incarceration, such as: (1) implementation and incentivization of adequate funding and resources towards indigent defense systems; (2) implementation of practices that promote access to stable employment and laws that ensure employment non-discrimination for workers with previous non-felony criminal records; and (3) housing support for formerly incarcerated people, including programs that facilitate access to immediate housing after release from carceral settings.
2. Our AMA will partner with public health organizations and other interested stakeholders to urge Congress, the Department of Justice, the Department of Health and Human Services, and state officials and agencies to minimize the negative health effects of incarceration by supporting programs that facilitate employment at a living wage, and safe, affordable housing opportunities for formerly incarcerated individuals, as well as research into alternatives to incarceration. [Res. 902, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(I-23)

Introduced by: Medical Student Section

Subject: Indian Water Rights

Referred to: Reference Committee B

Whereas, the United States is a signatory of the 2007 United Nations Declaration on the Rights of Indigenous People (UNDRIP), which states that Indigenous Peoples "have the right to own, use, develop, and control the lands, territories and resources that they possess by reason of traditional ownership or other traditional occupation or use, as well as those which they have otherwise acquired"[1]; and

Whereas, nearly half of American Indian/Alaska Native (AI/AN) households on reservations lack access to clean water or adequate sanitation, including 6.5% of American Indian households on and off reservations and 13.5% of Alaska Native villages and reservations (compared to under 1% of the general US population)[2-6]; and

Whereas, regardless of income, AI/AN households are 10 times as likely as white households to lack indoor plumbing, an early correlate of high COVID rates on reservations[2,7]; and

Whereas, only 42 AI/AN Tribes and Villages meet Environmental Protection Agency (EPA) standards for water quality[8]; and

Whereas, a third of Navajo Nation residents lack access to clean water and are 67 times more likely than other Americans to live without running water or toilets, due in part to drought and heavy metals, such as uranium, leached from abandoned mining sites[9-11]; and

Whereas, unsafe groundwater resources on the Navajo Nation and other Tribal lands, lead to higher rates of cancer, kidney disease, autoimmune disorders, skin infection, diabetes, and infant hospitalizations for pneumonia[12-14]; and

Whereas, water systems are part of Indigenous ways of knowing and ceremonies in many Indigenous cultures, thus water insecurity impacts physical, cultural, and spiritual wellbeing in AI/AN communities, with loss of culture itself a risk factor for many chronic conditions among AI/AN individuals[13-17]; and

Whereas, individuals without adequate water sources require vehicles, sleds, or wheelbarrows to travel miles to wells and water stations and haul water back to their homes[18]; and

Whereas, Navajo Nation families spend $43,000 per acre-foot of water with hauled water, compared to $600 for the average American with running water[16]; and

Whereas, Winters v US (1908) ruled that Tribes and their members have a right to sufficient water access for residential, economic, governmental, and other needs[19-20]; and

Whereas, lengthy disputes over Indian water rights to settle claims of water rights holders and improve water management in AI/AN communities are expensive to litigate[21]; and

Whereas, Congress must approve all Indian water right settlements between Tribes, states, and the US, delaying implementation, funds, and land transfers for years[22-24]; and

Whereas, the Biden-Harris Administration is coordinating federal agencies to meet Tribal water needs, support Indian water right settlements, and increase Tribal participation in stewardship of federal lands and water systems of significance to Tribal Nations[25]; and

Whereas, the Indian Health Service (IHS) investigates and manages environmental health services on Tribal lands, including the provision of health services[26]; and

Whereas, the IHS provides environmental engineering and sanitation facilities to AI/AN communities, including the cooperative development and construction of safe water sources, wastewater management, and solid waste systems[27-28]; and

Whereas, Indian water rights settlements harm access to health care, considering the year long closure of a newly constructed hospital on the Navajo Nation due to inadequate access to on-site water[29]; and

Whereas, for every $1 spent on water and sewage infrastructure, the IHS could save $1.23 in healthcare costs from diseases related to unsafe water[30]; therefore be it

RESOLVED, that our American Medical Association will: (1) raise awareness about ongoing water rights issues for federally-recognized American Indian and Alaska Native Tribes and Villages in appropriate forums and (2) support improving access to water and adequate sanitation, water treatment, and environmental support and health services on American Indian and Alaska Native trust lands. (New HOD Policy)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 09/27/2023

REFERENCES

1. United Nations Declaration on the Rights of Indigenous Peoples. United Nations. Published online September 13, 2007. https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html#:~:text=The%20United%20Nations%20Declaration%20on,%2C%20Bangladesh%2C%20Bhutan%2C%20Burundi%2C
2. Tanana H. Universal Access to Clean Water for Tribes in the Colorado River Basin. Water and Tribes Initiative. Published online April 2021. https://www.naturalresourcespolicy.org/docs/water-tribes/wti-full-report-4.21.pdf
3. Whitt R. Turning the tide: addressing water rights in Indigenous communities. University of New Mexico Newsroom. Published online November 24, 2020. http://news.unm.edu/news/turning-the-tide-addressing-water-rights-in-indigenous-communities
4. Alaska Native Tribal Health Consortium. In rural Alaska, access to water is preventive medicine. Anchorage Daily News. Published online September 15, 2020. https://www.adn.com/sponsored-content/2020/09/15/in-rural-alaska-access-to-water-is-preventative-medicine/
5. Mattos K. Water Infrastructure Brief. Alaska Native Tribal Consortium. Published online August 2020. https://anthc.org/wp-content/uploads/2021/04/Washeteria-Technical-Brief.pdf
6. Creating The Healthiest Nation: Water and Health Equity. American Public Health Association. Published online 2022. https://www.apha.org/-/media/Files/PDF/factsheets/WaterHealthEquity_Factsheet2022_FinalVersion.ashx
7. Rodriguez-Lonebear D, Barcelo N, Akee R, Carroll S. American Indian Reservations and COVID-19: Correlates of Early Infection Rates in the Pandemic. https://journals.lww.com/jphmp/fulltext/2020/07000/american_indian_reservations_and_covid_19_.14.aspx
8. FY 2017 Indian Country Budget Request. National Congress of American Indians. Published online 2017. https://www.ncai.org/resources/ncai-publications/13_FY2017_environmental_protection.pdf
9. Dig Deep. The Navajo Water Project. https://www.navajowaterproject.org/project-specifics

10. Barney Y. Providing Safe Drinking Water in Areas with Abandoned Uranium Mines. Environmental Protection Agency. Published June 21, 2022. https://www.epa.gov/navajo-nation-uranium-cleanup/providing-safe-drinking-water-areas-abandoned-uranium-mines
11. Ingram JC, Jones L, Credo J, Rock T. Uranium and arsenic unregulated water issues on Navajo lands. J Vac Sci Technol A. 2020 May;38(3):031003. doi: 10.1116/1.5142283. Epub 2020 Mar 20. PMID: 32226218; PMCID: PMC7083651.
12. Thomas T, Heavener M. Extreme water conservation in Alaska: limitations in access to water and consequences to health. Public Health. Published online February 16, 2016. https://pubmed.ncbi.nlm.nih.gov/27395332/
13. Our Relationship to Water and Experience of Water Insecurity among Apsáalooke (Crow Indian) People, Montana. Int J Environ Res Public Health. Published online January 12, 2021. https://www.mdpi.com/1660-4601/18/2/582
14. Erdei E, Shuey C, Pacheco B, Cajero M, Lewis J, Rubin RL. Elevated autoimmunity in residents living near abandoned uranium mine sites on the Navajo Nation. J Autoimmun. 2019 May;99:15-23. doi: 10.1016/j.jaut.2019.01.006. Epub 2019 Mar 14. PMID: 30878168; PMCID: PMC6489502.
15. Larned S. Water is Life: The Native American Tribal Role in Protecting Natural Resources. Barry University Environmental and Earth Law Journal. 2018;8(1). https://lawpublications.barry.edu/cgi/viewcontent.cgi?article=1072&context=ejejj
16. Tanana H, Combs J, Hoss A. Water Is Life: Law, Systemic Racism, and Water Security in Indian Country. Health Security. 2021;19. https://www.liebertpub.com/doi/10.1089/hs.2021.0034
17. Ahmed N, Jouk N. Cultural Competence In Caring For American Indians and Alaska Natives. Stat Pearls. Published online May 8, 2022. https://www.ncbi.nlm.nih.gov/books/NBK570619
18. Solomon, Starks, Attacki, Molina, Cordova-Marks. The Generational Impact Of Racism On Health: Voices From American Indian Communities. Health Affairs. 2022;41. https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01419
19. U.S. Reports: Winters v. United States, 207 U.S. 564 (1908). https://www.loc.gov/item/usrep207564/
20. Federal Reserved Water Rights and State Law Claims. The United States Department of Justice. Published online January 3, 2022. https://www.justice.gov/enrd/federal-reserved-water-rights-and-state-law-claims#:~:text=Reserved%20Water%20Rights%20and%20the%20Supreme%20Court&text=There%2C%20the%20United%20States%20Supreme,the%20date%20of%20the%20reservation
21. Groundwater and Streamflow Information Program. Indian Water Rights Settlements. US Geological Survey. Published online 2023. https://www.usgs.gov/programs/groundwater-and-streamflow-information-program/indian-water-rights-settlements
22. S. 306. Tule River Tribe Reserved Water Rights Settlement Act of 2023. US Senate. February 7, 2023. https://www.congress.gov/bill/118th-congress/senate-bill/306/text?s=2&r=1&q=%7B%22search%22%3A%5B%22water+rights%22%5D%7D
23. S. 4104. Hualapai Tribe Water Rights Settlement Act of 2022. US Senate. April, 28, 2022. https://www.congress.gov/bill/117th-congress/senate-bill/4104?q=%7B%22search%22%3A%5B%22water+rights%22%5D%7D&s=3&r=5
24. S. 4898. Pueblos of Acoma and Laguna Water Rights Settlement Act of 2022. US Senate. September 20, 2022. https://www.congress.gov/bill/117th-congress/senate-bill/4898?q=%7B%22search%22%3A%5B%22water+rights%22%5D%7D&s=4&r=8
25. Biden-Harris Administration Announces New Actions to Support Indian Country and Native Communities Ahead of the Administration's Second Tribal Nations Summit. The White House. Published online November 30, 2022. https://www.whitehouse.gov/briefing-room/statements-releases/2022/11/30/fact-sheet-biden-harris-administration-announces-new-actions-to-support-indian-country-and-native-communities-ahead-of-the-administrations-second-tribal-nations-summit/#:~:text=President%20Biden%20has%20recognized%20the,of%20significance%20to%20Tribal%20communities
26. IHS Profile. Indian Health Service. Published online August 2020. https://www.ihs.gov/newsroom/factsheets/ihsprofile
27. Division of Sanitation Facilities Construction. Indian Health Service. https://www.ihs.gov/dsfc
28. FY 2022 Annual Report of Sanitation Deficiency Levels. Indian Health Service. Published online 2022. https://www.ihs.gov/sites/dsfc/themes/responsive2017/display_objects/documents/FY_2022_Appendix_Project_Listing.pdf
29. Smith AV, Olalde M, Farooq U. How Arizona squeezes tribes for water. High Country News. June 14, 2023. Accessed September 2, 2023. https://www.hcn.org/issues/55.7/indigenous-affairs-colorado-river-how-arizona-stands-between-tribes-and-their-water-squeezed#:~:text=For%20the%20people%20of%20the,so%20the%20hospital%20sits%20empty.
30. IHS Allocates $700 Million From President Biden's Bipartisan Infrastructure Law to Improve Tribal Water and Sanitation Systems. Health and Human Services. Published online May 31, 2022. https://www.hhs.gov/about/news/2022/05/31/ihs-allocates-700-million-dollars-from-president-bidens-bipartisan-infrastructure-law-to-improve-tribal-water-sanitation-systems.html

RELEVANT AMA POLICY

H-135.928 Safe Drinking Water

Our AMA supports updates to the U.S. Environmental Protection Agency's Lead and Copper Rule as well as other state and federal laws to eliminate exposure to lead through drinking water by:
(1) Removing, in a timely manner, lead service lines and other leaded plumbing materials that come into contact with drinking water;
(2) Requiring public water systems to establish a mechanism for consumers to access information on lead service line locations;
(3) Informing consumers about the health-risks of partial lead service line replacement;
(4) Requiring the inclusion of schools, licensed daycare, and health care settings among the sites routinely tested by municipal water quality assurance systems;
(5) Creating and implementing standardized protocols and regulations pertaining to water quality testing, reporting and remediation to ensure the safety of water in schools and child care centers;

(6) Improving public access to testing data on water lead levels by requiring testing results from public water systems to be posted on a publicly available website in a reasonable timeframe thereby allowing consumers to take precautions to protect their health;
(7) Establishing more robust and frequent public education efforts and outreach to consumers that have lead service lines, including vulnerable populations;
(8) Requiring public water systems to notify public health agencies and health care providers when local water samples test above the action level for lead;
(9) Seeking to shorten and streamline the compliance deadline requirements in the Safe Drinking Water Act; and
(10) Actively pursuing changes to the federal lead and copper rules consistent with this policy.
[Res. 409, A-16; Modified: Res. 422, A-18; Reaffirmed: BOT Rep. 29, A-19]

D-440.924 Universal Access for Essential Public Health Services
Our AMA: (1) supports equitable access to the 10 Essential Public Health Services and the Foundational Public Health Services to protect and promote the health of all people in all communities; (2) encourages state, local, tribal, and territorial public health departments to pursue accreditation through the Public Health Accreditation Board (PHAB); (3) will work with appropriate stakeholders to develop a comprehensive list of minimum necessary programs and services to protect the public health of citizens in all state and local jurisdictions and ensure adequate provisions of public health, including, but not limited to clean water, functional sewage systems, access to vaccines, and other public health standards; and (4) will work with the National Association of City and County Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), the Big Cities Health Coalition, the Centers for Disease Control and Prevention (CDC), and other related entities that are working to assess and assure appropriate funding levels, service capacity, and adequate infrastructure of the nation's public health system, including for rural jurisdictions. [Res. 419, A-19; Modified: CSAPH Rep. 2, A-22]

H-350.977 Indian Health Service
The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.
(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.
(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.
(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from

organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.
(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.
(6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.
(7) Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs. [CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Appended: Res. 305, A-23; Reaffirmed: BOT Rep. 09, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(I-23)

Introduced by: Medical Student Section

Subject: Medical-Legal Partnerships & Legal Aid Services

Referred to: Reference Committee B

Whereas, medical-legal partnerships (MLPs) address social determinants of health relating to civil law, such as family violence, child support and custody, workplace conditions, employment conflicts, financial exploitation, post-incarceration rehabilitation, housing, utility shutoffs, disability access, debt relief, and veteran benefits, by integrating lawyers in clinical settings team to meet patient's legal needs[1-6]; and

Whereas, 70% of low-income households experience civil legal problems, with 40% experiencing at least 5, 20% experiencing at least 10, and the average low-income individual managing 2 to 3 legal issues at a time[7-8]; and

Whereas, unmet civil legal needs may lead to or exacerbate both physical and mental illness, as seen with inadequate housing, eviction, and even threat of eviction being connected to anxiety, depression, bodily injury, asthma, and respiratory infection[9-11]; and

Whereas, MLPs demonstrate success in access to retroactive benefits, improved asthma control and neonatal preventive care use, and decreased length of hospitalization, readmission rates, and emergency department visits[7]; and

Whereas, while MLPs are found at only 26% of medical schools, studies indicate that MLPs can help educate physicians and medical students on screening for social determinants and legal needs, addressing issues impacting health through legal advocacy, and referring patients to reliable legal resources[1,12-15]; and

Whereas, civil legal aid often includes free or low-cost direct legal services by lawyers as well as legal education to help low- and middle-income people navigate social systems[16]; and

Whereas, the high cost of civil legal aid is a significant barrier to access, with low-income Americans reporting only seek aid for 1 out of 4 civil legal problems and receiving inadequate legal aid for 92% of their needs[8,17]; and

Whereas, civil legal aid services in the US are chronically underfunded, turning away an average of 50% of eligible individuals who seek services due to inadequate funds[16]; and

Whereas, the Association of American Medical Colleges and the American Bar Association both conduct initiatives relating to MLPs, including creation of models and directories[18-19]; therefore be it

RESOLVED, that our American Medical Association support the establishment and funding of medical-legal partnerships and civil legal aid services to meet patients' legal needs. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 09/27/2023

REFERENCES

1. Regenstein M, Trott J, Williamson A, Theiss J. Addressing Social Determinants Of Health Through Medical-Legal Partnerships. *Health Affairs*. 2018;37(3):378-385. doi:10.1377/hlthaff.2017.1264
2. Cloud DH, Bassett MT, Graves J, Fullilove RE, Brinkley-Rubinstein L. Documenting and addressing the health impacts of carceral systems. Am J Public Health. 2020;110(suppl 1) S5–S5.
3. Swope CB, Hernández D. Housing as a determinant of health equity: a conceptual model. Soc Sci Med. 2019;243:112571.
4. Gong, G., Phillips, S. G., Hudson, C., Curti, D., & Philips, B. U. Higher US rural mortality rates linked to socioeconomic status, physician shortages, and lack of health insurance. Health Affairs, 2019; 38(12), 2003-2010.
5. Keith-Jennings B, Llobrera J, Dean S. Links of the Supplemental Nutrition Assistance Program with food insecurity, poverty, and health: evidence and potential. Am J Public Health. 2019;109(12):1636–1640.
6. Girard, V. et al. The Academic Medical-Legal Partnership. September 26, 2022.
7. Mead, Allee. Bringing Law and Medicine Together to Help Rural Patients. Rural Health Information Hub. Last accessed September 22, 2022. https://www.ruralhealthinfo.org/rural-monitor/medical-legal-partnerships
8. 2022 Justice Gap Study, Legal Services Corporation. Last accessed August 31, 2022. https://justicegap.lsc.gov/resource/executive-summary
9. Jassar, Sunam. Access to Justice as a Social Determinant of Health: The Basis for Reducing Health Disparity and Advancing Health Equity of Marginalized Communities, Windsor Yearbook of Access to Justice 37 (2021), https://wyaj.uwindsor.ca/index.php/wyaj/article/view/7283
10. Cannon, Yael. Unmet Legal Needs as Health Injustice. University of Richmond Law Review, Vol. 56, pp. 801-877 (2022). https://scholarship.law.georgetown.edu/facpub/2452
11. Making Justice Equal, Center for American Progress (Dec. 8, 2016). https://www.americanprogress.org/article/making-justice-equal
12. Girard, V. W., Moore, E. S., Kessler, L. P., Perry, D., & Cannon, Y. An Interprofessional Approach to Teaching Advocacy Skills: Lessons from an Academic Medical–Legal Partnership. Journal of Legal Medicine, 2020; 40(2), 265-278.
13. Pettignano, R., Bliss, L., McLaren, S., & Caley, S. Interprofessional medical–legal education of medical students: assessing the benefits for addressing social determinants of health. Academic Medicine, 2017; 92(9), 1254-1258.
14. Coleman, R., Dunn, C., & McDonald, D. Medical Legal Partnerships: A Novel Way to Help Address Health-harming Legal Needs and Social Determinants of Health in Pediatric Patients with Asthma. The Florida Pediatrician, 2022; 41(1).
15. John, J. et al. Efficacy of Medical Legal Partnerships to Address Health Harming Legal Needs: A Systematic Review of Experimental Studies in the Field. 2022. https://doi.org/10.21203/rs.3.rs-1625222/v1
16. U.S. Department of Justice, Civil Legal Aid 1010. Last accessed September 22, 2022. https://www.justice.gov/atj/civil-legal-aid-101
17. Emery G. Lee, Law Without Lawyers: Access to Civil Justice and the Cost of Legal Services, University of Miami Law Review 69:499 (April 2015). https://lawreview.law.miami.edu/wp-content/uploads/2015/04/Lee.pdf.
18. AAMC releases three tools to help MLPs measure their impact on health and health equity. National Center for Medical-Legal Partnership, Milken Institute School of Public Health, The George Washington University. Published September 26, 2019. https://medical-legalpartnership.org/aamc-evaluation-tools
19. Medical-Legal Partnerships. American Bar Association. https://www.americanbar.org/groups/health_law/interest_groups/educational_outreach/medical-legal-partnerships-

RELEVANT AMA POLICY

H-165.822 Health Plan Initiatives Addressing Social Determinants of Health

Our AMA:

1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;

5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs. [CMS Rep. 7, I-20Reaffirmed: CMS Rep. 5, I-21Reaffirmed: CMS Rep. 5, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(I-23)

Introduced by: Medical Student Section

Subject: Humanitarian Efforts to Resettle Refugees

Referred to: Reference Committee B

Whereas, “refugee” is defined in the Immigration and Nationality Act as an individual experiencing persecution or a well-founded fear of persecution on account of their race, religion, nationality, membership in a particular social group, or political opinion[1-3]; and

Whereas, the US consistently admits fewer refugees than its cap, leading to 5,000 to 40,000 unallocated refugees[4]; and

Whereas, a record 29 million refugees are expected in 2023, including 14 million children[5-6]; and

Whereas, over a 20-year period, refugees in the US ages 18 to 45 pay on average $21,000-$43,707 more in taxes than they receive in benefits[7-10]; and

Whereas, refugees in general contribute $21 billion in taxes annually, including to Social Security and Medicare, offsetting the costs our aging population[13]; and

Whereas, analyses from Ohio, Michigan, and Minnesota demonstrate how refugees produce billions of dollars in economic activity annually and create thousands of jobs[9,11]; and

Whereas, 77% of refugees are working age, as opposed to the 39.7% of the US-born population and male refugees participate in the labor force at higher rates than US males[7,12,14]; and

Whereas, under 3% of refugees return to their country of origin, and 84% of long-term refugees make the US their home by taking steps to become citizens[6,10,15]; and

Whereas, when annual refugee admissions decreased 86% between 2016-2020, the 295,000 person gap actually harmed the US economy by nearly $10 billion annually[8]; and

Whereas, decreased resettlement caps and worsening backlogs delay family reunification and leave people displaced for decades, remaining indefinitely in refugee camps[16]; and

Whereas, forced displacement and restrictions on refugee admissions result in distinct chronic medical and psychiatric phenomena and generational trauma[16-18]; therefore be it

RESOLVED, that our American Medical Association support increases and oppose decreases to the annual refugee admissions cap in the United States. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 09/27/2023

REFERENCES

1. United Nations High Commissioner for Refugees. Convention and Protocol Relating to the Status of Refugees. The UN Refugee Agency. Accessed March 5, 2023. https://www.unhcr.org/protection/basic/3b66c2aa10/convention-protocol-relating-status-refugees.html
2. 8 USC 1101: Definitions. Accessed March 5, 2023. https://uscode.house.gov/view.xhtml?req=granuleid%3AUSC-prelim-title8-section1101&num=0&edition=prelim#sourcecredit
3. Refugee Admissions. United States Department of State. Accessed March 5, 2023. https://www.state.gov/refugee-admissions/
4. Bruno A. Refugee Admissions and Resettlement Policy. Congr Res Serv Rep Congr. Published online August 8, 2013.
5. UNHCR. Global Appeal 2023. Accessed March 5, 2023. https://reporting.unhcr.org/globalappeal2023/pdf
6. Global Trends - Forced Displacement in 2018 - UNHCR. UNHCR Global Trends 2018. Accessed March 5, 2023. https://www.unhcr.org/globaltrends2018/
7. Evans W, Fitzgerald D. The Economic and Social Outcomes of Refugees in the United States: Evidence from the ACS. National Bureau of Economic Research; 2017:w23498. doi:10.3386/w23498
8. Clemens MA. The Economic and Fiscal Effects on the United States from Reduced Numbers of Refugees and Asylum Seekers. Published online 2022.
9. National Immigration Forum. Immigrants as Economic Contributors: Refugees Are A Fiscal Success Story for America. https://www.immigrationresearch.org/system/files/Economic-and-Fiscal-Impact-of-Refugees.pdf
10. New American Economy. From Struggle to Resilience.; 2017. https://www.immigrationresearch.org/system/files/NAE_Struggle_to_Resilience.pdf
11. New American Economy. New Americans in Minneapolis: The Demographic and Economic Contributions of Immigrants and Refugees in the Area.
12. Immigrants Contribute Greatly to U.S. Economy, Despite Administration's "Public Charge" Rule Rationale Center on Budget and Policy Priorities. Published August 15, 2019. Accessed March 6, 2023. https://www.cbpp.org/research/poverty-and-inequality/immigrants-contribute-greatly-to-us-economy-despite-administrations
13. Schneider MJ. Introduction to Public Health. Jones & Bartlett Learning; 2020.
14. Capps R. The Integration Outcomes of U.S. Refugees. Migr Policy Inst.
15. Protecting the Nation From Foreign Terrorist Entry Into the United States. Federal Register. Published February 1, 2017. Accessed March 6, 2023. https://www.federalregister.gov/documents/2017/02/01/2017-02281/protecting-the-nation-from-foreign-terrorist-entry-into-the-united-states
16. Lorenz ML. U.S. Refugee Resettlement Is in Ruins-It Is Our Duty to Rebuild It. J Gen Intern Med. 2022;37(4):940-943. doi:10.1007/s11606-021-07373-5
17. Murray KE, Davidson GR, Schweitzer RD. Review of refugee mental health interventions following resettlement: best practices and recommendations. Am J Orthopsychiatry. 2010;80(4):576-585. doi:10.1111/j.1939-0025.2010.01062.x
18. Asylum in the United States. American Immigration Council. https://www.americanimmigrationcouncil.org/research/asylum-united-states. Published June 11, 2020. Accessed April 9, 2023.

RELEVANT AMA POLICY

D-65.984 Humanitarian and Medical Aid Support to Ukraine

Our AMA will advocate for: (1) continuous support of organizations providing humanitarian missions and medical care to Ukrainian refugees in Ukraine, at the Polish-Ukrainian border, in nearby countries, and/or in the US; (2) an early implementation of mental health measures, including suicide prevention efforts, and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian refugees with special attention to vulnerable populations including but not limited to young children, mothers, pregnant women, and the elderly; and (3) educational measures to enhance the understanding of war-related trauma in war survivors and promote broad protective factors (e.g., financial, employment, housing, and food stability) that can improve adjustment and outcomes for war-affected people, particularly when applied to vulnerable categories of people. [Res. 017, A-22]

;AMERICAN MEDICAL ASSOCIATION HOOUSE OF DELEGATES

Resolution: 221
(I-23)

Introduced by: Oregon

Subject: Support for Physicians Pursuing Collective Bargaining and Unionization

Referred to: Reference Committee B

Whereas, the American Medical Association supports the right of physicians to engage in collective bargaining, and it is AMA policy to work for expansion of the numbers of physicians eligible for that right under federal law; and

Whereas, while AMA policy supports expanding rights for physicians rights and abilities to collectively bargain, the last study of this policy area last occurred pre-pandemic as the paradigm shift of physician as employee continues to expand, particularly for younger generations of physicians who would be more likely to leverage and seek unionization; and

Whereas, the AMA points out that bargaining units composed entirely of physicians are presumed appropriate, a recommendation that makes sense in recognition of physicians' unique skills and ethical and professional obligations; and

Whereas, in 1999 the AMA provided financial support for the establishment of a national labor organization - Physicians for Responsible Negotiation (PRN) - under the National Labor Relations Board (NLRA) to support the development and operation of local physician negotiating units as an option for employed physicians and physicians in-training, but ultimately withdrew support in 2004 as few physicians signed up; and

Whereas, the numbers of physicians who are union members is estimated to have grown significantly since then with a 26% increase from 2014 to 2019 when 67,673 physicians were members of a union; and

Whereas, the percentage of physicians now employed by hospitals, health systems, or corporate entities has increased significant, most recently reported up to 73.9% as of January 2022 (up from 47.4% in 2018), and the number of physician practices acquired by hospitals and corporate entities between 2019-2022 also accelerated during the pandemic; and

Whereas, dominant hospitals, healthcare systems, and other corporate entities employing physicians may present limited alternatives to physicians working in a market largely controlled by their employer or where covenants-not-to-compete may further contribute to the employer's bargaining advantage; and

Whereas, the transition from independent professional physician workforce to employed physician workforce fundamentally alters the dynamics between hospitals, health systems, corporate entities and physicians, with a risk of negatively affecting the conditions of care delivery and quality of care provided; and

Whereas, the corporatization of medicine, including involvement of private equity in healthcare, raises questions about incentive alignment, costs, and downstream effects on patients; and

Whereas, recent years have seen an increase in physician burnout, which accelerated during the COVID-19 pandemic, directly related to time spent on electronic health record documentation, bureaucratic administrative tasks, and moral injury related to an incongruence between what physicians care about and what they are incentivized to do by the health care system; and

Whereas, physicians face a dominant power when negotiating with hospital employers and may not have countervailing influence without collective bargaining; and

Whereas, collective bargaining is an effective tool for protecting patient care safety standards, improving work conditions, ensuring pay and job security, and a providing a process for grievances; and

Whereas, the National Labor Relations Board determined in 2022 that employed physicians are not in a supervisory role and are therefore eligible to unionize; and

Whereas, interest in exploring collective bargaining for residents and practicing physician groups has increased in some parts of the country including in Oregon, likely driven by dynamics seen in the profession's shift to "employed status" for the majority of physicians; therefore be it

RESOLVED, that our American Medical Association convene an updated study of opportunities for the AMA or physician associations to support physicians initiating a collective bargaining process, including but not limited to unionization. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 10/10/23

REFERENCES

1. https://www.ama-assn.org/system/files/advocacy-issue-brief-physician-unions.pdf
2. AMA analysis shows most physicians work outside of private practice | American Medical Association
3. https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf?ver=ksWkgjKXB_yZfImFdXlvGg%3d%3d
4. https://www.ama-assn.org/system/files/2019-07/prp-fewer-owners-benchmark-survey-2018.pdf
5. https://jamanetwork.com/journals/jama/fullarticle/2799930?guestaccesskey=4b40dae9-69a2-4ec1-b2db-b5f235c67122&utm_source=silverchair&utm_medium=email&utm_campaign=article_alert-jama&utm_content=etoc&utm_term=122722
6. https://acpinternist.org/archives/2022/03/3-cs-corporatization-consolidation-commodification.htm
7. https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01535
8. https://www.mayoclinicproceedings.org/article/S0025-6196(22)00515-8/fulltext
9. https://academic.oup.com/jamia/article/26/2/106/5230918
10. https://www.medscape.com/slideshow/2022-lifestyle-burnout-6014664?icd=login_success_email_match_norm#1
11. https://www.acpjournals.org/doi/10.7326/M16-0961
12. https://nap.nationalacademies.org/catalog/25521/taking-action-against-clinician-burnout-a-systems-approach-to-professional
13. https://www.jdsupra.com/legalnews/following-the-doctor-s-orders-nlrb-7925443/
14. https://www.nytimes.com/2016/01/10/business/doctors-unionize-to-resist-the-medical-machine.html
15. https://www.nytimes.com/2023/06/15/magazine/doctors-moral-crises.html?smid=nytcore-ios-share&referringSource=articleShare
16. https://www.medpagetoday.com/special-reports/features/104210

RELEVANT AMA POLICY

Collective Bargaining for Physicians H-385.946
The AMA will seek means to remove restrictions for physicians to form collective bargaining units in order to negotiate reasonable payments for medical services and to compete in the current managed care environment; and will include the drafting of appropriate legislation.
Topic: Physician Payment Policy Subtopic: NA Meeting Type: Annual Year Last Modified: 2019 Action: Reaffirmed Type: Health Policies Council & Committees: NA

Physician Collective Bargaining H-385.976
Our AMA's present view on the issue of physician collective negotiation is as follows: (1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians.
(2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature.
(3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively.
(4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients.
(5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care.
Topic: Physician Payment Policy Subtopic: NA Meeting Type: Annual Year Last Modified: 2019 Action: Reaffirmed Type: Health Policies Council & Committees: NA

Employee Associations and Collective Bargaining for Physicians D-383.981
Our AMA will study and report back on physician unionization in the United States.
Topic: Physician Negotiating Policy Subtopic: NA Meeting Type: Annual Year Last Modified: 2019 Action: Reaffirmed Type: Directives Council & Committees: NA

Investigation into Residents, Fellows and Physician Unions D-383.977
Our AMA will study the risks and benefits of collective bargaining for physicians and physicians-in-training in today’s health care environment.
Topic: Physician Negotiating Policy Subtopic: NA Meeting Type: Annual Year Last Modified: 2019 Action: NA Type: Directives Council & Committees: NA

Physicians' Ability to Negotiate and Undergo Practice Consolidation H-383.988
Our AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and (3) find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare.
Topic: Physician Negotiation Policy Subtopic: NA Meeting Type: Annual Year Last Modified: 2019 Action: Reaffirmed Type: Health Policies Council & Committees: NA

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(I-23)

Introduced by: Medical Student Section

Subject: Fairness for International Medical Students

Referred to: Reference Committee C

Whereas, international students comprise over 10% of US graduate students but only 0.6% of US medical students, indicating that the US recruits globally for academia, research, and highly educated professions, but not for medicine[1–3]; and

Whereas, only 35% of medical schools consider international applicants, only 17% of whom are admitted compared to 38% of domestic applicants[4-7]; and

Whereas, international medical students are ineligible for public loans, may be ineligible for medical school scholarships, require a US cosigner for private loans, and may be required to deposit up to four years of tuition upfront into an escrow account prior to matriculation[7-10]; and

Whereas, many common national medical student scholarships, including the AMA Physicians of Tomorrow scholarship, the Tylenol Future Care scholarship, and the National Medical Fellowships awards, are restricted to domestic students only[11–13]; and

Whereas, international medical students offer valuable diversity of thought, cultural perspectives, and unique life experiences that enrich medical schools, complement efforts to improve physician workforce diversity, address physician shortages, and allow the US to attract and retain the best and brightest future doctors from around the world[9,14]; therefore be it

RESOLVED, that our American Medical Association encourage additional medical schools to consider applications from and to admit international students to their programs alongside domestic students (New HOD Policy); and be it further

RESOLVED, that our AMA amend policy H-255.968 “Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools” by addition and deletion to read as follows:

> Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools H-255.968
> Our AMA:
> 1. supports the autonomy of medical schools to determine optimal tuition requirements for international students;
> 2. encourages medical schools and undergraduate institutions to fully inform international students interested in medical education in the US of the limited options available to them for tuition assistance;
> 3. supports the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process

for international students by including school policy on tuition requirements in the Medical School Admission Requirements (MSAR); ~~and~~
4. supports efforts to re-evaluate and minimize the use of pre-payment requirements specific to international medical students; and
5. encourages medical schools to explore alternative means of prepayment, such as a letter of credit, ~~for four years~~ for covering the costs of medical school. (Modify Current HOD Policy)

and be it further

RESOLVED, that our AMA advocate for increased scholarship and funding opportunities for international students accepted to or currently attending United States medical schools. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 09/27/2023

REFERENCES

1. Open Doors. IIE Open Doors / Academic Level. IIE Open Doors / Academic Level. Accessed September 22, 2022. https://opendoorsdata.org/data/international-students/academic-level/
2. National Center for Education Statistics. The Integrated Postsecondary Education Data System. Accessed September 22, 2022. https://nces.ed.gov/ipeds/search/ViewTable?tableId=29448
3. AAMC. Matriculants to U.S. MD-Granting Medical Schools by State of Legal Residence, 2012-2013 through 2021-2022. https://www.aamc.org/media/6011/download?attachment
4. Medical School Admission Requirements. Accessed August 30, 2022. https://mec.aamc.org/msar-ui/#/landing
5. American Association of Colleges of Osteopathic Medicine. Choose DO Explorer. Choose DO. Accessed September 22, 2022. https://choosedo.org/explorer/
6. Table A-7.2: Applicants, First-Time Applicants, Acceptees, and Matriculants to U.S. MD-Granting Medical Schools by Sex, 2012-2013 through 2021-2022.
7. Docs A. Applying to Medical School as an International Applicant. AAMC Students & Residents. Accessed August 30, 2022. https://students-residents.aamc.org/applying-medical-school/applying-medical-school-international-applicant
8. National Academies of Sciences E, Division H and M, Practice B on PH and PH. *Financial Barriers to Medical Education*. National Academies Press (US); 2018. Accessed August 30, 2022. https://www.ncbi.nlm.nih.gov/books/NBK518880/
Datta J, Miller BM. International students in United States' medical schools: does the medical community know they exist? *Med Educ Online*. 2012;17:10.3402/meo.v17i0.15748. doi:10.3402/meo.v17i0.15748
9. Virji AZ. As a non-U.S. citizen, I faced hurdles applying to U.S. medical schools. Now that I've made it, I want to help others like me. AAMC. Accessed September 22, 2022. https://www.aamc.org/news-insights/non-us-citizen-i-faced-hurdles-applying-us-medical-schools-now-i-ve-made-it-i-want-help-others-me
10. AMA Physicians of Tomorrow Scholarship. AMA Foundation. Accessed August 30, 2022. https://amafoundation.org/programs/scholarships/
11. Tylenol Future Care Scholarship FAQ. https://www.tylenol.com/sites/tylenol_us/files/22-23_tylenolr_future_care_scholarship_faq.pdf
12. National Medical Fellowships. Scholarships and Awards. Published June 28, 2021. Accessed August 30, 2022. https://nmfonline.org/scholarships-programs/scholarships-and-awards/
13. Krislov M. Why International Students Are Good For Colleges, Universities And America. Forbes. Accessed August 30, 2022. https://www.forbes.com/sites/marvinkrislov/2019/03/22/why-international-students-are-good-for-colleges-universities-and-america
14. Retaining U.S. International Student Graduates Could Help Fill Millions of Critical Job Openings. FWD.us. Accessed August 30, 2022. https://www.fwd.us/news/us-international-students

RELEVANT AMA POLICY

D-255.980 Impact of Immigration Barriers on the Nation's Health
1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and

student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S. [Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21; Reaffirmed: Res. 234, A-22; Reaffirmed: Res. 210, A-23]

H-295.888 Progress in Medical Education: the Medical School Admission Process
1. Our AMA encourages: (A) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (B) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly-educated applicant pool; and (C) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges.
2. Our AMA: (A) will continue to work with the Association of American Medical Colleges (AAMC) and other relevant organizations to encourage improved assessment of personal qualities in the recruitment process for medical school applicants including types of information to be solicited in applications to medical school; (B) will work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants, including those used by related fields; (C) encourages the development of innovative methodologies to assess personal qualities among medical school applicants; (D) will work with medical schools and other relevant stakeholder groups to review the ways in which medical schools communicate the importance of personal qualities among applicants, including how and when specified personal qualities will be assessed in the admissions process; (E) encourages continued research on the personal qualities most pertinent to success as a medical student and as a physician to assist admissions committees to adequately assess applicants; and (F) encourages continued research on the factors that impact negatively on humanistic and empathetic traits of medical students during medical school. [CME Rep. 8, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: CME Rep. 3, A-11; Reaffirmed: CME Rep. 1, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(I-23)

Introduced by: Medical Student Section

Subject: Inclusive Language for Immigrants in Relevant Past and Future AMA Policies

Referred to: Reference Committee F

Whereas, the terms “illegal immigrant” and “alien” imply negative sentiments such as criminality, fear, prejudice, and dehumanization toward people of various immigration statuses[1-5]; and

Whereas, anti-immigration rhetoric and xenophobia affect increase discrimination and othering in clinical settings and lead to avoidance of care by immigrant patients[6-9]; and

Whereas, as of 2013, the Associated Press Style Book no longer sanctions the term "illegal immigrant” and recommends only using “illegal” to describe actions, not people[10]; and

Whereas, in 2021, President Biden ordered immigration agencies to shift their terminology from “illegal alien” to "undocumented noncitizen"[4]; and

Whereas, AMA policies such as H-130.967, D-160.988, H-290.983, H-160.956, H-255.989, and H-255.985 contain the stigmatizing terms “illegal,” “legal,” and “aliens” in reference to immigrants and noncitizens; therefore be it

RESOLVED, that our American Medical Association utilize the terms “documented," "undocumented," "immigrant,” and/or “noncitizen” in all future policies and publications when broadly addressing the United States immigrant population (New HOD Policy); and be it further

RESOLVED, that our AMA revise all relevant and active policies to utilize the term “documented/undocumented immigrant” in place of the terms "legal/illegal immigrant" where such text appears (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA revise all relevant and active policies to utilize the term “immigrant/noncitizen” in place of the term "alien" where such text appears. (Modify Current HOD Policy)

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

Received: 09/19/2023

REFERENCES

1. Reporting terminology and definitions. U.S. Department of Homeland Security. 2022. https://www.dhs.gov/immigration-statistics/reporting-terminology-definitions#21.
2. Nelson RL, Davis-Wiley P. Illegal or undocumented: An analysis of immigrant terminology in contemporary American media. *International Journal of Social Science Studies*. 2018;6(6):8. doi:10.11114/ijsss.v6i6.3254.
3. Caicedo DA, Badaan V. Legislation, linguistics, and location: exploring attitudes on unauthorized immigration. *Journal of International Migration and Integration*. 2020;22(3):967-985. doi:10.1007/s12134-020-00780-3.
4. Rose J. Immigration agencies ordered not to use term 'illegal alien' under new Biden policy. *NPR.* 2021. http://www.npr.org/2021/04/19/988789487/immigration-agencies-ordered-not-to-use-term-illegal-alien-under-new-biden-polic.

5. Pearson MR. How “undocumented workers” and “illegal aliens” affect prejudice toward Mexican immigrants. *Social Influence*. 2010;5(2):118-132. doi:10.1080/15534511003593679.
6. Martinez O, Wu E, Sandfort T, et al. Evaluating the impact of immigration policies on health status among undocumented immigrants: a systematic review. *J Immigrant Minority Health.* 2015;17:947–970. https://doi.org/10.1007/s10903-013-9968-4.
7. Suleman S, et al. Xenophobia as a determinant of health: an integrative review. *Journal of Public Health Policy*. 2018;39(4)407–23. https://doi.org/10.1057/s41271-018-0140-1.
8. Vargas ED, et al. Fear by association: perceptions of anti-immigrant policy and health outcomes. *Journal of Health Politics, Policy and Law.* 2017;42(3):459-483. doi:10.1215/03616878-3802940.
9. Galvan T, et al. Another brick in the wall: Healthcare access difficulties and their implications for undocumented Latino/a immigrants. *Journal of Immigrant and Minority Health*. 2021;23(5):885–94. https://doi.org/10.1007/s10903-021-01187-7.
10. Colford P. ‘Illegal immigrant’ no more. *Associated Press Stylebook*. 2013. www.apstylebook.com/blog_posts/1.

RELEVANT AMA POLICY

H-65.950 Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment

Our AMA recognizes broad and evolving protected personal characteristics spanning identity, origin, and status that include those outlined by regulatory authorities overlapping with those prioritized by AMA. To prevent misunderstandings and facilitate collaboration to move medicine forward, AMA acknowledges preferred terminology for protected personal characteristics outlined in the actual sources used in the 2021 AMA Strategic Plan to Embed Racial Justice and Advance Health Equity and the AMA-AAMC Advancing Health Equity such as the CDC’s Health Equity Guiding Principles for Inclusive Communication that may be used in AMA policies and position statements. [BOT Rep. 5, I-21; Reaffirmed: BOT Rep. 5, I-22; Modified: BOT Rep. 12, I-22]

D-65.990 Utilization of "LGBTQ" in Relevant Past and Future AMA Policies

Our AMA will: (1) utilize the terminology “lesbian, gay, bisexual, transgender, and queer” and the abbreviation “LGBTQ” in all future policies and publications when broadly addressing this population; (2) revise all relevant and active policies to utilize the abbreviation “LGBTQ” in place of the abbreviations “LGBT” and “GLBT” where such text appears; and (3) revise all relevant and active policies to utilize the terms “lesbian, gay, bisexual, transgender, and queer” to replace “lesbian, gay, bisexual, and transgender” where such text appears. [Res. 016, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(I-23)

Introduced by: Texas

Subject: Improving the Efficiency of the House of Delegates Resolution Process

Referred to: Reference Committee F

Whereas, the introduction of online testimony so far has been viewed as a successful way to increase participation in the resolution process; and

Whereas, online testimony is not being fully utilized because of a perception that online testimony does not influence the recommendations of the reference committees and that in-person testimony carries more weight; and

Whereas, this perception would be most easily reversed if each reference committee issued an interim report that serves as a “working final report” of its recommendations for each resolution rather than a mere summary of the testimony submitted; and

Whereas, interim reports would enable the authors of a resolution to identify areas of disagreement and work with others to write alternative language to be submitted and discussed at the hearing; and

Whereas, interim reports also would also help make the in-person hearings more efficient by eliminating the need for testimony by those who agree with the interim recommendations; and

Whereas, interim reports also would increase the likelihood that the recommendations in the final report are agreeable to the HOD, reducing the need for extractions and wordsmithing on the floor; and

Whereas, several state medical associations already use interim reports and have seen the benefits outlined above; therefore be it

RESOLVED, that our American Medical Association House of Delegates instruct its reference committees to issue interim reports of their recommendations (1) based on online testimony and other information received and (2) made available to house members with ample time for delegates to evaluate recommendations and, if desired, prepare comments in advance of live reference committee hearings (Directive to Take Action); and be it further

RESOLVED, that our AMA HOD require resolution authors to submit their initial testimony online and include in detail how the new resolution is not a reaffirmation of existing policy; the authors would have the option of submitting additional testimony during the in-person hearings to respond to any concerns raised in the interim report or in testimony from others. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 9/15/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(I-23)

Introduced by: Resident and Fellow Section

Subject: Updating Language Regarding Families and Pregnant Persons

Referred to: Reference Committee F

Whereas, current AMA policy includes gendered language such as “mother” and “pregnant woman” when discussing families and persons in need of obstetric and gynecologic care such as in H-20.917, H-320.954, H-420.950, H-420.962, H-420.969, and more; and

Whereas, The Human Rights Campaign (HRC) definition of “family” when used in hospital visitation policy is stated as: “‘Family’ means any person(s) who plays a significant role in an individual’s life. This may include a person(s) not legally related to the individual. Members of ‘family’ include spouses, domestic partners, and both different-sex and same-sex significant others. ‘Family’ includes a minor patient’s parents, regardless of the gender of either parent.’’[1]; and

Whereas, in 2022 the American College of Obstetricians and Gynecologists (ACOG) published a policy statement stating “To be inclusive of women and all patients in need of obstetric and gynecologic care, ACOG will move beyond the exclusive use of gendered language and definitions”[1]; and

Whereas, The World Professional Association for Transgender Health (WPATH)’s *Standards of Care - version 8*, published in 2022, includes guideline 1.2 which states that “We recommend health care professionals use language in health care settings that uphold the principles of safety, dignity, and respect”[3]; and

Whereas, AMA policy H-65.942, adopted in June 2023, strongly encourages the use of gender-neutral language supports the use of gender-neutral language in AMA policies and communications, but as written this policy will not apply to other resources the AMA creates and distributes; therefore be it

RESOLVED, that our American Medical Association review and update the language used in AMA policy and other resources and communications to ensure that the language used to describe families and persons in need of obstetric and gynecologic care is inclusive of all genders and family structures. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 9/26/23

References:
1. The Human Rights Campaign Foundation. LGBTQ+ inclusive definitions of family. HRC Foundation. https://www.thehrcfoundation.org/professional-resources/lgbtq--inclusive-definitions-of-family. Accessed April 17, 2023.
2. The American College of Obstetricians and Gynecologists. Inclusive language: Statement of Policy. ACOG. https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/inclusive-language. Published February 2022. Accessed April 17, 2023.
3. E. Coleman, A. E. Radix, W. P. Bouman, G. R. Brown, A. L. C. de Vries, M. B. Deutsch, R. Ettner, L. Fraser, M. Goodman, J. Green, A. B. Hancock, T. W. Johnson, D. H. Karasic, G. A. Knudson, S. F. Leibowitz, H. F. L. Meyer-Bahlburg, S. J. Monstrey, J. Motmans, L. Nahata, T. O. Nieder, S. L. Reisner, C. Richards, L. S. Schechter, V. Tangpricha, A. C. Tishelman, M. A. A. Van Trotsenburg, S. Winter, K. Ducheny, N. J. Adams, T. M. Adrián, L. R. Allen, D. Azul, H. Bagga, K. Başar, D. S. Bathory, J. J. Belinky, D. R. Berg, J. U. Berli, R. O. Bluebond-Langner, M.- B. Bouman, M. L. Bowers, P. J. Brassard, J. Byrne, L. Capitán, C. J. Cargill, J. M. Carswell, S. C. Chang, G. Chelvakumar, T. Corneil, K. B. Dalke, G. De Cuypere, E. de Vries, M. Den Heijer, A. H. Devor, C. Dhejne, A. D'Marco, E. K. Edmiston, L. Edwards-Leeper, R. Ehrbar, D. Ehrensaft, J. Eisfeld, E. Elaut, L. Erickson-Schroth, J. L. Feldman, A. D. Fisher, M. M. Garcia, L. Gijs, S. E. Green, B. P. Hall, T. L. D. Hardy, M. S. Irwig, L. A. Jacobs, A. C. Janssen, K. Johnson, D. T. Klink, B. P. C. Kreukels, L. E. Kuper, E. J. Kvach, M. A. Malouf, R. Massey, T. Mazur, C. McLachlan, S. D. Morrison, S. W. Mosser, P. M. Neira, U. Nygren, J. M. Oates, J. Obedin-Maliver, G. Pagkalos, J. Patton, N. Phanuphak, K. Rachlin, T. Reed, G. N. Rider, J. Ristori, S. Robbins-Cherry, S. A. Roberts, K. A. Rodriguez-Wallberg, S. M. Rosenthal, K. Sabir, J. D. Safer, A. I. Scheim, L. J. Seal, T. J. Sehoole, K. Spencer, C. St. Amand, T. D. Steensma, J. F. Strang, G. B. Taylor, K. Tilleman, G. G. T'Sjoen, L. N. Vala, N. M. Van Mello, J. F. Veale, J. A. Vencill, B. Vincent, L. M. Wesp, M. A. West & J. Arcelus (2022) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, International Journal of Transgender Health, 23:sup1, S1-S259, DOI: 10.1080/26895269.2022.2100644

Relevant AMA Policy:

HIV/AIDS and Substance Abuse H-20.903
Our AMA: (1) urges federal, state, and local governments to increase funding for drug treatment so that drug abusers have immediate access to appropriate care, regardless of ability to pay. Experts in the field agree that this is the most important step that can be taken to reduce the spread of HIV infection among intravenous drug abusers; (2) advocates development of regulations and incentives to encourage retention of HIV-positive and AIDS-symptomatic patients in drug treatment programs so long as such placement is clinically appropriate; (3) encourages the availability of opioid maintenance for persons addicted to opioids. Federal and state regulations governing opioid maintenance and treatment of drug dependent persons should be reevaluated to determine whether they meet the special needs of intravenous drug abusers, particularly those who are HIV infected or AIDS symptomatic. Federal and state regulations that are based on incomplete or inaccurate scientific and medical data that restrict or inhibit opioid maintenance therapy should be removed; and (4) urges development of educational, medical, and social support programs for intravenous drug abusers and their sexual or needle-sharing partners to reduce risk of HIV infection, as well as risk of other bloodborne and sexually transmissible diseases. Such efforts must target (a) pregnant intravenous drug abusers and those who may become pregnant to address the current and future health care needs of both mothers and newborns and (b) adolescent substance abusers, especially homeless, runaway, and detained adolescents who are seropositive or AIDS symptomatic and those whose lifestyles place them at risk for contracting HIV infection. Citation: [CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13]

Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV Transmission H-20.918
In view of the significance of the finding that treatment of HIV-infected pregnant women with appropriate antiretroviral therapy can reduce the risk of transmission of HIV to their infants, our AMA recommends the following statements:
(1) Given the prevalence and distribution of HIV infection among women in the United States, the potential for effective early treatment of HIV infection in both women and their infants, and the significant reduction in perinatal HIV transmission with treatment of pregnant women with appropriate antiretroviral therapy, routine education about HIV infection and testing should be part of a comprehensive health care program for all women. The ideal would be for all women to know their HIV status before considering pregnancy.
(2) Universal HIV testing of all pregnant women, with patient notification of the right of refusal, should be a routine component of perinatal care. Basic counseling on HIV prevention and treatment should also be provided to the patient, consistent with the principles of informed consent.
(3) The final decision about accepting HIV testing is the responsibility of the woman. The decision to consent to or refuse an HIV test should be voluntary. When the choice is to reject testing, the patient's refusal should be recorded. Test results should be confidential within the limits of existing law and the need to provide appropriate medical care for the woman and her infant.

(4) To assure that the intended results are being achieved, the proportion of pregnant women who have accepted or rejected HIV testing and follow-up care should be monitored and reviewed periodically at the appropriate practice, program or institutional level. Programs in which the proportion of women accepting HIV testing is low should evaluate their methods to determine how they can achieve greater success.
(5) Women who are not seen by a health care professional for prenatal care until late in pregnancy or after the onset of labor should be offered HIV testing at the earliest practical time, but not later than during the immediate postpartum period.
(6) When HIV infection is documented in a pregnant woman, proper post-test counseling should be provided. The patient should be given an appropriate medical evaluation of the stage of infection and full information about the recommended management plan for her own health. Information should be provided about the potential for reducing the risk of perinatal transmission of HIV infection to her infant through the use of antiretroviral therapy, and about the potential but unknown long-term risks to herself and her infant from the treatment course. The final decision to accept or reject antiretroviral treatment recommended for herself and her infant is the right and responsibility of the woman. When the woman's serostatus is either unknown or known to be positive, appropriate counseling should also be given regarding the risks associated with breastfeeding for both her own disease progression and disease transmission to the infant.
(7) Appropriate medical treatment for HIV-infected pregnant women should be determined on an individual basis using the latest published Centers for Disease Control and Prevention recommendations. The most appropriate care should be available regardless of the stage of HIV infection or the time during gestation at which the woman presents for prenatal or intrapartum care.
(8) To facilitate optimal medical care for women and their infants, HIV test results (both positive and negative) and associated management information should be available to the physicians taking care of both mother and infant. Ideally, this information will be included in the confidential medical records. Physicians providing care for a woman or her infant should obtain the appropriate consent and should notify the other involved physicians of the HIV status of and management information about the mother and infant, consistent with applicable state law.
(9) Continued research into new interventions is essential to further reduce the perinatal transmission of HIV, particularly the use of rapid HIV testing for women presenting in labor and for women presenting in the prenatal setting who may not return for test results. The long-term effects of antiretroviral therapy during pregnancy and the intrapartum period for both women and their infants also must be evaluated. For both infected and uninfected infants exposed to perinatal antiretroviral treatment, long-term follow-up studies are needed to assess potential complications such as organ system toxicity, neurodevelopmental problems, pubertal development problems, reproductive capacity, and development of neoplasms.

(10) Health care professionals should be educated about the benefits of universal HIV testing, with patient notification of the right of refusal, as a routine component of prenatal care, and barriers that may prevent implementation of universal HIV testing as a routine component of prenatal care should be addressed and removed. Federal funding for efforts to prevent perinatal HIV transmission, including both prenatal testing and appropriate care of HIV-infected women, should be maintained Citation: [CSA Rep. 4, A-03; Reaffirmed: CEJA Rep. 3, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

Lead Contamination in Municipal Water Systems as Exemplified by Flint, Michigan H-60.918
1. Our AMA will advocate for biologic (including hematological) and neurodevelopmental monitoring at established intervals for children exposed to lead contaminated water with resulting elevated blood lead levels (EBLL) so that they do not suffer delay in diagnosis of adverse consequences of their lead exposure.
2. Our AMA will urge existing federal and state-funded programs to evaluate at-risk children to expand services to provide automatic entry into early-intervention screening programs to assist in the neurodevelopmental monitoring of exposed children with EBLL.
3. Our AMA will advocate for appropriate nutritional support for all people exposed to lead contaminated water with resulting elevated blood lead levels, but especially exposed pregnant women, lactating mothers and exposed children. Support should include Vitamin C, green leafy vegetables and other calcium resources so that their bodies will not be forced to substitute lead for missing calcium as the children grow.
4. Our AMA promotes screening, diagnosis and acceptable treatment of lead exposure and iron deficiency in all people exposed to lead contaminated water. Citation: [Res. 428, A-16]

Reducing Lead Poisoning H-60.924
1. Our AMA: (a) supports regulations and policies designed to protect young children from exposure to lead; (b) urges the Centers for Disease Control and Prevention to give priority to examining the current weight of scientific evidence regarding the range of adverse health effects associated with blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure; (c) encourages physicians and public health departments to screen children based on current recommendations and guidelines and to report all children with elevated blood levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children. In some cases this will be done by the physician, and in other communities by the laboratories; (d) promotes community awareness of the hazard of lead-based paints; and (e) urges paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.
2. Our AMA will call on the United States government to establish national goals to: (a) ensure that no child has a blood lead level >5 µg/dL (>50 ppb) by 2021, and (b) eliminate lead exposures to pregnant women and children, so that by 2030, no child would have a blood lead level >1 µg/dL (10 ppb).
3. Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals: (a) adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant women and children from lead toxicity and neurodevelopmental impairment; (b) identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer products) to protect children before they are exposed; (c) continue targeted screening of children to identify those who already have elevated blood lead levels for case management, as well as educational and other services; (d) eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out all remaining uses of lead in products (aviation gas, cosmetics, wheel weights, industrial paints, batteries, lubricants, and other sources), and the export of products containing lead, and setting more protective limits on emissions from battery recyclers and other sources of lead emissions; (e) provide a dedicated funding stream to enhance the resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical services to mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities that are disproportionately exposed to lead; and (f) establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant women and children, defined as blood lead levels above 1 µg/dL (10 ppb).
4. Our AMA supports requiring an environmental assessment of dwellings, residential buildings, or child care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level, to determine the potential source of lead poisoning, including testing the water supply. Citation: [CCB/CLRPD Rep. 3, A-14; Appended: Res. 926, I-16; Appended: Res. 412, A-17]

Provision of Health Care and Parenting Classes to Adolescent Parents H-60.973
1. It is the policy of the AMA (A) to encourage state medical and specialty societies to seek to increase the number of adolescent parenting programs within school settings which provide health care for infant and mother, and child development classes in addition to current high school courses and (B) to support programs directed toward increasing high school graduation rates, improving parenting skills and decreasing future social service dependence of teenage parents.
2. Our AMA will actively provide information underscoring the increased risk of poverty after adolescent pregnancy without marriage when combined with failure to complete high school. **Citation: [**Res. 422, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 422, A-13]

Humanitarian and Medical Aid Support to Ukraine D-65.984
Our AMA will advocate for: (1) continuous support of organizations providing humanitarian missions and medical care to Ukrainian refugees in Ukraine, at the Polish-Ukrainian border, in nearby countries, and/or in the US; (2) an early implementation of mental health measures, including suicide prevention efforts, and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian refugees with special attention to vulnerable populations including but not limited to young children, mothers, pregnant women, and the elderly; and (3) educational measures to enhance the understanding of war-related trauma in war survivors and promote broad protective factors (e.g., financial, employment,

housing, and food stability) that can improve adjustment and outcomes for war-affected people, particularly when applied to vulnerable categories of people. (Res. 017, A-22)

Accuracy, Importance, and Application of Data from the US Vital Statistics System H-85.961
Our AMA encourages physicians to provide complete and accurate information on prenatal care and hospital patient records of the mother and infant, as this information is the basis for the health and medical information on birth certificates. Citation: [CSA Rep. 6, I-00; Reaffirmed: Sub. Res. 419, A-02; Modified: CSAPH Rep. 1, A-12; Reaffirmed: CSAPH Rep. 1, A-22]

Addiction and Unhealthy Substance Use H-95.976
Our AMA is committed to efforts that can help the national problem of addiction and unhealthy substance use from becoming a chronic burden. The AMA pledges its continuing involvement in programs to alert physicians and the public to the dimensions of the problem and the most promising solutions. The AMA, therefore:
(1) supports cooperation in activities of organizations in fostering education, research, prevention, and treatment of addiction;
(2) encourages the development of addiction treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant women and women with infant children through a comprehensive array of essential services;
(3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant women, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals;
(4) supports pursuing the development of educational materials for physicians, physicians in training, other health care providers, and the public on prevention, diagnosis, and treatment of perinatal addiction. In this regard, the AMA encourages further collaboration in delivering appropriate messages to health professionals and the public on the risks and ramifications of perinatal drug and alcohol use;
(5) urges the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Substance Abuse and Mental Health Services Administration to continue to support research and demonstration projects around effective prevention and intervention strategies;
(6) urges that public policy be predicated on the understanding that alcoholism and drug dependence, including tobacco use disorder as indicated by the Surgeon General's report, are diseases characterized by compulsive use in the face of adverse consequences;
(7) affirms the concept that addiction is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the mother, the fetus and resultant offspring; and
(8) calls for better coordination of research, prevention, and intervention services for women and infants at risk for both HIV infection and perinatal addiction. (BOT Rep. Y, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-09; Modified: CSAPH Rep. 01, A-19)

Mercury and Fish Consumption: Medical and Public Health Issues H-150.947
AMA policy is that: (1) Women who might become pregnant, are pregnant, or who are nursing should follow federal, state or local advisories on fish consumption. Because some types of fish are known to have much lower than average levels of methylmercury and can be safely consumed more often and in larger amounts, women should also seek specific consumption recommendations from those authorities regarding locally caught or sold fish. (2) Physicians should (a) assist in educating patients about the relative mercury content of fish and shellfish products; (b) make patients aware of the advice contained in both national and regional consumer fish consumption advisories; and (c) have sample materials available, or direct patients to where they can access information on national and regional fish consumption advisories. (3) Testing of the mercury content of fish should be continued by appropriate agencies; results should be publicly accessible and reported in a consumer-friendly format. **Citation: [**CSA Rep. 13, A-04; Modified: Res. 538, A-05; Modified: CSAPH Rep. 1, A-15**]**

AMA Support for Breastfeeding H-245.982
1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and

Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.

2. Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.
3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.
4. Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).
5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines. Citation: [CSA Rep. 2, A-05; Res. 325, A-05; Reaffirmation A-07; Reaffirmation A-12; Modified in lieu of Res. 409, A-12 and Res. 410, A-12; Appended: Res. 410, A-16; Appended: Res. 906, I-17; Reaffirmation: I-18]

Accommodating Lactating Mothers Taking Medical Examinations H-295.861
Our AMA: (1) urges all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give breastfeeding individuals additional break time and a suitable environment during examinations to express milk; and (2) encourages that such accommodations to breastfeeding individuals include necessary time per exam day, in addition to the standard pool of scheduled break time found in the specific exam, as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump. Citation: [Sub. Res. 903, I-14; Modified: Res. 310, A-17]

Protecting Trainees' Breastfeeding Rights D-310.950
Our AMA will: (1) work with appropriate bodies, such as the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee on Medical Education (LCME), to include language in housestaff manuals or similar policy references of all training programs regarding protected times and locations for milk expression and secure storage of breast milk; and (2) work with appropriate bodies, such as the LCME, ACGME, and Association of American Medical Colleges (AAMC), to include language related to the learning and work environments for breastfeeding mothers in regular program reviews. Citation: [Res. 302, I-16]

Post-Partum Hospital Stay and Nurse Home Visits H-320.954
The AMA: (1) opposes the imposition by third party payers of mandatory constraints on hospital stays for vaginal deliveries and cesarean sections as arbitrary and as detrimental to the health of the mother and of the newborn; and (2) urges that payers provide payment for appropriate follow-up care for the mother and newborn. Citation: [Sub. Res. 105, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16]

Substance Use Disorders During Pregnancy H-420.950
Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance use disorder during pregnancy represents child abuse; (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation; and (4) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual's family structure, (b) the patient's treatment status, and (c) current impairment status when substance use is suspected. Citation: [Res. 209, A-18; Modified: Res. 520, A-19]

Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953
Our AMA: (1) supports improvements in current mental health services for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs. Citation: [Res. 102, A-12; Modified: Res. 503, A-17]

Shackling of Pregnant Women in Labor H-420.957
1. Our AMA supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents:
- An immediate and serious threat of harm to herself, staff or others; or
- A substantial flight risk and cannot be reasonably contained by other means.
If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used."
2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist. Citation: [Res. 203, A-10; Reaffirmed: BOT Rep. 04, A-20]

Perinatal Addiction - Issues in Care and Prevention H-420.962
Our AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care. Citation: [CSA Rep. G, A-92; Reaffirmation A-99; Reaffirmation A-09; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Modified: Alt. Res. 507, A-16; Modified: Res. 906, I-17; Reaffirmed: Res. 514, A-19]

Fetal Alcohol Syndrome Educational Program H-420.964
Our AMA supports informing physicians about Fetal Alcohol Syndrome and the referral and treatment of alcohol abuse by pregnant women or women at risk of becoming pregnant. Citation: [Res. 122, A-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

Universal Hepatitis B Virus (HBV) Antigen Screening for Pregnant Women H-420.968
It is the policy of the AMA to communicate the available guidelines for testing all pregnant women for HBV infection. Citation: [Res. 19, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

Legal Interventions During Pregnancy H-420.969
Court Ordered Medical Treatments And Legal Penalties For Potentially Harmful Behavior By Pregnant Women:
(1) Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases which do not present such exceptional circumstances.
(2) The physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's decision.
(3) A physician should not be liable for honoring a pregnant woman's informed refusal of medical treatment designed to benefit the fetus.
(4) Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate.
(5) Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs.
(6) To minimize the risk of legal action by a pregnant patient or an injured fetus, the physician should document medical recommendations made including the consequences of failure to comply with the physician's recommendation. Citation: [BOT Rep. OO, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed: Res. 507, A-16; Reaffirmed: Res. 209, A-18]

AMA Statement on Family and Medical Leave H-420.979
Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:
(1) medical leave for the employee, including pregnancy, abortion, and stillbirth;
(2) maternity leave for the employee-mother;
(3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and
(4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. Citation: [BOT Rep. A, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: CMS Rep. 03, A-16; Modified: Res. 302, I-22]

Research into Preterm Birth and Related Cardiovascular and Cerebrovascular Risks in Women D-420.992
Our AMA will advocate for more research on ways to identify risk factors linking preterm birth to cardiovascular or cerebrovascular disease in pregnant women. Citation: [Res. 504, A-17]

Bonding Programs for Women Prisoners and their Newborn Children H-430.990
Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. However, since there are established benefits of breast milk for infants and breast milk expression for mothers, the AMA advocates for policy and legislation that extends the right to breastfeed directly and/or privately pump and safely store breast milk to include incarcerated mothers. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of incarcerated females who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills and breastfeeding/breast pumping training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children. Citation: [CSA Rep. 3, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17; Modified: Res. 431, A-22]

7.3.4 Maternal-Fetal Research
Maternal-fetal research, i.e., research intended to benefit pregnant women and/or their fetuses, must balance the health and safety of the woman who participates and the well-being of the fetus with the desire to develop new and innovative therapies. One challenge in such research is that pregnant women may face external pressure or expectations to enroll from partners, family members, or others that may compromise their ability to make a fully voluntary decision about whether to participate.
Physicians engaged in maternal-fetal research should demonstrate the same care and concern for the pregnant woman and fetus that they would in providing clinical care.
In addition to adhering to general guidelines for the ethical conduct of research and applicable law, physicians who are involved in maternal-fetal research should:
(a) Base studies on scientifically sound clinical research with animals and nongravid human participants that has been carried out prior to conducting maternal-fetal research whenever possible.
(b) Enroll a pregnant woman in maternal-fetal research only when there is no simpler, safer intervention available to promote the well-being of the woman or fetus.
(c) Obtain the informed, voluntary consent of the pregnant woman.
(d) Minimize risks to the fetus to the greatest extent possible, especially when the intervention under study is intended primarily to benefit the pregnant woman. (Issued: 2016)

Supporting the Use of Gender-Neutral Language H-65.942
Our American Medical Association will (1) Recognize the importance of using gender-neutral language such as gender neutral pronouns, terms, imagery, and symbols in respecting the spectrum of gender identity, (2) prospectively amend all current AMA policy, where appropriate, to include gender-neutral language by way of the reaffirmation and sunset processes, (3) utilize gender-neutral language in future policies1 internal communications, and external communications where gendered language does not specifically need to be used, (4) encourage the use of gender-neutral language in public health and medical messaging, (5) encourage other professional societies to utilize gender-neutral language in their work, and (6) support the use of gender-neutral language in clinical spaces that may serve both cisgender and gender-diverse individuals. Citation: [Res. 602, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 605
(I-23)

Introduced by: Young Physicians Section

Subject: Ranked Choice Voting

Referred to: Reference Committee F

Whereas, our American Medical Association elections require run-off elections to elect candidates by majority; and

Whereas, ranked-choice voting elections can be run more efficiently without the need for runoff elections, while still ensuring the outcome preferred by a majority of voters; therefore be it

RESOLVED, that our American Medical Association study ranked-choice voting for all elections within the House of Delegates. (Directive to Take Action)

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

Received: 9/26/23

RELEVANT AMA POLICY

Elections. B-3.4
3.4.1 Time of Election. Officers of the AMA, except the Secretary, the medical student trustee, and the public trustee, shall be elected by the House of Delegates at the Annual Meeting, except as provided in Bylaws 3.6 and 3.7. The public trustee may be elected at any meeting of the House of Delegates at which the Selection Committee for the Public Trustee submits a nomination for approval by the House of Delegates. On recommendation of the Committee on Rules and Credentials, the House of Delegates shall set the day and hour of such election. The Medical Student Section shall elect the medical student trustee in accordance with Bylaw 3.5.6.

3.4.2 Method of Election. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by ballot.

3.4.2.1 At-Large Trustees.

3.4.2.1.1 First Ballot. All nominees for the office of At-Large Trustee shall be listed alphabetically on a single ballot. Each elector shall have as many votes as the number of Trustees to be elected, and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer or more votes than the number of Trustees to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if he or she has received a vote on a majority of the legal ballots cast and is one of the nominees receiving the largest number of votes within the number of Trustees to be elected.

3.4.2.1.2 Runoff Ballot. A runoff election shall be held to fill any vacancy not filled because of a tie vote.

3.4.2.1.3 Subsequent Ballots. If all vacancies for Trustees are not filled on the first ballot and 3 or more Trustees are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and

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

3.4.2.2 All Other Officers, except the Medical Student Trustee and the Public Trustee. All other officers, except the medical student trustee and the public trustee, shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

3.4.2.3 Medical Student Trustee. The medical student trustee is elected by the Medical Student Section in accordance with Bylaw 3.5.6.

3.4.2.4 Public Trustee. The public trustee shall be elected separately. The nomination for the public trustee shall be submitted to the House of Delegates by the Selection Committee for the Public Trustee. Nominations from the floor shall not be accepted. A majority vote of delegates present and voting shall be necessary to elect.

Election - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health. B-6.8
6.8.1 Nomination and Election. Members of these Councils, except the medical student member, shall be elected by the House of Delegates. Nominations shall be made by the Board of Trustees and may also be made from the floor by a member of the House of Delegates.

6.8.1.1 Separate Election. The resident/fellow physician member of these Councils shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

6.8.1.2 Other Council Members. With reference to each such Council, all nominees for election shall be listed alphabetically on a single ballot. Each elector shall have as many votes as there are members to be elected, and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer votes or more votes than the number of members to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if he or she has received a vote on a majority of the legal ballots cast and is one of the nominees receiving the largest number of votes within the number of members to be elected.

6.8.1.3 Run-Off Ballot. A run-off election shall be held to fill any vacancy that cannot be filled because of a tie vote.

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

6.8.2 Medical Student Member. Medical student members of these Councils shall be appointed by the Governing Council of the Medical Student Section with the concurrence of the Board of Trustees.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 607
(I-23)

Introduced by: The American Academy of Pediatrics

Subject: Equity-Focused Person-First Language in AMA Reports and Policies

Referred to: Reference Committee F

Whereas, Dominant narratives, often coded in the language we use, have been deeply rooted in value systems and ingrained in cultural practices that have given preference to the interests of society's most powerful social groups and can also be wielded as a weapon to oppress others; and

Whereas, Physicians and physicians in training must continuously reexamine the role of language and re-evaluate the long-held dominant narratives that exacerbate inequities in health care; and

Whereas, In 2019, the AMA established the Center for Health Equality to embed and advance equity across all aspects of health care, including within the American Medical Association itself; and

Whereas, Our AMA developed, in partnership with the Association of American Medical Colleges (AAMC) Center for Health Justice, one of the most comprehensive health equity communication guides; and

Whereas, *Advancing Health Equity: A Guide to Language, Narrative and Concepts* provides guidance and promotes a deeper understanding of equity-focused, person-first language and why it matters; and

Whereas, Better understanding about language and dominant narratives can help ensure that we are centering the lived experience of patients and communities without reinforcing labels, objectification, stigmatization and marginalization; therefore be it

RESOLVED, That our American Medical Association Board, Council and Task Force reports and recommendations use equity-focused, person-first language consistent with the AMA *Advancing Health Equity: A Guide to Language, Narrative and Concepts* (Directive to Take Action); and be it further

RESOLVED, That our AMA support, as policies are reviewed for sunset, if they are recommended to be maintained in policy, that the review committee recommend amendments as needed to ensure the use of equity-focused, person-first language consistent with the AMA *Advancing Health Equity: A Guide to Language, Narrative and Concepts* (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage sections, state and specialty societies and individual members to use equity-focused, person-first language consistent with the AMA *Advancing Health Equity: A Guide to Language, Narrative and Concepts* when writing resolutions and

include information about and a link to the guide in any educational materials about resolution writing and submission that they develop to share with their groups. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 9/27/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 810
(I-23)

Introduced by: Medical Student Section

Subject: Racial Misclassification

Referred to: Reference Committee J

Whereas, the National Center for Health Statistics maintains a National Death Index (NDI), a centralized database of death record information on file in state vital statistics offices[1-2]; and

Whereas, this data can be linked to databases maintained by agencies like the Centers for Disease Control, Food and Drug Administration, and Centers for Medicare and Medicaid Services to increase the availability of information on an individual's cause of death[1-5]; and

Whereas, a key limitation of these vital statistic data is the misclassification of race and ethnicity on death certificates and in other databases (e.g., inaccurate from minority identification to white), limiting the quality and applicability of data available for racial and ethnic minority populations experiencing health disparities[6-7]; and

Whereas, populations more likely to be misclassified on their death certificates include, but are not limited to, American Indians and Alaska Natives (AI/AN), Asian Americans, and Native Hawaiians and Other Pacific Islanders (NHPI)[6,8-13]; and

Whereas, a retrospective linkage of regional records maintained by the Indian Health Service and Oklahoma State Health Department Vital Records reported a 29% underestimation of all-cause mortality in the AI/AN population[6]; and

Whereas, an updated version of the National Longitudinal Mortality Study (1999-2011 decedents versus 1990-1998 decedents) found that racial misclassification remained high at 40% for the AI/AN population, improved, from 5% to 3%, for the Hispanic population, and from 7% to 3% for the Asian or Pacific Islander (API) population[14-15]; and

Whereas, racial misclassification on death certificates is compounded by missing or incorrect race and ethnicity data in other databases, such as those maintained by federal health programs, hospital systems, and related entities[15-19]; and

Whereas, a 2021 study of 4,231,370 Medicare beneficiaries who utilized home health care services in 2015 found substantial racial misclassification of self-identified Hispanic, Asian American, Pacific Islander, and AI/AN beneficiaries (more than 80% for AI/AN in 24 states and Puerto Rico) as non-Hispanic white[20]; and

Whereas, a 2019 study that conducted ICD-9/ICD-10 record linkages between the Northwest Tribal Registry and Oregon and Washington hospital discharge datasets increased the ascertainment of neonatal abstinence syndrome cases among AI/AN newborns by 8.8% in Oregon and by 18.1% in Washington[21]; and

Whereas, according to the United States Centers for Disease Control and Prevention, more AI/AN patients are misclassified as another race in cancer registry records than patients in other racial groups, likely from one group to identification as non-Hispanic white[22-23]; and

Whereas, a 2021 prospective observational study of patients admitted to an urban Level 1 trauma center found that 45 of 98 patients self-identifying as Hispanic (45.9%) had inaccurately recorded ethnicity in the trauma registry[24]; and

Whereas, decedent race and ethnicity may be subject to bias as a 2018 project by the National Consortium for Urban Indian Health found that 48% of surveyed funeral directors were recording an individual's race on death certificates by observation of the individual rather than asking their next of kin[9,25]; and

Whereas, mortality-related research data, combined with other clinically-based registries, is a fundamental tool for establishing public health priorities (e.g., advocacy, resource allocation, stakeholder engagement) at the local, state, tribal and federal level and is an important part of Indigenous Data Sovereignty (H-460.884)[26]; therefore be it

RESOLVED, that our American Medical Association amend H-85.953, "Improving Death Certification Accuracy and Completion," by addition as follows:

> Improving Death Certification Accuracy and Completion H-85.953
> 1. Our AMA: (a) acknowledges that the reporting of vital events is an integral part of patient care; (b) urges physicians to ensure completion of all state vital records carefully and thoroughly with special attention to the use of standard nomenclature, using legible writing and accurate diagnoses; and (c) supports notifying state medical societies and state departments of vital statistics of this policy and encouraging their assistance and cooperation in implementing it.
> 2. Our AMA also: (a) supports the position that efforts to improve cause of death statistics are indicated and necessary; (b) endorses the concept that educational efforts to improve death certificates should be focused on physicians, particularly those who take care of patients in facilities where patients are likely to die, namely in acute hospitals, nursing homes and hospices; and (c) supports the concept that training sessions in completion of death certificates should be (i) included in hospital house staff orientation sessions and clinical pathologic conferences; (ii) integrated into continuing medical education presentations; (iii) mandatory in mortality conferences; and (iv) included as part of in-service training programs for nursing homes, hospices and geriatric physicians.
> 3. Our AMA further: (a) promotes and encourages the use of ICD codes among physicians as they complete medical claims, hospital discharge summaries, death certificates, and other documents; (b) supports cooperating with the National Center for Health Statistics (NCHS) in monitoring the four existing models for collecting tobacco-use data; (c) urges the NCHS to identify appropriate definitions, categories, and methods of collecting risk-factor data, including quantification of exposure, for inclusion on the U.S. Standard Certificates, and that subsequent data be appropriately disseminated; and (d) continues to encourage all physicians to report tobacco use, exposure to environmental tobacco smoke, and other risk factors using the current standard death certificate format.

4. Our AMA further supports HIPAA-compliant data linkages between Native Hawaiian and Tribal Registries, population-based and hospital-based clinical trial and disease registries, and local, state, tribal, and federal vital statistics databases aimed at minimizing racial misclassification. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 09/27/2023

REFERENCES

1. Enhancing Data Resources for Researching Patterns of Mortality in Patient-Centered Outcomes Research. ASPE Office of the Assistant Secretary for Planning and Evaluation. Published online 2017. https://aspe.hhs.gov/enhancing-data-resources-researching-patterns-mortality-patient-centered-outcomes-research
2. National Death Index. Centers for Disease Control and Prevention. Published online 2022. https://www.cdc.gov/nchs/ndi/index.htm
3. Chopra S. Access to the National Death Index Made Easy. Published online March 21, 2022. https://irp.nih.gov/catalyst/28/6/news-you-can-use-national-death-index
4. Kwong SL, Perkins CI, Snipes KP, Wright WE. Improving American Indian cancer data in the California Cancer Registry by linkage with the Indian Health Service. J Registry Manage. 1998;25(1):17–20.
5. Partin MR, Rith-Najarian SJ, Slater JS, Korn JE, Cobb N, Soler JT. Improving cancer incidence estimates for American Indians in Minnesota. Am J Public Health. 1999;89(11):1673–1677
6. Dougherty TM, Janitz AE, Williams MB, et al. Racial Misclassification in Mortality Records Among American Indians/Alaska Natives in Oklahoma From 1991 to 2015. J Public Health Manag Pract. 2019;25 Suppl 5, Tribal Epidemiology Centers: Advancing Public Health in Indian Country for Over 20 Years(Suppl 5 TRIBAL EPIDEMIOLOGY CENTERS ADVANCING PUBLIC HEALTH IN INDIAN COUNTRY FOR OVER 20 YEARS):S36-S43. doi:10.1097/PHH.0000000000001019
7. Puukka E, Stehr-Green P, Becker TM. Measuring the health status gap for American Indians/Alaska Natives: getting closer to the truth. Am J Public Health. 2005;95(5):838–843.
8. Rhoades DA. Racial misclassification and disparities in cardiovascular disease among American Indians and Alaska Natives. Circulation. 2005;111(10):1250-1256. doi:10.1161/01.CIR.0000157735.25005.3F
9. Jim MA, Arias E, Seneca DS, et al. Racial misclassification of American Indians and Alaska Natives by Indian Health Service Contract Health Service Delivery Area. Am J Public Health. 2014;104 Suppl 3(Suppl 3):S295-S302. doi:10.2105/AJPH.2014.301933
10. Thoroughman DA, Frederickson D, Cameron HD, Shelby LK, Cheek JE. Racial misclassification of American Indians in Oklahoma State surveillance data for sexually transmitted diseases. Am J Epidemiol. 2002;155(12):1137-1141. doi:10.1093/aje/155.12.1137
11. Stehr-Green P, Bettles J, Robertson LD. Effect of racial/ethnic misclassification of American Indians and Alaskan Natives on Washington State death certificates, 1989-1997. Am J Public Health. 2002;92(3):443-444. doi:10.2105/ajph.92.3.443
12. McClure, Gartner, Bell. Challenges with misclassification of American Indian/Alaska Native race and Hispanic ethnicity on death records in North Carolina occupational fatalities surveillance. Frontiers in Epidemiology. Published online October 21, 2022. https://www.frontiersin.org/articles/10.3389/fepid.2022.878309/full
13. Harwell TS, Hansen D, Moore KR, Jeanotte D, Gohdes D, Helgerson SD. Accuracy of race coding on American Indian death certificates, Montana 1996-1998. Public Health Rep. 2002;117(1):44–49.
14. Arias E, Heron M, Hakes JK. The validity of race and Hispanic-origin reporting on death certificates in the United States: An update. National Center for Health Statistics. Vital Health Stat 2(172). 2016.
15. Johnson CL, Paulose-Ram R, Ogden CL, et al. National Health and Nutrition Examination Survey: Analytic guidelines, 1999–2010. National Center for Health Statistics. Vital Health Stat 2(161). 2013.
16. Yi, Kwon, Doan, John, Islam, Trinh-Shevrin. The Mutually Reinforcing Cycle Of Poor Data Quality And Racialized Stereotypes That Shapes Asian American Health. Health Affairs. 2022;41. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01417
17. Erikson, Flannery, Leipertz, et al. Data Genocide of American Indians and Alaska Natives in COVID-19 Data. Urban Indian Health Institute. Published online February 15, 2021. https://www.uihi.org/projects/data-genocide-of-american-indians-and-alaska-natives-in-covid-19-data/
18. Friedman J, Hansen H, Gone JP. Deaths of despair and Indigenous data genocide [published online ahead of print, 2023 Jan 25]. Lancet. 2023;S0140-6736(22)02404-7. doi:10.1016/S0140-6736(22)02404-7
19. Weikel BW, Klawetter S, Bourque SL, et al. Defining an Infant's Race and Ethnicity: A Systematic Review. Pediatrics. 2023;151(1):e2022058756. doi:10.1542/peds.2022-058756
20. Grafova IB, Jarrín OF. Beyond Black and White: Mapping Misclassification of Medicare Beneficiaries Race and Ethnicity. Med Care Res Rev. 2021;78(5):616-626. doi:10.1177/1077558720935733
21. Lan CW, Joshi S, Dankovchik J, et al. Racial Misclassification and Disparities in Neonatal Abstinence Syndrome Among American Indians and Alaska Natives. J Racial Ethn Health Disparities. 2022;9(5):1897-1904. doi:10.1007/s40615-021-01127-z

22. U.S. Cancer Statistics American Indian and Alaska Native Incidence Data. Centers for Disease Control and Prevention. Published online June 6, 2022. https://www.cdc.gov/cancer/uscs/about/tools/AIAN-incidence-analytic-db.htm
23. Frost F, Taylor V, Fries E. Racial misclassification of Native Americans in a Surveillance, Epidemiology, and End Results cancer registry. J Natl Cancer Inst. 1992;84(12):957–962.
24. Gore A, Truche P, Iskerskiy A, Ortega G, Peck G. Inaccurate Ethnicity and Race Classification of Hispanics Following Trauma Admission. J Surg Res. 2021;268:687-695. doi:10.1016/j.jss.2021.08.003
25. Kalweit, Clark, Ishcomer-Aazami. Determinants of Racial Misclassification in COVID-19 Mortality Data: The Role of Funeral Directors and Social Context. American Indian Culture and Research Journal. Published online July 6, 2021. http://www.books.aisc.ucla.edu/abstracts/44.3.KALWEITCLARKISHCOMER-AAZAMI.pdf
26. RACIAL MISCLASSIFICATION. National Council of Urban Indian Health. https://ncuih.org/misclassification

RELEVANT AMA POLICY

H-315.963 Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities

Our AMA encourages the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race, ethnicity, and preferred language. [Res. 03, I-19]

H-350.950 Tribal Public Health Authority

Our AMA will support; (1) the Department of Health and Human Services issuing guidance, through the Centers for Disease Control and Prevention and the Indian Health Service, on Public Health and Tribal-affiliated data-sharing with American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers; and (2) the use of data-sharing agreements between local and state public health departments and American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers. [Res. 206, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 816
(I-23)

Introduced by: GLMA: Health Professionals Advancing LGBTQ+ Equality

Subject: Reducing Barriers to Gender-Affirming Care through Improved Payment and Reimbursement

Referred to: Reference Committee J

Whereas, access to gender-affirming care is lifesaving for transgender and gender diverse patients[1]; and

Whereas, gender-affirming care remains a target of political attacks and legislation that restricts access[2]; and

Whereas, many health care payers consider gender-affirming care and related procedures not medically necessary and/or cosmetic[3]; and

Whereas, improving payment and reimbursement for gender-affirming care will improve access for patients[3]; therefore be it

RESOLVED, that our American Medical Association appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care. (Directive to Take Action)

Fiscal Note: $77,162. Host ad hoc meeting, staff time and potential consulting assistance.

Received: 9/27/23

REFERENCES

1. Tordoff D.M, Wanta J.W., Collin A., et al (2022). "Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care." JAMA Network Open 5 (2): e220978. doi:10.1001/jamanetworkopen.2022.0978
2. Keller J (2023). "New data: As far-right extremist politicians escalate attacks on transgender healthcare, nearly 8-in-10 LGBTQ+ Americans report increased fears for personal safety, further intensifying an already dangerous state of emergency." Human Rights Campaign. https://www.hrc.org/press-releases/new-data-as-far-right-extremist-politicians-escalate-attacks-on-transgender-healthcare-nearly-8-in-10-lgbtq-americans-report-increased-fears-for-personal-safety-further-intensifying-an-already-dangerous-state-of-emergency. Accessed 9/27/2023.
3. Patel H, Camacho J.M., Salehi N., Garakani R., Friedman L., Reid C.M (2023). "Journeying through the hurdles of gender-affirming care insurance: A literature analysis." Cureus 15 (3): e36849. doi: 10.7759/cureus.36849

RELEVANT AMA POLICY

H-70.919 Use of CPT Editorial Panel Process
Our AMA reinforces that the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance issues and all interested stakeholders should avail themselves of the well-established and documented CPT Editorial Panel process for the development of new and revised CPT codes, descriptors, guidelines, parenthetic statements and modifiers. [BOT Rep. 4, A-06; Reaffirmed: A-07; Reaffirmed: I-08; Reaffirmed: A-09; Reaffirmed: A-10; Reaffirmed: A-11; Reaffirmed: I-14; Reaffirmed:

CMS Rep. 4, I-15; Reaffirmed in lieu of: Res. 117, A-16; Reaffirmed in lieu of: Res. 121, A-17; Reaffirmed: A-18; Reaffirmed: I-18; Reaffirmed: Res 816, I-19]

H-185.927 Clarification of Medical Necessity for Treatment of Gender Dysphoria
Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; (2) will work with state and specialty societies and other interested stakeholders to: A) Advocate for federal, state, and local laws and policies to protect access to evidence-based care for gender dysphoria and gender incongruence; B) Oppose laws and policies that criminalize, prohibit or otherwise impede the provision of evidence-based, gender-affirming care, including laws and policies that penalize parents and guardians who support minors seeking and/or receiving gender-affirming care; C) Support protections against violence and criminal, civil, and professional liability for physicians and institutions that provide evidence-based, gender-affirming care and patients who seek and/or receive such care, as well as their parents and guardians; and D) Communicate with stakeholders and regulatory bodies about the importance of gender-affirming care for patients with gender dysphoria and gender incongruence; and (3) will advocate for equitable, evidence-based coverage of gender-affirming care by health insurance providers, including public and private insurers. [Res. 05, A-16; Modified: Res. 015, A-21; Modified: Res. 223, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 907
(I-23)

Introduced by: Medical Student Section

Subject: Occupational Screenings for Lung Disease

Referred to: Reference Committee K

Whereas, from 1999 to 2016, the average years of potential life lost due to pneumoconiosis has increased from 8.1 to 12.6 years[1]; and

Whereas, the recent resurgence of pneumoconiosis poses a threat to younger patients, with increased disease burden at initial diagnosis, and affects a growing number of occupations such as metal miners, denim workers, pottery and ceramics workers, and stone masons[2-6.]; and

Whereas, laborers affected by pneumoconiosis are disproportionately of Latine or American Indian descent, are more likely to live in isolated and rural communities without access to adequate preventive care, and are less likely to have graduated high school[7-8.]; and

Whereas, many laborers who depended heavily on mobile health clinics and screening centers were left without options for care when many of these were halted due to COVID[8.]; and

Whereas, occupational screening measures, including the federal National Institute for Occupational Safety & Health's Coal Workers' Health Surveillance Program for radiographic and spirometric screenings, have helped decrease pneumoconiosis mortality[5,9-12]; therefore be it

RESOLVED, that our American Medical Association amend Policy H-365.988, "Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies" by addition and deletion as follows:

> Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies, H-365.988
> Our AMA ~~supports~~: (1) supports the integration of occupational health and environmental health and injury prevention programs within existing health departments at the state and local level; (2) supports taking a leadership role in assisting state medical societies in implementation of such programs; ~~and~~ (3) supports working with federal agencies to ensure that "health" is the primary determinant in establishing environmental and occupational health policy; (4) recognizes barriers to accessibility and utilization of such programs; (5) recognizes inequities in occupational health screenings for pulmonary lung disease and supports efforts to increase accessibility of these screenings in marginalized communities; and (6) encourages utilization of accessible screenings, such as those used in the NIOSH Coal Workers Health Surveillance Program, for other at risk occupational groups and utilization of these free screenings. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 09/19/2023

REFERENCES

1. Mazurek JM, Wood J, Blackley DJ, Weissman DN. Coal Workers' Pneumoconiosis-Attributable Years of Potential Life Lost to Life Expectancy and Potential Life Lost Before Age 65 Years - United States, 1999-2016. *MMWR Morb Mortal Wkly Rep*. 2018;67(30):819-824. Published 2018 Aug 3.
2. Qi, Xian-Mei1; Luo, Ya1; Song, Mei-Yue2; Liu, Ying1; Shu, Ting1; Liu, Ying3; Pang, Jun-Ling1; Wang, Jing1; Wang, Chen3. Pneumoconiosis: current status and future prospects. Chinese Medical Journal: April 20, 2021 - Volume 134 - Issue 8 - p 898-907 doi: 10.1097/CM9.0000000000001461
3. Blackley DJ, Crum JB, Halldin CN, Storey E, Laney AS. Resurgence of Progressive Massive Fibrosis in Coal Miners - Eastern Kentucky, 2016. *MMWR Morb Mortal Wkly Rep*. 2016;65(49):1385-1389. Published 2016 Dec 16. doi:10.15585/mmwr.mm6549a1
4. Rose C, Heinzerling A, Patel K, et al. Severe Silicosis in Engineered Stone Fabrication Workers - California, Colorado, Texas, and Washington, 2017-2019. *MMWR Morb Mortal Wkly Rep*. 2019;68(38):813-818. Published 2019 Sep 27. doi:10.15585/mmwr.mm6838a1
5. Bell JL, Mazurek JM. Trends in Pneumoconiosis Deaths - United States, 1999-2018. *MMWR Morb Mortal Wkly Rep*. 2020;69(23):693-698. Published 2020 Jun 12. doi:10.15585/mmwr.mm6923a1
6. Akgün M. Denim production and silicosis. *Curr Opin Pulm Med*. 2016;22(2):165-169. doi:10.1097/MCP.0000000000000249
7. Evans K, Lerch S, Boyce TW, et al. An Innovative Approach to Enhancing Access to Medical Screening for Miners using a Mobile Clinic with Telemedicine Capability. *J Health Care Poor Underserved*. 2016;27(4A):62-72. doi:10.1353/hpu.2016.0182
8. Sood A, Pollard C, Suer KL, Vlahovich K, Walker J. Caring for Miners During the Coronavirus Disease-2019 (COVID-19) Pandemic. *J Rural Health*. 2021;37(1):165-168. doi:10.1111/jrh.12444
9. Reynolds LE, Wolfe AL, Clark KA, et al. Strengthening the Coal Workers' Health Surveillance Program. *J Occup Environ Med*. 2017;59(4):e71. doi:10.1097/JOM.0000000000000993
10. Voelker R. Black Lung Resurgence Raises New Challenges for Coal Country Physicians. *JAMA*. 2019;321(1):17-19. doi:10.1001/jama.2018.15966
11. Laney AS, Blackley DJ, Halldin CN. Radiographic disease progression in contemporary US coal miners with progressive massive fibrosis. *Occup Environ Med*. 2017;74(7):517-520. doi:10.1136/oemed-2016-104249
12. Li T, Yang X, Xu H, Liu H. Early Identification, Accurate Diagnosis, and Treatment of Silicosis. *Can Respir J*. 2022;2022:3769134. Published 2022 Apr 25. doi:10.1155/2022/3769134

RELEVANT AMA POLICY

H-185.936 Lung Cancer Screening to be Considered Standard Care

Our AMA: (1) recommends that coverage of screening low-dose CT (LDCT) scans for patients at high risk for lung cancer by Medicare, Medicaid, and private insurance be a required covered benefit; (2) will empower the American public with knowledge through an education campaign to raise awareness of lung cancer screening with low-dose CT scans in high-risk patients to improve screening rates and decrease the leading cause of cancer death in the United States; and (3) will work with interested national medical specialty societies and state medical associations to urge the Centers for Medicare & Medicaid Services and state Medicaid programs to increase access to low-dose CT screening for Medicaid patients at high risk for lung cancer by including it as a covered benefit, without cost-sharing or prior authorization requirements, and increasing funding for research and education to improve awareness and utilization of the screening among eligible enrollees. [Sub. Res. 114, A-14; Appended: Res. 418, A-22; Appended: Res. 112, A-23]

H-135.944 Further Limit of Asbestos in the United States

Our AMA supports legislation further restricting the use of asbestos in the United States. [Res. 215, A-07; Reaffirmed: BOT Rep. 22, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 908
(I-23)

Introduced by: Michigan

Subject: Sexuality and Reproductive Health Education

Referred to: Reference Committee K

Whereas, the American Academy of Pediatrics (AAP) has identified the timely need for equitable access to comprehensive sex education as a critical component of adolescent health; and

Whereas, the Centers for Disease Control and Prevention (CDC) states: “A quality sexual health education curriculum includes medically accurate, developmentally appropriate, and culturally relevant content and skills that target key behavioral outcomes and promote healthy sexual development. The curriculum is age-appropriate and planned across grade levels to provide information about health risk behaviors and experiences.”; and

Whereas, the CDC identifies the following benefits of students receiving sexual health education: Delay initiation of sexual intercourse; Have fewer sex partners; Have fewer experiences of unprotected sex; Increase their use of protection, specifically condoms; and, Improve their academic performance; and

Whereas, meta-analysis of comprehensive sex education programs showed marked effectiveness reducing sexual partners, unprotected sex, sexually transmitted infections (STIs), and pregnancy, while abstinence-only sex education programs did not indicate a statistically significant reduction in these measures; and

Whereas, states that have laws that require or stress abstinence-only programs have higher rates of teenage pregnancy; and

Whereas, in states that do not require medically accurate sexual education, rates of teen pregnancy, birth, and sexually transmitted infection are the highest; and

Whereas, 95 percent of unintended pregnancies were due to lack of contraception use and incorrect or inconsistent contraception usage; and

Whereas, the APP states that “comprehensive sex education should occur across the developmental spectrum, beginning at early ages and continuing throughout childhood and adolescence”; and

Whereas, our American Medical Association Policy H-170.968 also recognizes the importance of “developmentally appropriate sexuality education programming in the schools at all levels, at local option and direction”; therefore be it

RESOLVED, that our American Medical Association reaffirm AMA Policy H-170.968, “Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools,” and continue to advocate for the adoption of developmentally appropriate, culturally competent,

comprehensive sexuality and reproductive health education and reproductive rights curriculum. (Reaffirm HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 9/27/23

REFERENCES

1. American College of Obstetricians and Gynecologists. Women's global health and rights. Statement of Policy. Reaffirmed July 2021.
2. https://www.aap.org/en/patient-care/adolescent-sexual-health/equitable-access-to-sexual-and-reproductive-health-care-for-all-youth/.
3. https://www.cdc.gov/healthyyouth/whatworks/what-works-sexual-health-education.htm.
4. Chin H, Sipe T, Elder R, et al. (2012, March). The Effectiveness of Group-Based Comprehensive Risk-Reduction and Abstinence Education Interventions to Prevent or Reduce the Risk of Adolescent Pregnancy, Human Immunodeficiency Virus, and Sexually Transmitted Infections: Two Systematic Reviews for the Guide to Community Preventive Services. American Journal of Preventive Medicine. 2012;42(3):272-294. Doi: 10.1016/j.amepre.2011.11.006
5. Stanger-Hall, K. F., & Hall, D. W. (2011, October 14). Abstinence-Only Education and Teen Pregnancy Rates: Why We Need Comprehensive Sex Education in the U.S. Retrieved from http://journals.plos.org/plosone/article?id=10.1371 percent2Fjournal.pone.0024658&utm_source=AOL&utm_medium=readMore&utm_campaign=partner
6. Jozkowski, K. N., & Crawford, B. L. (2015). The Status of Reproductive and Sexual Health in Southern USA: Policy Recommendations for Improving Health Outcomes. Sexuality Research and Social Policy, 13(3), 252-262. doi:10.1007/s13178-015-0208-7
7. Gold, RB, Sonfield A, Richards CL, Frost JJ. (2009). Next Steps for America's Family Planning Program. New York: Guttmacher Institute

RELEVANT AMA POLICY

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968

(1) Supports the concept of sexuality education in the home, when possible, as well as developmentally appropriate sexuality education programming in the schools at all levels, at local option and direction;
(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms and other effective barrier protection methods available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ+ youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;
(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;
(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;
(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;

(7) Supports federal funding of comprehensive sex education programs that stress the importance of preventing unwanted teenage pregnancy and sexually transmitted infections via comprehensive education, including contraceptive choices, abstinence, and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and
(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and
(10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate. [CSA Rep. 7 and Reaffirmation I-99; Reaffirmed: Res. 403, A-01; Modified Res. 441, A-03; Appended: Res. 834, I-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: Res. 405, A-16; Appended: Res. 401, A-16; Appended: Res. 414, A-18; Appended: Res. 428, A-18; Modified: Res. 413, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 911
(I-23)

Introduced by: Medical Student Section

Subject: Support for Research on the Nutritional and Other Impacts of Plant-Based Meat

Referred to: Reference Committee K

Whereas, alternatives to animal meats are a growing industry, prompting the global food sector to undertake efforts to ensure the safety of foods in this category[1-7]; and

Whereas, plant-based meats present considerable nutritional and economic potential without many of the ethical and antibiotic resistance challenges of traditional factory meat production[6-10]; and

Whereas, emerging studies claim health benefits from consuming plant-based meat instead of animal meat, including improved cardiovascular and gut microbiome health[8,11-13]; and

Whereas, numerous experts, including in a Journal of the American Medical Association piece, recommend further research into the health effects of plant-based meat consumption[3,7,9,14-17]; therefore be it

RESOLVED, that our American Medical Association work with appropriate parties to support plant-based meat research funding. (Directive to Take Action)

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

Received: 09/27/2023

REFERENCES

1. Lawrence AS, Huang H, Johnson BJ, Wycherley TP. Impact of a Switch to Plant-Based Foods That Visually and Functionally Mimic Animal-Source Meat and Dairy Milk for the Australian Population-A Dietary Modelling Study. Nutrients. 2023;15(8):1825. doi:10.3390/nu15081825
2. Andreani G, Sogari G, Marti A, Froldi F, Dagevos H, Martini D. Plant-Based Meat Alternatives: Technological, Nutritional, Environmental, Market, and Social Challenges and Opportunities. Nutrients. 2023;15(2):452. doi:10.3390/nu15020452
3. Rizzolo-Brime L, Orta-Ramirez A, Puyol Martin Y, Jakszyn P. Nutritional Assessment of Plant-Based Meat Alternatives: A Comparison of Nutritional Information of Plant-Based Meat Alternatives in Spanish Supermarkets. Nutrients. 2023;15(6):1325. doi:10.3390/nu15061325
4. Salomé M, Mariotti F, Dussiot A, Kesse-Guyot E, Huneau JF, Fouillet H. Plant-based meat substitutes are useful for healthier dietary patterns when adequately formulated - an optimization study in French adults (INCA3). Eur J Nutr. 2023;62(4):1891-1901. doi:10.1007/s00394-023-03117-9
5. Alessandrini R, Brown MK, Pombo-Rodrigues S, Bhageerutty S, He FJ, MacGregor GA. Nutritional Quality of Plant-Based Meat Products Available in the UK: A Cross-Sectional Survey. Nutrients. 2021;13(12):4225. doi:10.3390/nu13124225
6. Guess N, Klatt K, Wei D, et al. A Cross-Sectional Analysis of Products Marketed as Plant-Based Across the United States, United Kingdom, and Canada Using Online Nutrition Information. Curr Dev Nutr. 2023;7(3):100059. doi:10.1016/j.cdnut.2023.100059
7. Munialo CD, Vriesekoop F. Plant-based foods as meat and fat substitutes. Food Sci Nutr. 2023;11(9):4898-4911. doi:10.1002/fsn3.3421
8. Hadi J, Brightwell G. Safety of Alternative Proteins: Technological, Environmental and Regulatory Aspects of Cultured Meat, Plant-Based Meat, Insect Protein and Single-Cell Protein. Foods Basel Switz. 2021;10(6):1226. doi:10.3390/foods10061226
9. Hu FB, Otis BO, McCarthy G. Can Plant-Based Meat Alternatives Be Part of a Healthy and Sustainable Diet? JAMA. 2019;322(16):1547-1548. doi:10.1001/jama.2019.13187

10. Curtain F, Grafenauer S. Plant-Based Meat Substitutes in the Flexitarian Age: An Audit of Products on Supermarket Shelves. Nutrients. 2019;11(11):2603. doi:10.3390/nu11112603
11. Crimarco A, Landry MJ, Carter MM, Gardner CD. Assessing the effects of alternative plant-based meats v. animal meats on biomarkers of inflammation: a secondary analysis of the SWAP-MEAT randomized crossover trial. J Nutr Sci. 2022;11:e82. doi:10.1017/jns.2022.84
12. Toribio-Mateas MA, Bester A, Klimenko N. Impact of Plant-Based Meat Alternatives on the Gut Microbiota of Consumers: A Real-World Study. Foods Basel Switz. 2021;10(9):2040. doi:10.3390/foods10092040
13. Xiao X, Zou PR, Hu F, Zhu W, Wei ZJ. Updates on Plant-Based Protein Products as an Alternative to Animal Protein: Technology, Properties, and Their Health Benefits. Mol Basel Switz. 2023;28(10):4016. doi:10.3390/molecules28104016
14. Tyndall SM, Maloney GR, Cole MB, Hazell NG, Augustin MA. Critical food and nutrition science challenges for plant-based meat alternative products. Crit Rev Food Sci Nutr. Published online August 16, 2022:1-16. doi:10.1080/10408398.2022.2107994
15. Flint M, Bowles S, Lynn A, Paxman JR. Novel plant-based meat alternatives: future opportunities and health considerations. Proc Nutr Soc. 2023;82(3):370-385. doi:10.1017/S0029665123000034
16. Romão B, Botelho RBA, Torres ML, et al. Nutritional Profile of Commercialized Plant-Based Meat: An Integrative Review with a Systematic Approach. Foods Basel Switz. 2023;12(3):448. doi:10.3390/foods12030448
17. Augustin Mihalache O, Dellafiora L, Dall'Asta C. A systematic review of natural toxins occurrence in plant commodities used for plant-based meat alternatives production. Food Res Int Ott Ont. 2022;158:111490. doi:10.1016/j.foodres.2022.111490

RELEVANT AMA POLICY

H-150.922 Reduction in Consumption of Processed Meats

Our AMA supports: (1) reduction of processed meat consumption, especially for patients diagnosed or at risk for cardiovascular disease, type 2 diabetes, and cancer; (2) initiatives to reduce processed meats consumed in public schools, hospitals, food markets and restaurants while promoting healthy alternatives such as a whole foods and plant-based nutrition; (3) public awareness of the risks of processed meat consumption; and (4) educational programs for health care professionals on the risks of processed meat consumption and the benefits of healthy alternatives. [Res. 406, A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 912
(I-23)

Introduced by: Medical Student Section

Subject: Fragrance Regulation

Referred to: Reference Committee K

Whereas, fragrances include many contact allergens, irritants, cross-reactors, or other substance or natural extract often found in personal care products, cosmetics, household products, drugs, and wound care products[1-11]; and

Whereas, individuals with fragrance sensitivity experience adverse effects after exposure, especially patients with allergies, asthma, eczema, lung disease, and migraine[1,2-26]; and

Whereas, due to wide use, fragrances are the most common cause of contact allergy and lead to debilitating systemic dermatologic, neurologic, and immunologic side effects[12-16]; and

Whereas, large surveys show that over 30% of individuals may experience fragrance sensitivity, 50% prefer that healthcare facilities be fragrance-free, and 7% lose workdays due to workplace fragrance exposure[1,11-14]; and

Whereas, fragranced products can lower both indoor and outdoor air quality by releasing hazardous air pollutants that contribute to diseases and illness[1,5,8,14,22]; and

Whereas, the severity of fragrance sensitivity often meets Americans with Disabilities Act (ADA) criteria for a disability ("physical or mental impairment that substantially limits one or more major life activities") and may be considered an "invisible disability" ("impairment…not always obvious to the onlooker")[30-32]; and

Whereas, *Core v. Champaign County Board of County Commissioners* (2012) and *McBride v. the City of Detroit* (2009) found that severe fragrance sensitivity can be an invisible disability, leading Detroit to add a fragrance-free policy to their employee ADA handbook[33-34]; and

Whereas, fragrance-free policies are recommended by the Centers for Disease Control and Prevention, the American Lung Association, and the US Department of Labor Office of Disability Employment Policy and are in place in multiple healthcare facilities, workplaces, schools, and other organizations across the US[35-39]; and

Whereas, the US Food and Drug Administration and US Consumer Product Safety Commission do not currently regulate fragrances[2,40-45]; and

Whereas, the European Union has already banned nearly 1,400 chemicals from cosmetics and required premarket safety assessments, mandatory registration, and government authorization for the use of certain materials, compared to only 30 chemicals in the US[46-48]; therefore be it

RESOLVED, that our American Medical Association recognize fragrance sensitivity as a disability where the presence of fragranced products can limit accessibility of healthcare settings (New HOD Policy); and be it further

RESOLVED, that our AMA encourage all hospitals, outpatient clinics, urgent cares, and other patient care areas inclusive of medical schools to adopt a fragrance-free policy that pertains to employees, patients, and visitors of any kind (New HOD Policy); and be it further

RESOLVED, that our AMA work with relevant parties to advocate for governmental regulatory bodies, including but not limited to the Occupational Safety and Health Administration (OSHA), the Centers for Disease Control and Prevention (CDC), and the National Institute for Occupational Safety and Health (NIOSH) to recommend fragrance-free policies in all medical offices, buildings, and places of patient care (Directive to Take Action); and be it further

RESOLVED, that our AMA work with relevant parties to support the appropriate labeling of fragrance-containing personal care products, cosmetics, and drugs with warnings about possible allergic reactions or adverse events due to the fragrance, and advocates for increased categorization in the use of a “fragrance free” designation (Directive to Take Action); and be it further

RESOLVED, that our AMA support increased identification of hazardous chemicals in fragrance compounds, as well as research focused on fragrance sensitivity in order to remove these allergens from products applied to one’s body. (New HOD Policy)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 09/27/2023

REFERENCES

1. Steinemann A. International prevalence of fragrance sensitivity. Air Qual Atmosphere Health. 2019;12(8):891-897. doi:10.1007/s11869-019-00699-4
2. Pastor-Nieto MA, Gatica-Ortega ME. Ubiquity, Hazardous Effects, and Risk Assessment of Fragrances in Consumer Products. Curr Treat Options Allergy. 2021;8(1):21-41. doi:10.1007/s40521-020-00275-7
3. Shawa H, Wu PA, Dahle S, Isseroff RR, Sood A. Potential Allergens in Wound Care Products. Dermat Contact Atopic Occup Drug. 2023;34(1):51-55. doi:10.1089/DERM.0000000000000946
4. Ravichandran J, Karthikeyan BS, Jost J, Samal A. An atlas of fragrance chemicals in children’s products. Sci Total Environ. 2022;818:151682. doi:10.1016/j.scitotenv.2021.151682
5. Rádis-Baptista G. Do Synthetic Fragrances in Personal Care and Household Products Impact Indoor Air Quality and Pose Health Risks? J Xenobiotics. 2023;13(1):121-131. doi:10.3390/jox13010010
6. Wieck S, Olsson O, Kümmerer K, Klaschka U. Fragrance allergens in household detergents. Regul Toxicol Pharmacol RTP. 2018;97:163-169. doi:10.1016/j.yrtph.2018.06.015
7. Couteau C, Morin T, Diarra H, Coiffard L. Influence of Cosmetic Type and Distribution Channel on the Presence of Regulated Fragrance Allergens: Study of 2044 Commercial Products. Clin Rev Allergy Immunol. 2020;59(1):101-108. doi:10.1007/s12016-020-08790-w
8. Steinemann A, Nematollahi N, Rismanchi B, Goodman N, Kolev SD. Pandemic products and volatile chemical emissions. Air Qual Atmosphere Health. 2021;14(1):47-53. doi:10.1007/s11869-020-00912-9
9. Kumar M, Devi A, Sharma M, Kaur P, Mandal UK. Review on perfume and present status of its associated allergens. J Cosmet Dermatol. 2021;20(2):391-399. doi:10.1111/jocd.13507
10. Panico A, Serio F, Bagordo F, et al. Skin safety and health prevention: an overview of chemicals in cosmetic products. J Prev Med Hyg. 2019;60(1):E50-E57. doi:10.15167/2421-4248/jpmh2019.60.1.1080
11. Uter W, Werfel T, Lepoittevin JP, White IR. Contact Allergy-Emerging Allergens and Public Health Impact. Int J Environ Res Public Health. 2020;17(7):2404. doi:10.3390/ijerph17072404
12. Silvestre JF, Mercader P, González-Pérez R, et al. Sensitization to fragrances in Spain: A 5-year multicentre study (2011-2015). Contact Dermatitis. 2019;80(2):94-100. doi:10.1111/cod.13152
13. Pastor-Nieto MA, Gatica-Ortega ME. Ubiquity, hazardous effects, and risk assessment of fragrances in consumer products. Curr Treat Options Allergy. 2021;8(1):21-41. doi: 10.1007/s40521-020-00275-7 [doi].
14. Nematollahi N, Doronila A, Mornane PJ, Duan A, Kolev SD, Steinemann A. Volatile chemical emissions from fragranced baby products. Air Qual Atmos Health. 2018;11(7):785-790. doi: 10.1007/s11869-018-0593-1 [doi].

15. Tam I, Yu J. Allergic contact dermatitis in children: Recommendations for patch testing. Current Allergy and Asthma Reports. 2020;20(9):41. https://doi.org/10.1007/s11882-020-00939-z. doi: 10.1007/s11882-020-00939-z.
16. Warshaw EM, Schlarbaum JP, Silverberg JI, et al. Contact dermatitis to personal care products is increasing (but different!) in males and females: North american contact dermatitis group data, 1996-2016. Journal of the American Academy of Dermatology. 2021;85(6):1446-1455. https://www.sciencedirect.com/science/article/pii/S0190962220327547. doi: https://doi.org/10.1016/j.jaad.2020.10.003.
17. de Groot AC. Fragrances: Contact allergy and other adverse effects. Dermatitis®. 2020;31(1). https://journals.lww.com/dermatitis/Fulltext/2020/01000/Fragrances__Contact_Allergy_and_Other_Adverse.3.aspx.
18. Johansen JD, Werfel T. Highlights in allergic contact dermatitis 2018/2019. Current Opinion in Allergy and Clinical Immunology. 2019;19(4). https://journals.lww.com/co-allergy/Fulltext/2019/08000/Highlights_in_allergic_contact_dermatitis.11.aspx.
19. Zhou J, Tierney NK, McCarthy TJ, Black KG, Hernandez M, Weisel CP. Estimating infants' and toddlers' inhalation exposure to fragrance ingredients in baby personal care products. Int J Occup Environ Health. 2017;23(4):291-298. doi: 10.1080/10773525.2018.1475446
20. Herz RS, Larsson M, Trujillo R, et al. A three-factor benefits framework for understanding consumer preference for scented household products: psychological interactions and implications for future development. Cogn Res Princ Implic. 2022;7(1):28. doi:10.1186/s41235-022-00378-6
21. Nassau S, Fonacier L. Allergic Contact Dermatitis. Med Clin North Am. 2020;104(1):61-76. doi:10.1016/j.mcna.2019.08.012
22. Nematollahi N, Kolev SD, Steinemann A. Volatile chemical emissions from 134 common consumer products. Air Qual Atmosphere Health. 2019;12(11):1259-1265. doi:10.1007/s11869-019-00754-0
23. Steinemann A, Nematollahi N. Migraine headaches and fragranced consumer products: an international population-based study. Air Qual Atmosphere Health. 2020;13(4):387-390. doi:10.1007/s11869-020-00807-9
24. Steinemann A. Ten questions concerning fragrance-free policies and indoor environments. Build Environ. 2019;159:106054. doi:10.1016/j.buildenv.2019.03.052
25. Warshaw EM, Schlarbaum JP, Silverberg JI, et al. Contact dermatitis to personal care products is increasing (but different!) in males and females: North American Contact Dermatitis Group data, 1996-2016. J Am Acad Dermatol. 2021;85(6):1446-1455. doi:10.1016/j.jaad.2020.10.003
26. Johansen JD, Werfel T. Highlights in allergic contact dermatitis 2018/2019. Curr Opin Allergy Clin Immunol. 2019;19(4):334. doi:10.1097/ACI.0000000000000552
27. Maung TZ, Bishop JE, Holt E, Turner AM, Pfrang C. Indoor Air Pollution and the Health of Vulnerable Groups: A Systematic Review Focused on Particulate Matter (PM), Volatile Organic Compounds (VOCs) and Their Effects on Children and People with Pre-Existing Lung Disease. Int J Environ Res Public Health. 2022;19(14):8752. doi:10.3390/ijerph19148752
28. Vardoulakis S, Giagloglou E, Steinle S, et al. Indoor Exposure to Selected Air Pollutants in the Home Environment: A Systematic Review. Int J Environ Res Public Health. 2020;17(23):8972. doi:10.3390/ijerph17238972
29. Nematollahi N, Doronila A, Mornane PJ, Duan A, Kolev SD, Steinemann A. Volatile chemical emissions from fragranced baby products. Air Qual Atmosphere Health. 2018;11(7):785-790. doi:10.1007/s11869-018-0593-1
30. Rossi S, Pitidis A. Multiple Chemical Sensitivity: Review of the State of the Art in Epidemiology, Diagnosis, and Future Perspectives. J Occup Environ Med. 2018;60(2):138-146. doi:10.1097/JOM.0000000000001215
31. Steinemann, A., Health and societal effects from exposure to fragranced consumer products. Preventive medicine reports, 2016. 5: p. 45-47.
32. Why go fragrance free? Invisible Disabilities® Association. (2021, January 11). Retrieved March 16, 2022, from https://invisibledisabilities.org/publications/chemicalsensitivities/whygofragrancefree
33. Town Hall meeting transcript for Chicago. U.S. Equal Employment Opportunity Commission. (n.d.). Retrieved March 17, 2022, from https://www.eeoc.gov/town-hall-meeting-transcript-chicago
34. “Core v. Champaign County Board of County Commissioners, No. 3:2011CV00166 - Document 51 (S.D. Ohio 2012).” Justia Law, https://law.justia.com/cases/federal/district-courts/ohio/ohsdce/3:2011cv00166/146509/51/.
35. Accommodation and Compliance: Fragrance Sensitivity. Job Accommodation Network. https://askjan.org/disabilities/Fragrance-Sensitivity.cfm. Accessed March 17, 2022.
36. Centers For Disease Control and Prevention, Department of Health and Human Services. (2009, June 22). CDC1 indoor environmental quality policy. Retrieved March 17, 2022, from https://irp-cdn.multiscreensite.com/c4e267ab/files/uploaded/DskIT9BfRF6ZwAsibvxq_CDC_Indoor%20Environmental%20Quality%20Policy_2009.pdf
37. “Indoor Environmental Quality: Chemicals and Odors.” Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 25 Feb. 2022, https://www.cdc.gov/niosh/topics/indoorenv/chemicalsodors.html.
38. “Department of Labor Logo United States department of Labor.” Indoor Air Quality - Overview | Occupational Safety and Health Administration, https://www.osha.gov/indoor-air-quality.
39. Consumer Products Smog.California Air Resources Board.(n.d.).Retrieved March 20, 2022, from https://ww2.arb.ca.gov/our-work/programs/consumer-products-program/consumer-products-smog
40. FDA regulation of cosmetics and personal care products. Congressional Research Service. 2022:1-33.
41. Nutrition, Center for Food Safety and Applied. Is it a cosmetic, a drug, or both? (or is it soap?). FDA. 2022. https://www.fda.gov/cosmetics/cosmetics-laws-regulations/it-cosmetic-drug-or-both-or-it-soap. Accessed Aug 31, 2022.
42. Affairs OoR. Are all "personal care products" regulated as cosmetics? FDA. 2022. https://www.fda.gov/industry/fda-basics-industry/are-all-personal-care-products-regulated-cosmetics. Accessed Aug 31, 2022.
43. Nutrition, Center for Food Safety and Applied. Cosmetics guidance & regulation. FDA Web site. https://www.fda.gov/cosmetics/cosmetics-guidance-regulation. Updated 2022. Accessed Aug 31, 2022.
44. Nutrition, Center for Food Safety and Applied. FDA authority over cosmetics: How cosmetics are not FDA-approved, but are FDA-regulated. FDA Web site. https://www.fda.gov/cosmetics/cosmetics-laws-regulations/fda-authority-over-cosmetics-how-cosmetics-are-not-fda-approved-are-fda-regulated. Updated 2013. Accessed Aug 31, 2022.

45. Boozalis E, Patel S. Clinical utility of marketing terms used for over-the-counter dermatologic products. J Dermatol Treat. 2018;29(8):841-845. https://doi.org/10.1080/09546634.2018.1467540. doi: 10.1080/09546634.2018.1467540.
46. EUR-Lex - 32009R1223 - EN - EUR-Lex. Accessed September 16, 2023. https://eur-lex.europa.eu/eli/reg/2009/1223/oj
47. Klaschka, U., Between attraction and avoidance: from perfume application to fragrance-free policies. Environmental Sciences Europe, 2020. 32(1): p. 98.
48. Scientific Committee on Consumer Safety (SCCS). Accessed September 16, 2023. https://health.ec.europa.eu/scientific-committees/scientific-committee-consumer-safety-sccs_en

RELEVANT AMA POLICY

H-440.855 National Cosmetics Registry and Regulation

1. Our AMA: (a) supports the creation of a publicly available registry of all cosmetics and their ingredients in a manner which does not substantially affect the manufacturers' proprietary interests and (b) supports providing the Food and Drug Administration with sufficient authority to recall cosmetic products that it deems to be harmful.
2. Our AMA will monitor the progress of HR 759 (Food and Drug Administration Globalization Act of 2009) and respond as appropriate. [BOT Action in response to referred for decision Res. 907, I-09; Reaffirmed in lieu of: Res. 502, A-17]

Informational Reports

Report(s) of the Board of Trustees

03 Update on Climate Change and Health – AMA Activities
04 Update on Firearm Injury Prevention Task Force
08 AMA Efforts on Medicare Payment Reform

Opinion(s) of the Council on Ethical and Judicial Affairs

01 Responsibilities to Promote Equitable Care

Report(s) of the Council on Long Range Planning and Development

02 Generative AI in Medicine and Health Care

Report(s) of the Council on Medical Service

04 Physician-Owned Hospitals

Report(s) of the Speakers

01 Report of the Resolution Modernization Task Force Update

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

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

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

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

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

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

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

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

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

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

"As physicians, we are aware of all the health threats but what can one doctor do?"

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

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

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

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

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

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

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

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

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

AMA Actions to Advance Priority Areas

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

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

REFERENCES

[1] NASA. Scientific Consensus: Earth's Climate Is Warming. Available at https://climate.nasa.gov/scientific-consensus/.
[2] NOAA. Climate Change: Global Temperature. Available at https://www.climate.gov/news-features/understanding-climate/climate-change-global-temperature#:~:text=According%20to%20NOAA's%202021%20Annual,0.18%20%C2%B0C)%20per%20decade.
[3] NOAA. Climate Change: Global Temperature. Available at https://www.climate.gov/news-features/understanding-climate/climate-change-global-temperature#:~:text=According%20to%20NOAA's%202021%20Annual,0.18%20%C2%B0C)%20per%20decade.
[4] Kaiser C. Canadian wildfire smoke puts around 70 million US residents under air quality alerts. *CNN*, July17, 2023. Available at https://www.cnn.com/2023/07/16/weather/canada-Kwildfires-us-air-quality-alerts-sunday.
[5] Chiu A. et al. Phoenix hits record for 19th day of 110+ degrees in a row — with more ahead. *Washington Post*, July 18, 2023. Available at https://www.washingtonpost.com/weather/2023/07/18/phoenix-heat-wave-record-temperature-streak/?utm_campaign=wp_the7&utm_medium=email&utm_source=newsletter&wpisrc=nl_the7.
[6] NASA – Earth Observatory. Relentless Heat in the Southwest. July 25, 2023. Available at: https://earthobservatory.nasa.gov/images/151632/relentless-heat-in-the-southwest#:~:text=An%20unprecedented%20streak%20of%20extreme,Southwest%20on%20July%2025%2C%202023.
[7] Salahieh N. and Mascarenhas L. Catastrophic flooding swamped Vermont's capital as intense storms forced evacuations and closures in Northeast. *CNN*, July 12, 2023. Available at https://www.cnn.com/2023/07/11/us/northeast-storms-flooding-excessive-rainfall-tuesday/index.html.
[8] American Medical Association. Lower costs by going green! 2017. Available at: https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/ps2/transition-green-physician-practice.pdf
[9] National Academy of Medicine. Key Actions to Reduce Greenhouse Gas Emissions by U.S. Hospitals and Health Systems. Available at https://nam.edu/programs/climate-change-and-human-health/action-collaborative-on-decarbonizing-the-u-s-health-sector/key-actions-to-reduce-greenhouse-gas-emissions-by-u-s-hospitals-and-health-systems/#:~:text=To%20address%20these%20impacts%2C%20the%20NAM%20Climate%20Collaborative,systems%20starting%20their%20journey%20to%20reach%20decarbonization%20goals.
[10] Adams G., Entwistle D., Hochman R., and Lassiter III W. Embracing sustainability makes good business sense. *Modern Healthcare, Thought Leadership*, June 19, 2023. Available at https://www.modernhealthcare.com/Reprint-MH23054NationalAcademy.
[11] American Public Health Association, Center for Climate, Health and Equity. Available at https://www.apha.org/topics-and-issues/climate-change/center.

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

American College of Emergency Physicians
American College of Obstetricians and Gynecologists
American College of Physician
American College of Preventive Medicine
American College of Surgeons
American Geriatrics Society
American Pediatric Surgical Association
American Psychiatric Association
National Medical Association
Society of Critical Care Medicine

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

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

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

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

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

Federation Engagement

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

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

Grassroots, Media, and Outreach

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

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

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

CONCLUSION

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

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.

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

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

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

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

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

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

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

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

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

CLRPD Report 2-I-23, Generative AI in Medicine and Health Care

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.

TERMINOLIGIES AND COMPONENTS OF AI

CLRPD Report 1-A-18, A Primer on Artificial and Augmented Intelligence[1] 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.

DEFINTION 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]

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

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

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

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

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

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

tools provide digests based on the best available evidence. Although efforts are underway[10] to train LLMs on exclusively authoritative, medically relevant texts, they are still nascent and prior efforts have faltered.[11]

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

GENERATIVE AI MODELS

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

- Transformer-based models: These models, such as OpenAI's ChatGPT and GPT-3.5, are neural networks designed for natural language processing. They are trained on large amounts of data to learn the relationships between sequential data — like words and sentences — making them useful for text-generation tasks.

- Generative adversarial networks (GANs): GANs are made up of two neural networks, a generator, and a discriminator that work in a competitive or adversarial capacity. The generator creates data, while the discriminator evaluates the quality and authenticity of said data. Over time, both networks get better at their roles, leading to more realistic outputs.

- Variational autoencoders (VAEs): VAEs use an encoder and a decoder to generate content. The encoder takes the input data, such as images or text, and simplifies it into a more compact form. The decoder takes this encoded data and restructures it into something new that resembles the original input.

- Multimodal models: Multimodal models can process multiple types of input data, including text, audio, and images. They combine different modalities to create more sophisticated outputs, such as DALL-E 2[14] and OpenAI's GPT-4[15], which is also capable of accepting image and text inputs.

OpenAI ChatGPT

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

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

GPT-3.5 in a series of simulated benchmark exams. It has also reduced the number of "hallucinations" produced by the chatbot.[17]

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

Google Bard and Med-PaLM

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

In April 2023, Google announced a new version of its medical LLM, called Med-PaLM 2.[22] An AI platform for analyzing medical data, it aims to assist physicians with routine tasks and provide more reliable answers to patient questions than "Dr. Google." *PaLM 2, the Pathways Language Model*, is more critical than Bard for medicine. With 540 billion parameters, it draws knowledge from scientific papers and websites, can reason logically, and perform complex mathematical calculations.[23] Google is actively developing its large language model (LLM), Med-PaLM 2, which they anticipate will excel at healthcare discussions over general-purpose algorithms, given its training on questions and answers from medical licensing exams. They are collaborating with Mayo Clinic and other health systems and partnering with the healthcare technology vendor, CareCloud.[24]

Microsoft Bing AI

In early February 2023, Microsoft unveiled[25] a new version of Bing[26] -- and its standout feature is its integration with GPT-4. When it was announced, Microsoft shared that Bing Chat was powered by a next-generation version of OpenAI's large language model, making it "more powerful than ChatGPT."[27]

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

Building a generative AI model has for the most part been a major undertaking, to the extent that only a few well-resourced tech heavyweights have tried. OpenAI, the company behind ChatGPT, 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

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

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

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

REGULATORY FRAMEWORK FOR USE OF GENERATIVE AI IN MEDICINE

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

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

- Any regulatory framework should ensure that only safe, clinically validated, high-quality tools enter the marketplace. "We can't allow AI to introduce additional bias" into clinical care, cautioning that this could erode public confidence in the tools that come to the marketplace.[59]

- There also needs to be a balance between strong oversight and ensuring the regulatory system is not overly burdensome to developers, entrepreneurs, and manufacturers, "while also thinking about how we limit liability in appropriate ways for physicians," added Dr. Ehrenfeld.

- The FDA has a medical device action plan on AI and machine-learning software that would enable the agency to track and evaluate a software product from premarket development to post market performance.[60] The AMA has weighed in on the plan, saying the agency must guard against bias in AI and focus on patient outcomes.[61]

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

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

CLRPD DISCUSSION

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 a substantial contributor to physician burnout.

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

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

Relevant AMA Policy

Augmented Intelligence in Health Care H-480.939[66]
Augmented Intelligence in Health Care H-480.940[67]
Augmented Intelligence in Medical Education H-295.857[68]
Professionalism in Health Care Systems E-11.2.1 [69]
Assessing the Potentially Dangerous Intersection Between AI and Misinformation H-480.935[70]

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.

REFERENCES

[1] AMA. "CLRPD Report 1-A-18: A Primer on Artificial and Augmented Intelligence." https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/hod/a18-clrpd01.pdf. Accessed August 22, 2023.
[2] McKinsey. "What is ChatGPT, DALL-E, and generative AI?" https://www.mckinsey.com/featured-insights/mckinsey-explainers/what-is-generative-ai. Accessed August 22, 2023.
[3] Friedland A. "What are Generative AI, Large Language Models, and Foundation Models?" Center for Security and Emerging Technology. https://cset.georgetown.edu/article/what-are-generative-ai-large-language-models-and-foundation-models/. Accessed August 22, 2023.
[4] Callaway E. "DeepMind's AI Makes Gigantic Leap in Solving Protein Structures." Scientific American. https://www.scientificamerican.com/article/deepminds-ai-makes-gigantic-leap-in-solving-protein-structures/. Accessed August 22, 2023.

[5] Gordon R. "3 Questions: Jacob Andreas on Large Language Models." MIT News | Massachusetts Institute of Technology. https://news.mit.edu/2023/3-questions-jacob-andreas-large-language-models-0511. Published May 11, 2023. Accessed August 22, 2023.
[6] Chen BX. "Get the Best from ChatGPT with These Golden Prompts." The New York Times. https://www.nytimes.com/2023/05/25/technology/ai-chatbot-chatgpt-prompts.html. Published May 25, 2023. Accessed August 22, 2023.
[7] Pifer R. "Hurtling into the Future: The Potential and Thorny Ethics of Generative AI in Healthcare." Healthcare Dive. https://www.healthcaredive.com/news/generative-AI-healthcare-gpt-potential/648104/. Accessed August 22, 2023.
[8] AXIOS. " Terms-of-service land grab: Tech firms seek private data to train AI." Accessed August 24, 2023.
[9] Mello M, Guha N. "ChatGPT and Physicians' Malpractice Risk." JAMA. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2805334? Accessed August 22, 2023.
[10] Bolton E, Hall D, Yasunaga M, et. All. "Stanford CRFM Introduces PubMed GPT 2.7B." Stanford HAI. https://hai.stanford.edu/news/stanford-crfm-introduces-pubmedgpt-27b. Accessed August 22, 2023.
[11] Heaven WD. "Why Meta's latest Large Language Model Survived Only Three Days Online." MIT Technology Review. https://www.technologyreview.com/2022/11/18/1063487/meta-large-language-model-ai-only-survived-three-days-gpt-3-science/. Accessed August 22, 2023.
[12] Field H. "OpenAI is Pursuing a New Way to Fight A.I. "Hallucinations." CNBC. https://www.cnbc.com/2023/05/31/openai-is-pursuing-a-new-way-to-fight-ai-hallucinations.html. Published May 31, 2023. Accessed August 22, 2023.
[13] Hu L. "Generative AI and Future. Medium." https://pub.towardsai.net/generative-ai-and-future-c3b1695876f2. Published November 15, 2022. Accessed August 22, 2023.
[14] "OpenAI. DALL·E 2. OpenAI." https://openai.com/dall-e-2. Published 2023. Accessed August 22, 2023.
[15] Crouse M. "GPT-4 Cheat Sheet: What is GPT-4, and What is it Capable Of?" TechRepublic. https://www.techrepublic.com/article/gpt-4-cheat-sheet/. Published July 7, 2023. Accessed August 22, 2023.
[16] Agomuoh F. "ChatGPT: How to Use the AI Chatbot Faking Over the World." https://www.digitaltrends.com/computing/how-to-use-openai-chatgpt-text-generation-chatbot/. Published January 19, 2023. Accessed August 22, 2023.
[17] "OpenAI GPT-4." https://openai.com/research/gpt-4. Accessed August 22, 2023.
[18] NBC News. "ChatGPT passes MBA exam given by a Wharton Professor". https://www.nbcnews.com/tech/tech-news/chatgpt-passes-mba-exam-wharton-professor-rcna67036. Accessed August 22, 2023.
[19] Digital Trends. "How to Use Google Bard". https://www.digitaltrends.com/computing/how-to-use-google-bard/. Accessed August 22, 2023.
[20] Google Technology. "AI LaMDA". https://blog.google/technology/ai/lamda/. Accessed August 22, 2023.
[21] ZdNet. "Google's ChatGPT Competitor Spaces Out at the Start". https://www.zdnet.com/article/googles-chatgpt-competitor-spaces-out-at-the-start/. Accessed August 22, 2023.
[22] Google Technology. "AI MedPalm Research". https://blog.google/technology/health/ai-llm-medpalm-research-thecheckup/. Accessed August 22, 2023.
[23] Cloud Google. "MedPalm2 Large Language Model". https://cloud.google.com/blog/topics/healthcare-life-sciences/sharing-google-med-palm-2-medical-large-language-model. Accessed August 22, 2023.
[24] Forbes. "Big Techs New Weapon Against Physician Burnout. https://www.forbes.com/sites/davidchou/2023/08/02/big-techs-new-weapon-against-physician-burnout-generative-ai/?sh=79c0241b1f7b. Accessed August 22, 2023.
[25] Zdnet. "Microsoft Taps ChatGPT to Improve Bing and Edge Browser." https://www.zdnet.com/article/microsoft-taps-chatgpt-to-improve-bing-and-the-edge-browser/. Accessed August 22, 2023.
[26] ZdNet. "What is the New Bing. Here's everything You Need to Know." https://www.zdnet.com/article/what-is-the-new-bing-heres-everything-you-need-to-know/. Accessed August 22, 2023.
[27] Digital Trends. "How to Use Microsoft ChatGPT Bing Edge." https://www.digitaltrends.com/computing/how-to-use-microsoft-chatgpt-bing-edge/ Accessed August 22, 2023.
[28] McKinsey. "What is Generative AI?" https://www.mckinsey.com/featured-insights/mckinsey-explainers/what-is-generative-ai. Accessed August 22, 2023.

[29] McKinsey. The state of AI in 2023: Generative AI's breakout year. McKinsey. "The state of AI in 2023: Generative AI's breakout year | McKinsey." Accessed August 24, 2023.
[30] McKinsey. The economic potential of generative AI. McKinsey. "The-economic-potential-of-generative-ai-the-next-productivity-frontier-vf.pdf." (mckinsey.com). Accessed August 24, 2023.
[31]AMA. AMA digital health care 2022 study findings. https://www.ama-assn.org/about/research/ama-digital-health-care-2022-study-findings. Accessed August 22, 2023.
[32] AMA. "Digital Machine Learning 101, Promise and Pitfalls." https://www.ama-assn.org/practice-management/digital/machine-learning-101-promise-pitfalls-and-medicine-s-future. Accessed August 22, 2023.
[33] AMA. "10 Ways AI Could Transform Primary Care." https://www.ama-assn.org/practice-management/digital/10-ways-health-care-ai-could-transform-primary-care. Accessed August 22, 2023.
[34] AMA. "Ophthalmologist Doing Health Care AI the Right Way." https://www.ama-assn.org/practice-management/digital/ophthalmologist-doing-health-care-ai-right-way. Accessed August 22, 2023.
[35] AMA. "Health2047's New Company Plans to Use AI Research to Improve Clinical Decision Making." https://health2047.com/media_coverage/health2047s-new-company-plans-to-use-ai-research-access-to-improve-clinical-decision-making/. Accessed August 22, 2023.
[36] Recoverx. "Scaling equitable, science-based healthcare." https://www.recoverx.com/. Accessed August 22, 2023.
[37] Crigger E. Rinebold K. Hanson C. Kao A. Blake D. Irons M. "Trustworthy Augmented Intelligence in Health Care." https://rdcu.be/de3cZ. Accessed August 22, 2023.
[38] AMA. CPT Developer Program. https://platform.ama-assn.org/ama/#/dev-program. Accessed August 22, 2023.
[39] National Academy of Medicine. "Artificial Intelligence for Health Professions Educators." https://nam.edu/artificial-intelligence-for-health-professions-educators/. Accessed August 22, 2023.
[40] JAMA. "Artificial Intelligence in Health Care. A Report From the National Academy of Medicine." https://jamanetwork.com/journals/jama/fullarticle/2757958. Accessed August 22, 2023.
[41] AMA. "7 Tips on Responsible Use of Health Care AI." https://www.ama-assn.org/practice-management/digital/7-tips-responsible-use-health-care-ai. Accessed August 22, 2023.
[42] AMA. "ChatGPT, What Physicians Should Consider." https://www.ama-assn.org/system/files/chatgpt-what-physicians-should-consider.pdf. Accessed August 22, 2023.
[43] Health Sciences, Arizona Edu. "Would You Trust AI Doctor, New Research Shows Patients Are Split." https://healthsciences.arizona.edu/newsroom/news-releases/0523/would-you-trust-ai-doctor-new-research-shows-patients-are-split. Accessed August 22, 2023.
[44] Robertson, C. Woods A. Bergstrand K. Findley J. Balser C. Slepian M. "Diverse patients' attitudes towards Artificial Intelligence (AI) in diagnosis." https://doi.org/10.1371/journal.pdig.0000237. Accessed August 22, 2023.
[45] Fierce Healthcare. "Epic Moves Forward Bringing Generative AI Healthcare. Here's Why a Handful of Health Systems Are." https://www.fiercehealthcare.com/health-tech/epic-moves-forward-bring-generative-ai-healthcare-heres-why-handful-health-systems-are. Accessed August 22, 2023.
[46] UCDavis Edu. "Epic Slicer Dicer." https://health.ucdavis.edu/data/epic-slicer-dicer.html. Accessed August 22, 2023.
[47] Microsoft. "Azure AI Overview." https://learn.microsoft.com/en-us/azure/ai-services/openai/overview. Accessed August 22, 2023.
[48] Microsoft Blog. "Microsoft and Epic expand AI collaboration to accelerate generative AI's impact in healthcare, addressing the industry's most pressing needs." Accessed August 22, 2023.
[49] Science Direct. "Opinion Paper: "So what if ChatGPT wrote it?" Multidisciplinary perspectives on opportunities, challenges, and implications of generative conversational AI for research, practice, and policy." https://www.sciencedirect.com/science/article/pii/S0268401223000233. Accessed August 22, 2023.
[50] Frontier. "AI chatbots not yet ready for clinical use." https://www.frontiersin.org/articles/10.3389/fdgth.2023.1161098/full?utm_source=S. Accessed August 22, 2023.
[51] JAMA. "Garbage in, Garbage out—Words of Caution on Big Data and Machine Learning in Medical Practice." https://jamanetwork.com/journals/jama-health-

forum/fullarticle/2801776?widget=personalizedcontent&previousarticle=2806091. Accessed August 22, 2023.
[52] The Brookings Institute. "Around the Halls, What Should the Regulation of Generative AI Look Like?" https://www.brookings.edu/blog/techtank/2023/06/02/around-the-halls-what-should-the-regulation-of-generative-ai-look-ike/?utm_campaign=Brookings%20Brief&utm_medium=email&utm_content=260949068&utm_source=hs_email. Accessed August 22, 2023.
[53] Girotra K. Meincke L. Terwiesch C. Ulrich K. "Working Paper, Ideas are Dimes a Dozen: Large Language Models for Idea Generation in Innovation." https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4526071. Accessed August 22, 2023.
[54] Al-Medfa MK. Al-Ansari A. Darwish AH. Qreeballa TA. Jahrami H. "Physicians' attitudes and knowledge toward artificial intelligence in medicine: Benefits and drawbacks." https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10073828/. Accessed August 22, 2023.
[55] Harner S. "Attention is not all you need: the complicated case of ethically using large language models in healthcare and medicine." https://www.thelancet.com/journals/ebiom/article/PIIS2352-3964(23)00077-4/fulltext. Accessed August 22, 2023.
[56] Coalition For Health AI. "Coalition for Health AI (CHAI™) Updates Progress and Plans to Issue Guidelines for the Responsible Use of AI in Healthcare." https://www.coalitionforhealthai.org/updates/october-6th-2022. Accessed August 22, 2023.
[57] "MITRE's Brian Anderson, M.D., Explains Coalition's AI Blueprint" https://www.hcinnovationgroup.com/analytics-ai/artifical-intelligence-machine-learning/article/53063115/mitres-brian-anderson-md-explains-coalitions-ai-blueprint. Accessed August 22, 2023.
[58] Digiorgio A. Ehrenfeld J. "Artificial Intelligence in Medicine & ChatGPT: De-Tether the Physician." https://link.springer.com/article/10.1007/s10916-023-01926-3. Accessed August 23, 2023.
[59] AMA. "Feds Warn Algorithms Can Induce Bias in Clinical Decisions." https://www.ama-assn.org/delivering-care/health-equity/feds-warned-algorithms-can-introduce-bias-clinical-decisions. Accessed August 22, 2023.
[60] FDA. "Artificial Intelligence and Machine Learning Software Regulation." https://www.fda.gov/medical-devices/software-medical-device-samd/artificial-intelligence-and-machine-learning-software-medical-device#regulation. Accessed August 22, 2023.
[61] AMA. "FDA Must Guard Against Bias AI Focus in Patient Outcomes." https://www.ama-assn.org/practice-management/digital/fda-must-guard-against-bias-ai-focus-patient-outcomes. Accessed August 22, 2023.
[62] Reuters. "Lawmakers Committee Reaches Deal on AI Act." https://www.reuters.com/technology/eu-lawmakers-committee-reaches-deal-artificial-intelligence-act-2023-04-27/. Accessed August 22, 2023.
[63] The AI Act. "What is the AI Act?" https://artificialintelligenceact.eu/. Accessed August 22, 2023.
[64] U.S. Copyright Office Fair Use Index. "2013 Joint Strategic Plan on Intellectual Property Enforcement." https://www.copyright.gov/fair-use/. Accessed August 22, 2023.
[65] Vokinger K. Gasser U. "Regulating AI in medicine in the United States and Europe." "https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7611759/. Accessed August 22, 2023.
[66] AMA PolicyFinder. Augmented Intelligence in Health Care H-480.939. Accessed August 22, 2023.
[67] AMA PolicyFinder. Augmented Intelligence in Health Care H-480.940. Accessed August 22, 2023.
[68] AMA PolicyFinder. Augmented Intelligence in Medical Education H-295.857. Accessed August 22, 2023.
[69] AMA PolicyFinder. Professionalism in Health Care Systems: Augmented Intelligence E-11.2.1. Accessed August 22, 2023.
[70] AMA PolicyFinder. Assessing the Potentially Dangerous Intersection Between AI and Misinformation H-480.935. Accessed August 22, 2023.

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 expanhding 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

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

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

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

CONCLUSION

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

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

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

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

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

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

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

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

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

Fiscal Note: Less than $500.

REFERENCES

[1]Physician-Led Healthcare for America. Physician-Led Hospitals: The Patient-Physician Relationship. Accessed: July 21, 2023. https://physiciansled.com/physician-owned-hospitals/#:~:text=Beginning%20in%20the%20early%202000s,owned%20and%20operated%20by%20physicians
[2]Miller, Brian J., et al. Reversing Hospital Consolidation. Health Affairs. April 12, 2021. https://www.healthaffairs.org/content/forefront/reversing-hospital-consolidation-promise-physician-owned-hospitals
[3]*Ibid*
[4]CMS.gov. Physician-Owned Hospitals. Accessed: July 20, 2023. https://www.cms.gov/medicare/fraud-and-abuse/physicianselfreferral/physician_owned_hospitals
[5]*Supra*. Note 2.
[6]Bryant, Meg. ACA is taking a toll on physician-owned hospitals. Healthcare Dive. July 11, 2017. https://www.healthcaredive.com/news/aca-is-taking-a-toll-on-physician-owned-hospitals/446761/
[7]Kane, Carol K. Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice Towards Larger Practice Size Continue through 2022. American Medical Association. 2023. https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf
[8]*Ibid*
[9]Henry, Tanya Albert. Physician-Owned Hospitals Seize their Moment. Journal of the Missouri Medical Association. July-August 2013. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6179879/
[10]*Supra*. Note 2.
[11]NDP Analytics. The Economic and Social Benefits of Physician-Led Hospitals. September 2022. https://physiciansled.com/wp-content/uploads/2022/09/Economic-Impact-Report-2022-1.pdf
[12]*Supra*. Note 2.
[13]Mandelberg, Matthew C., et. al. Hospital Competition and Restrictions on Physician-Owned Hospitals. February 5, 2023. https://ssm.com/abstract=4350105
[14]AMA Comment Letter to Centers for Medicare & Medicaid Services in Response to 2024 Inpatient Prospective Payment Systems Proposed Rule. June 9, 2023. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfcmt.zip%2F2023-6-9-Letter-to-Brooks-LaSure-re-2024-IPPS-Comments-v4.pdf
[15]*Supra.* Note 13.
[16]AMA Comment Letter to U.S. House of Representatives in Support of H.R. 977. June 1, 2023. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfcsot.zip%2F2023-6-1-Letter-to-House-re-PAHQHCA-Physician-Owned-Hospitals-Bill.pdf
[16]AMA Comment Letter to U.S. Senate in Support of S. 470. June 1, 2023. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfcsot.zip%2F2023-6-1-Letter-to-Senate-re-PAHQHCA-Physician-Owned-Hospitals-Bill.pdf
[17]Department of Health and Human Services – Centers for Medicare & Medicaid Services. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership; and Medicare Disproportionate Share Hospital (DSH) Payments: Counting Certain Days Associated with Section 1115 Demonstrations in the Medicaid Fraction. Federal Register. 42 CFR Parts 411, 412, 419, 489, and 495. August 1, 2023. https://public-inspection.federalregister.gov/2023-16252.pdf
[18]*Supra.* Note 13.
[19]AMA Statement to the U.S. Senate Finance Committee. Consolidation and Corporate Ownership in Health Care: Trends and Impacts on Access, Quality, and Costs. June 8, 2023. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfcsot.zip%2F2023-6-8-Senate-Finance-Comm-Statement-for-the-Record-Testimony-on-Consolidation-Corp.pdf
[20]AMA Statement to the U.S. House Committee on Ways and Means – Subcommittee on Health. Why Health Care is Unaffordable: Anticompetitive and Consolidated Markets. May 17, 2023. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfcsot.zip

%2F2023-5-17-WMs-Health-SubCmt-Statement-for-the-Record-on-Anticompetitive-and-Consolidated-Markets-v2.pdf

[21]AMA Statement to the U.S. House Committee on Energy and Commerce – Subcommittee on Health. Lowering Unaffordable Costs: Examining Transparency and Competition in Health Care. March 28, 2023. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fstmnt.zip%2FEC-Statement-For-the-Record-on-Transparency-and-Competition-X.pdf

[22]Sign-on Letter – Physician-Led Hospitals Coalition. July 27, 2023. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfsolg.zip%2F2023-7-27-Sigend-On-Coalition-Letter-re-Physician-Led-Hospitals.pdf.

[23]Swanson, A. "Physician investment in hospitals: Specialization, selection, and quality in cardiac care." Journal of Health Economics 80. 2021.

[24]*Supra*. Note 14.

[25]*Supra*. Note 13.

[26]*Supra* Note 13.

[27]*Supra*. Note 17.

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 Kyllo, MD
- Lisa Bohman Egbert, MD, Speaker, Ohio
- John H. Armstrong, MD, Vice Speaker, American College of Surgeons

BACKGROUND

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

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

ITEMS FOR CONSIDERATION

Unequal Time for Delegates to Evaluate Items of HOD Business

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

Topic #1 Increased Volume of Business

The volume of business has been increased at the last three in-person meetings. This may be attributed to the backlog of resolutions from the Federation that were unable to be handled during the Special Meetings, the increasing number of delegates leading to production of more resolutions, the focus on policy making within the Sections, and the politicization of issues related to science, medicine and health. Tracking this data is challenging as all processing of resolutions at the AMA level is done "by hand." The task force encourages individual delegations to review their recent resolution production and share those numbers at the upcoming open forum.

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

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

Topic # 2 Definition of "On-time Resolutions"

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

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

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

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

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

Topic #3 Avoiding Redundancy with Existing Policy

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

Resolution writing process

- Authors vary in their efforts and success in identifying existing AMA policy on the topics under consideration for resolutions.
- Policy Finder is not user-friendly, making searches of existing policy time-consuming and often unproductive. Updates to policy finder are ongoing but will not be completed in the short-term.
- Federation policymaking bodies are not compelled to review current AMA policy in writing resolutions for their own organizations before forwarding them to the AMA HOD. In addition, many organizations are required to forward all resolutions, as passed, to the AMA HOD, without consideration for alternative pathways to achieving their goals.

Identifying Submitted Resolutions for Reaffirmation

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

Pulling items off the reaffirmation consent calendar

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

Alternative Pathways

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

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

Topic #4 Reference Committee Process

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

Online Member Forum

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

Policy D-600.956 *Increasing the Effectiveness of Online Reference Committee Testimony* initiated a two-year trial of the production of a preliminary reference committee document, based on

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

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

Topic #5 Reference Committee Hearings

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

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

CONCLUSION

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

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 sunsetting 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 sunsetting 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~~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 ~~s~~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 ~~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~~ are 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 supere~~s~~sede 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.
(~~4~~6) All resolutions and reports should ~~will~~ be written to include both "MD and DO," unless specifically applicable to one or the other.
(~~5~~7) ~~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.
(~~6~~8) 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; (~~c~~d) Modify Bylaws; (~~d~~e) Rescind HOD Policy; (~~e~~f) Reaffirm HOD Policy; or (g) Directive to Take Action.
(~~7~~9) 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 s~~ 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 <u>Access</u> ~~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

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

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

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

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

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

Whereas, According to Bylaws 2.11.3.1.3, “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”; and

Whereas, According to Bylaws 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”; and

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

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

RESOLVED, That our AMA Speakers Task Force on the Resolution Process report back to our AMA House of Delegates by the 2024 Annual Meeting with recommendations regarding the 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

Informational Reports

Report(s) of the Board of Trustees

03 Update on Climate Change and Health – AMA Activities
04 Update on Firearm Injury Prevention Task Force
08 AMA Efforts on Medicare Payment Reform
09 Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted
11 Criminalization of Providing Medical Care
15 Redefining AMA's Position on ACA and Health Care Reform
16 2023 AMA Advocacy Efforts

Opinion(s) of the Council on Ethical and Judicial Affairs

01 Responsibilities to Promote Equitable Care

Report(s) of the Council on Long Range Planning and Development

02 Generative AI in Medicine and Health Care

Report(s) of the Council on Medical Education

02 Update on Continuing Board Certification

Report(s) of the Council on Medical Service

04 Physician-Owned Hospitals

Report(s) of the Speakers

01 Report of the Resolution Modernization Task Force Update

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

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

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

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

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

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

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

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

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

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

"As physicians, we are aware of all the health threats but what can one doctor do?"

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

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

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

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

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

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

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

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

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

AMA Actions to Advance Priority Areas

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

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

REFERENCES

[1] NASA. Scientific Consensus: Earth's Climate Is Warming. Available at https://climate.nasa.gov/scientific-consensus/.
[2] NOAA. Climate Change: Global Temperature. Available at https://www.climate.gov/news-features/understanding-climate/climate-change-global-temperature#:~:text=According%20to%20NOAA's%202021%20Annual,0.18%20%C2%B0C)%20per%20decade.
[3] NOAA. Climate Change: Global Temperature. Available at https://www.climate.gov/news-features/understanding-climate/climate-change-global-temperature#:~:text=According%20to%20NOAA's%202021%20Annual,0.18%20%C2%B0C)%20per%20decade.
[4] Kaiser C. Canadian wildfire smoke puts around 70 million US residents under air quality alerts. *CNN*, July17, 2023. Available at https://www.cnn.com/2023/07/16/weather/canada-Kwildfires-us-air-quality-alerts-sunday.
[5] Chiu A. et al. Phoenix hits record for 19th day of 110+ degrees in a row — with more ahead. *Washington Post*, July 18, 2023. Available at https://www.washingtonpost.com/weather/2023/07/18/phoenix-heat-wave-record-temperature-streak/?utm_campaign=wp_the7&utm_medium=email&utm_source=newsletter&wpisrc=nl_the7.
[6] NASA – Earth Observatory. Relentless Heat in the Southwest. July 25, 2023. Available at: https://earthobservatory.nasa.gov/images/151632/relentless-heat-in-the-southwest#:~:text=An%20unprecedented%20streak%20of%20extreme,Southwest%20on%20July%2025%2C%202023.
[7] Salahieh N. and Mascarenhas L. Catastrophic flooding swamped Vermont's capital as intense storms forced evacuations and closures in Northeast. *CNN*, July 12, 2023. Available at https://www.cnn.com/2023/07/11/us/northeast-storms-flooding-excessive-rainfall-tuesday/index.html.
[8] American Medical Association. Lower costs by going green! 2017. Available at: https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/ps2/transition-green-physician-practice.pdf
[9] National Academy of Medicine. Key Actions to Reduce Greenhouse Gas Emissions by U.S. Hospitals and Health Systems. Available at https://nam.edu/programs/climate-change-and-human-health/action-collaborative-on-decarbonizing-the-u-s-health-sector/key-actions-to-reduce-greenhouse-gas-emissions-by-u-s-hospitals-and-health-systems/#:~:text=To%20address%20these%20impacts%2C%20the%20NAM%20Climate%20Collaborative,systems%20starting%20their%20journey%20to%20reach%20decarbonization%20goals.
[10] Adams G., Entwistle D., Hochman R., and Lassiter III W. Embracing sustainability makes good business sense. *Modern Healthcare, Thought Leadership*, June 19, 2023. Available at https://www.modernhealthcare.com/Reprint-MH23054NationalAcademy.
[11] American Public Health Association, Center for Climate, Health and Equity. Available at https://www.apha.org/topics-and-issues/climate-change/center.

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

American College of Emergency Physicians
American College of Obstetricians and Gynecologists
American College of Physician
American College of Preventive Medicine
American College of Surgeons
American Geriatrics Society
American Pediatric Surgical Association
American Psychiatric Association
National Medical Association
Society of Critical Care Medicine

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

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

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

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

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

Federation Engagement

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

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

Grassroots, Media, and Outreach

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

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

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

CONCLUSION

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

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

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

BACKGROUND

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

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

f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and
g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.

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

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

DISCUSSION

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

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

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

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

- What organizations outside the Federation have you worked with and recommend engaging around these issues?

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

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

Next steps

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

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

CONCLUSION

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

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

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

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

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

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

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

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

CONCLUSION

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

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

1. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;
2. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
3. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;
4. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;
5. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;
6. 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;
7. 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; and
8. Making 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.

[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

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

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

<u>Cover Uninsured Eligible for Medicaid or Children's Health Insurance Program</u>

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

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

<u>Make Coverage More Affordable for People Not Eligible for ACA's Premium Tax Credits</u>

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

- Our AMA advocates for eliminating the subsidy "cliff," thereby expanding eligibility for premium tax credits beyond 400 percent FPL.
- Our AMA has been advocating for the establishment of a permanent federal reinsurance program, and the use of Section 1332 waivers for state reinsurance programs. Reinsurance plays a role in stabilizing premiums by reducing the incentive for insurers to charge higher premiums across the board in anticipation of higher-risk people enrolling in coverage. Section 1332 waivers have also been approved to provide funding for state reinsurance programs.
- Our AMA also is advocating for lowering the threshold that determines whether an employee's premium contribution is "affordable," allowing more employees to become eligible for premium tax credits to purchase marketplace coverage.

- Our AMA strongly advocated for the Internal Revenue Service proposed regulation on April 7, 2022 that would fix the so-called "family glitch" under the ACA, whereby families of workers remain ineligible for subsidized ACA marketplace coverage even though they face unaffordable premiums for health insurance coverage offered through employers. The proposed regulation would fix the family glitch by extending eligibility for ACA financial assistance to only the family members of workers who are not offered affordable job-based family coverage. The Biden Administration finalized the proposed rule on October 13, 2022.

EXPAND MEDICAID TO COVER MORE PEOPLE

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

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

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

AMERICAN RESCUE PLAN OF 2021

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

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

ARPA represents the largest coverage expansion since the ACA. Under the ACA, eligible individuals, and families with incomes between 100 and 400 percent of the FPL (between 133 and 400 percent FPL in Medicaid expansion states) have been provided with refundable and advanceable premium credits that are inversely related to income to purchase coverage on health insurance exchanges. However, consistent with Policy H-165.824, "Improving Affordability in the Health Insurance Exchanges," ARPA eliminated ACA's subsidy "cliff" for 2021 and 2022. As a result, individuals and families with incomes above 400 percent FPL ($51,520 for an individual and $106,000 for a family of four based on 2021 federal poverty guidelines) are eligible for premium tax credit assistance. Individuals eligible for premium tax credits include individuals who

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

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

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

LEGISLATIVE EXTENSION OF ARPA PROVISIONS

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

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

ACA ENROLLMENT

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

CONTINUOUS MEDICAID ENROLLMENT

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

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

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

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

SGR REPEAL

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

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

INDEPENDENT PAYMENT ADVISORY BOARD REPEAL

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

CONCLUSION

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

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

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

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

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

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

So far in 2023, the AMA has sent over 150 letters to federal and state policymakers advocating for AMA positions on these issues. Many of these letters stem directly from HOD resolutions. Further, some were sign-on letters written in conjunction with the Federation of Medicine, and the AMA is grateful for the partnership. AMA grassroots efforts have been robust to date and will intensify in

the second half of the year. Finally, there is a separate section later in this report detailing the options to participate in AMA advocacy efforts, and the HOD is encouraged to be engaged in all of them.

Medicare Payment Reform

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

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

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

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

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

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

The AMA has relaunched the FixMedicareNow.org website to help achieve the needed policy changes. In addition, advocacy materials have been made available to Federation groups at ama-assn.org/medicare-pay-reform. These materials include payment trend charts and other educational tools. The AMA also conducted public message testing with voter focus groups in June and a

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

Prior Authorization

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

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

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

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

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

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

Scope of Practice

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

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

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

Physician Wellness

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

regulatory, legislative and other solutions to direct more funding and resources to support the mental health needs of physicians.

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

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

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

Telehealth

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

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

- Permanently remove all geographic restrictions on telehealth services and expand originating sites to include the home and, by 2025, any other site that is deemed clinically appropriate for the service;
- Permanently allow health centers and rural health clinics to provide telehealth services;

- Remove unnecessary in-person visit requirement for telemental health services; and
- Allow for the waiver of telehealth restrictions during public health emergencies.

Surprise Billing

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

One of most challenging aspects of NSA implementation has been the physician-payer dispute resolution process. AMA advocated for a fair and balanced process to determine payment to physicians for out-of-network care that included an Independent Dispute Resolution (IDR) process where an independent arbiter could consider all the relevant factors used to determine fair payment. Litigation led by the Texas Medical Association has resulted in revised IDR guidance that better reflects the statutory language and Congressional intent; however, this result is being appealed.

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

Reproductive Health

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

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

Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted has been established and is being organized.

Firearm Violence

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

Maternal Health

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

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

The AMA also made progress in support of pregnant individuals with a substance use disorder across multiple fronts. The AMA developed new model legislation to support plans of family care for pregnant individuals and family members during the prenatal and postpartum periods. The

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

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

Access to Health Care

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

Drug Pricing Transparency

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

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

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

Mental Health and Substance Use Disorder Parity

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

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

Overdose Epidemic

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

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

Efforts by AMA to support decriminalization of fentanyl test strips has helped with more than 10 new state laws in 2022-2023 (Arizona, Florida, Georgia, Kansas, Kentucky, Mississippi, Montana, New Mexico, Ohio, Pennsylvania, Texas, Utah, and Wisconsin). The AMA also supported the enactment of legislation or other policies in more than a dozen states to help ensure that opioid

litigation settlement funds are focused on public health efforts. The AMA has also created a specific list of actions for state medical associations to take, including specific examples of evidence-based efforts they can use in their state.

Physician-Owned Hospitals

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

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

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

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

Physician Workforce

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

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

Augmented Intelligence

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

- Updated National Artificial Intelligence (AI) Research and Development Strategic Plan (PDF), encompassing an updated roadmap for federal investment in augmented intelligence; and

- Office of Science and Technology Policy (OSTP) Request for Information (PDF), seeking stakeholder input on national priorities for mitigating AI risks, protecting rights and safety, and harnessing AI to improve lives.

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

Gender-Affirming Care

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

Climate Change

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

Immigration

The AMA remains committed to ensuring fairness in the immigration process. The AMA sent a letter expressing support for S. 665, the "Conrad State 30 and Physician Access Reauthorization Act," which would reauthorize and make targeted improvements to the J-1 visa waiver program in a manner that helps alleviate the shortage of physicians, especially in rural and underserved areas, and promotes a more diversified workforce. The AMA also signed onto a letter raising concerns about a harmful immigration policy that was reportedly under consideration—the reinstatement of detention of immigrant families. Such family detention puts the health and safety of children and

their parents at risk and, as such, the AMA urged the Administration to abandon any effort to detain families in Immigration and Customs Enforcement facilities. The AMA sent a letter urging the Administration to allow more flexibility during public health emergencies in the worksite requirements governing where international medical graduates in H-1B status may practice and as a result of this letter received a meeting with the U.S. Department of Labor. Finally, AMA wrote to the Administration (letter) offering comments on the proposed amendments to the qualifying criteria for critical federal health programs. In the proposed rule, HHS cited a 2021 survey of DACA recipients which found that 34% of respondents reported that they were not covered by health insurance, 47% attested to having experienced a delay in medical care due to their immigration status, and 67% said that they or a family member were unable to pay medical bills or expenses. Please read more about AMA efforts here.

Nutrition

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

AMA ADVOCACY ONGOING UPDATES AND MEETINGS

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

- Sign up for AMA Advocacy Update—a biweekly newsletter that provides updates on AMA legislative, regulatory, and private sector efforts. We try to make sure all HOD members are on the email list, but if you are not receiving AMA Advocacy Update, please subscribe and encourage your colleagues to do so as well. Subscribers can read stories from previous editions here.
- Join the Physicians Grassroots Network for updates on AMA calls to action on federal legislative issues. And if you have connections with members of Congress, or are interested in developing one, the Very Influential Physician (VIP) program can help grow these relationships.
- Connect with the Physicians Grassroots Network on Facebook, Twitter, and Instagram.

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

CONCLUSION

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

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.

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

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

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

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

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

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

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

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

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

CLRPD Report 2-I-23, Generative AI in Medicine and Health Care

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.

TERMINOLIGIES AND COMPONENTS OF AI

CLRPD Report 1-A-18, A Primer on Artificial and Augmented Intelligence[1] 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.

DEFINTION 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]

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

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

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

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

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

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

tools provide digests based on the best available evidence. Although efforts are underway[10] to train LLMs on exclusively authoritative, medically relevant texts, they are still nascent and prior efforts have faltered.[11]

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

GENERATIVE AI MODELS

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

- Transformer-based models: These models, such as OpenAI's ChatGPT and GPT-3.5, are neural networks designed for natural language processing. They are trained on large amounts of data to learn the relationships between sequential data — like words and sentences — making them useful for text-generation tasks.

- Generative adversarial networks (GANs): GANs are made up of two neural networks, a generator, and a discriminator that work in a competitive or adversarial capacity. The generator creates data, while the discriminator evaluates the quality and authenticity of said data. Over time, both networks get better at their roles, leading to more realistic outputs.

- Variational autoencoders (VAEs): VAEs use an encoder and a decoder to generate content. The encoder takes the input data, such as images or text, and simplifies it into a more compact form. The decoder takes this encoded data and restructures it into something new that resembles the original input.

- Multimodal models: Multimodal models can process multiple types of input data, including text, audio, and images. They combine different modalities to create more sophisticated outputs, such as DALL-E 2[14] and OpenAI's GPT-4[15], which is also capable of accepting image and text inputs.

OpenAI ChatGPT

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

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

GPT-3.5 in a series of simulated benchmark exams. It has also reduced the number of "hallucinations" produced by the chatbot.[17]

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

Google Bard and Med-PaLM

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

In April 2023, Google announced a new version of its medical LLM, called Med-PaLM 2.[22] An AI platform for analyzing medical data, it aims to assist physicians with routine tasks and provide more reliable answers to patient questions than "Dr. Google." *PaLM 2, the Pathways Language Model*, is more critical than Bard for medicine. With 540 billion parameters, it draws knowledge from scientific papers and websites, can reason logically, and perform complex mathematical calculations.[23] Google is actively developing its large language model (LLM), Med-PaLM 2, which they anticipate will excel at healthcare discussions over general-purpose algorithms, given its training on questions and answers from medical licensing exams. They are collaborating with Mayo Clinic and other health systems and partnering with the healthcare technology vendor, CareCloud.[24]

Microsoft Bing AI

In early February 2023, Microsoft unveiled[25] a new version of Bing[26] -- and its standout feature is its integration with GPT-4. When it was announced, Microsoft shared that Bing Chat was powered by a next-generation version of OpenAI's large language model, making it "more powerful than ChatGPT."[27]

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

Building a generative AI model has for the most part been a major undertaking, to the extent that only a few well-resourced tech heavyweights have tried. OpenAI, the company behind ChatGPT, 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

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

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

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

REGULATORY FRAMEWORK FOR USE OF GENERATIVE AI IN MEDICINE

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

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

- Any regulatory framework should ensure that only safe, clinically validated, high-quality tools enter the marketplace. "We can't allow AI to introduce additional bias" into clinical care, cautioning that this could erode public confidence in the tools that come to the marketplace.[59]

- There also needs to be a balance between strong oversight and ensuring the regulatory system is not overly burdensome to developers, entrepreneurs, and manufacturers, "while also thinking about how we limit liability in appropriate ways for physicians," added Dr. Ehrenfeld.

- The FDA has a medical device action plan on AI and machine-learning software that would enable the agency to track and evaluate a software product from premarket development to post market performance.[60] The AMA has weighed in on the plan, saying the agency must guard against bias in AI and focus on patient outcomes.[61]

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

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

CLRPD DISCUSSION

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 a substantial contributor to physician burnout.

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

The AMA has addressed the importance of AI, has advocated for the use of the expression augmented intelligence, and has assumed thought leadership with its reports and guidelines for physicians. AMA policy states, "as a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of AI in medicine benefits patients, physicians, and the health care community."

Relevant AMA Policy

Augmented Intelligence in Health Care H-480.939[66]
Augmented Intelligence in Health Care H-480.940[67]
Augmented Intelligence in Medical Education H-295.857[68]
Professionalism in Health Care Systems E-11.2.1 [69]
Assessing the Potentially Dangerous Intersection Between AI and Misinformation H-480.935[70]

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.

REFERENCES

[1] AMA. "CLRPD Report 1-A-18: A Primer on Artificial and Augmented Intelligence." https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/hod/a18-clrpd01.pdf. Accessed August 22, 2023.
[2] McKinsey. "What is ChatGPT, DALL-E, and generative AI?" https://www.mckinsey.com/featured-insights/mckinsey-explainers/what-is-generative-ai. Accessed August 22, 2023.
[3] Friedland A. "What are Generative AI, Large Language Models, and Foundation Models?" Center for Security and Emerging Technology. https://cset.georgetown.edu/article/what-are-generative-ai-large-language-models-and-foundation-models/. Accessed August 22, 2023.
[4] Callaway E. "DeepMind's AI Makes Gigantic Leap in Solving Protein Structures." Scientific American. https://www.scientificamerican.com/article/deepminds-ai-makes-gigantic-leap-in-solving-protein-structures/. Accessed August 22, 2023.

[5] Gordon R. "3 Questions: Jacob Andreas on Large Language Models." MIT News | Massachusetts Institute of Technology. https://news.mit.edu/2023/3-questions-jacob-andreas-large-language-models-0511. Published May 11, 2023. Accessed August 22, 2023.
[6] Chen BX. "Get the Best from ChatGPT with These Golden Prompts." The New York Times. https://www.nytimes.com/2023/05/25/technology/ai-chatbot-chatgpt-prompts.html. Published May 25, 2023. Accessed August 22, 2023.
[7] Pifer R. "Hurtling into the Future: The Potential and Thorny Ethics of Generative AI in Healthcare." Healthcare Dive. https://www.healthcaredive.com/news/generative-AI-healthcare-gpt-potential/648104/. Accessed August 22, 2023.
[8] AXIOS. " Terms-of-service land grab: Tech firms seek private data to train AI." Accessed August 24, 2023.
[9] Mello M, Guha N. "ChatGPT and Physicians' Malpractice Risk." JAMA. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2805334? Accessed August 22, 2023.
[10] Bolton E, Hall D, Yasunaga M, et. All. "Stanford CRFM Introduces PubMed GPT 2.7B." Stanford HAI. https://hai.stanford.edu/news/stanford-crfm-introduces-pubmedgpt-27b. Accessed August 22, 2023.
[11] Heaven WD. "Why Meta's latest Large Language Model Survived Only Three Days Online." MIT Technology Review. https://www.technologyreview.com/2022/11/18/1063487/meta-large-language-model-ai-only-survived-three-days-gpt-3-science/. Accessed August 22, 2023.
[12] Field H. "OpenAI is Pursuing a New Way to Fight A.I. "Hallucinations." CNBC. https://www.cnbc.com/2023/05/31/openai-is-pursuing-a-new-way-to-fight-ai-hallucinations.html. Published May 31, 2023. Accessed August 22, 2023.
[13] Hu L. "Generative AI and Future. Medium." https://pub.towardsai.net/generative-ai-and-future-c3b1695876f2. Published November 15, 2022. Accessed August 22, 2023.
[14] "OpenAI. DALL·E 2. OpenAI." https://openai.com/dall-e-2. Published 2023. Accessed August 22, 2023.
[15] Crouse M. "GPT-4 Cheat Sheet: What is GPT-4, and What is it Capable Of?" TechRepublic. https://www.techrepublic.com/article/gpt-4-cheat-sheet/. Published July 7, 2023. Accessed August 22, 2023.
[16] Agomuoh F. "ChatGPT: How to Use the AI Chatbot Faking Over the World." https://www.digitaltrends.com/computing/how-to-use-openai-chatgpt-text-generation-chatbot/. Published January 19, 2023. Accessed August 22, 2023.
[17] "OpenAI GPT-4." https://openai.com/research/gpt-4. Accessed August 22, 2023.
[18] NBC News. "ChatGPT passes MBA exam given by a Wharton Professor". https://www.nbcnews.com/tech/tech-news/chatgpt-passes-mba-exam-wharton-professor-rcna67036. Accessed August 22, 2023.
[19] Digital Trends. "How to Use Google Bard". https://www.digitaltrends.com/computing/how-to-use-google-bard/. Accessed August 22, 2023.
[20] Google Technology. "AI LaMDA". https://blog.google/technology/ai/lamda/. Accessed August 22, 2023.
[21] ZdNet. "Google's ChatGPT Competitor Spaces Out at the Start". https://www.zdnet.com/article/googles-chatgpt-competitor-spaces-out-at-the-start/. Accessed August 22, 2023.
[22] Google Technology. "AI MedPalm Research". https://blog.google/technology/health/ai-llm-medpalm-research-thecheckup/. Accessed August 22, 2023.
[23] Cloud Google. "MedPalm2 Large Language Model". https://cloud.google.com/blog/topics/healthcare-life-sciences/sharing-google-med-palm-2-medical-large-language-model. Accessed August 22, 2023.
[24] Forbes. "Big Techs New Weapon Against Physician Burnout. https://www.forbes.com/sites/davidchou/2023/08/02/big-techs-new-weapon-against-physician-burnout-generative-ai/?sh=79c0241b1f7b. Accessed August 22, 2023.
[25] Zdnet. "Microsoft Taps ChatGPT to Improve Bing and Edge Browser." https://www.zdnet.com/article/microsoft-taps-chatgpt-to-improve-bing-and-the-edge-browser/. Accessed August 22, 2023.
[26] ZdNet. "What is the New Bing. Here's everything You Need to Know." https://www.zdnet.com/article/what-is-the-new-bing-heres-everything-you-need-to-know/. Accessed August 22, 2023.
[27] Digital Trends. "How to Use Microsoft ChatGPT Bing Edge." https://www.digitaltrends.com/computing/how-to-use-microsoft-chatgpt-bing-edge/ Accessed August 22, 2023.
[28] McKinsey. "What is Generative AI?" https://www.mckinsey.com/featured-insights/mckinsey-explainers/what-is-generative-ai. Accessed August 22, 2023.

[29] McKinsey. The state of AI in 2023: Generative AI's breakout year. McKinsey. "The state of AI in 2023: Generative AI's breakout year | McKinsey." Accessed August 24, 2023.
[30] McKinsey. The economic potential of generative AI. McKinsey. "The-economic-potential-of-generative-ai-the-next-productivity-frontier-vf.pdf." (mckinsey.com). Accessed August 24, 2023.
[31]AMA. AMA digital health care 2022 study findings. https://www.ama-assn.org/about/research/ama-digital-health-care-2022-study-findings. Accessed August 22, 2023.
[32] AMA. "Digital Machine Learning 101, Promise and Pitfalls." https://www.ama-assn.org/practice-management/digital/machine-learning-101-promise-pitfalls-and-medicine-s-future. Accessed August 22, 2023.
[33] AMA. "10 Ways AI Could Transform Primary Care." https://www.ama-assn.org/practice-management/digital/10-ways-health-care-ai-could-transform-primary-care. Accessed August 22, 2023.
[34] AMA. "Ophthalmologist Doing Health Care AI the Right Way." https://www.ama-assn.org/practice-management/digital/ophthalmologist-doing-health-care-ai-right-way. Accessed August 22, 2023.
[35] AMA. "Health2047's New Company Plans to Use AI Research to Improve Clinical Decision Making." https://health2047.com/media_coverage/health2047s-new-company-plans-to-use-ai-research-access-to-improve-clinical-decision-making/. Accessed August 22, 2023.
[36] Recoverx. "Scaling equitable, science-based healthcare." https://www.recoverx.com/. Accessed August 22, 2023.
[37] Crigger E. Rinebold K. Hanson C. Kao A. Blake D. Irons M. "Trustworthy Augmented Intelligence in Health Care." https://rdcu.be/de3cZ. Accessed August 22, 2023.
[38] AMA. CPT Developer Program. https://platform.ama-assn.org/ama/#/dev-program. Accessed August 22, 2023.
[39] National Academy of Medicine. "Artificial Intelligence for Health Professions Educators." https://nam.edu/artificial-intelligence-for-health-professions-educators/. Accessed August 22, 2023.
[40] JAMA. "Artificial Intelligence in Health Care. A Report From the National Academy of Medicine." https://jamanetwork.com/journals/jama/fullarticle/2757958. Accessed August 22, 2023.
[41] AMA. "7 Tips on Responsible Use of Health Care AI." https://www.ama-assn.org/practice-management/digital/7-tips-responsible-use-health-care-ai. Accessed August 22, 2023.
[42] AMA. "ChatGPT, What Physicians Should Consider." https://www.ama-assn.org/system/files/chatgpt-what-physicians-should-consider.pdf. Accessed August 22, 2023.
[43] Health Sciences, Arizona Edu. "Would You Trust AI Doctor, New Research Shows Patients Are Split." https://healthsciences.arizona.edu/newsroom/news-releases/0523/would-you-trust-ai-doctor-new-research-shows-patients-are-split. Accessed August 22, 2023.
[44] Robertson, C. Woods A. Bergstrand K. Findley J. Balser C. Slepian M. "Diverse patients' attitudes towards Artificial Intelligence (AI) in diagnosis." https://doi.org/10.1371/journal.pdig.0000237. Accessed August 22, 2023.
[45] Fierce Healthcare. "Epic Moves Forward Bringing Generative AI Healthcare. Here's Why a Handful of Health Systems Are." https://www.fiercehealthcare.com/health-tech/epic-moves-forward-bring-generative-ai-healthcare-heres-why-handful-health-systems-are. Accessed August 22, 2023.
[46] UCDavis Edu. "Epic Slicer Dicer." https://health.ucdavis.edu/data/epic-slicer-dicer.html. Accessed August 22, 2023.
[47] Microsoft. "Azure AI Overview." https://learn.microsoft.com/en-us/azure/ai-services/openai/overview. Accessed August 22, 2023.
[48] Microsoft Blog. "Microsoft and Epic expand AI collaboration to accelerate generative AI's impact in healthcare, addressing the industry's most pressing needs." Accessed August 22, 2023.
[49] Science Direct. "Opinion Paper: "So what if ChatGPT wrote it?" Multidisciplinary perspectives on opportunities, challenges, and implications of generative conversational AI for research, practice, and policy." https://www.sciencedirect.com/science/article/pii/S0268401223000233. Accessed August 22, 2023.
[50] Frontier. "AI chatbots not yet ready for clinical use." https://www.frontiersin.org/articles/10.3389/fdgth.2023.1161098/full?utm_source=S. Accessed August 22, 2023.
[51] JAMA. "Garbage in, Garbage out—Words of Caution on Big Data and Machine Learning in Medical Practice." https://jamanetwork.com/journals/jama-health-

forum/fullarticle/2801776?widget=personalizedcontent&previousarticle=2806091. Accessed August 22, 2023.
[52] The Brookings Institute. "Around the Halls, What Should the Regulation of Generative AI Look Like?" https://www.brookings.edu/blog/techtank/2023/06/02/around-the-halls-what-should-the-regulation-of-generative-ai-look-ike/?utm_campaign=Brookings%20Brief&utm_medium=email&utm_content=260949068&utm_source=hs_email. Accessed August 22, 2023.
[53] Girotra K. Meincke L. Terwiesch C. Ulrich K. "Working Paper, Ideas are Dimes a Dozen: Large Language Models for Idea Generation in Innovation." https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4526071. Accessed August 22, 2023.
[54] Al-Medfa MK. Al-Ansari A. Darwish AH. Qreeballa TA. Jahrami H. "Physicians' attitudes and knowledge toward artificial intelligence in medicine: Benefits and drawbacks." https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10073828/. Accessed August 22, 2023.
[55] Harner S. "Attention is not all you need: the complicated case of ethically using large language models in healthcare and medicine." https://www.thelancet.com/journals/ebiom/article/PIIS2352-3964(23)00077-4/fulltext. Accessed August 22, 2023.
[56] Coalition For Health AI. "Coalition for Health AI (CHAI™) Updates Progress and Plans to Issue Guidelines for the Responsible Use of AI in Healthcare." https://www.coalitionforhealthai.org/updates/october-6th-2022. Accessed August 22, 2023.
[57] "MITRE's Brian Anderson, M.D., Explains Coalition's AI Blueprint" https://www.hcinnovationgroup.com/analytics-ai/artifical-intelligence-machine-learning/article/53063115/mitres-brian-anderson-md-explains-coalitions-ai-blueprint. Accessed August 22, 2023.
[58] Digiorgio A. Ehrenfeld J. "Artificial Intelligence in Medicine & ChatGPT: De-Tether the Physician." https://link.springer.com/article/10.1007/s10916-023-01926-3. Accessed August 23, 2023.
[59] AMA. "Feds Warn Algorithms Can Induce Bias in Clinical Decisions." https://www.ama-assn.org/delivering-care/health-equity/feds-warned-algorithms-can-introduce-bias-clinical-decisions. Accessed August 22, 2023.
[60] FDA. "Artificial Intelligence and Machine Learning Software Regulation." https://www.fda.gov/medical-devices/software-medical-device-samd/artificial-intelligence-and-machine-learning-software-medical-device#regulation. Accessed August 22, 2023.
[61] AMA. "FDA Must Guard Against Bias AI Focus in Patient Outcomes." https://www.ama-assn.org/practice-management/digital/fda-must-guard-against-bias-ai-focus-patient-outcomes. Accessed August 22, 2023.
[62] Reuters. "Lawmakers Committee Reaches Deal on AI Act." https://www.reuters.com/technology/eu-lawmakers-committee-reaches-deal-artificial-intelligence-act-2023-04-27/. Accessed August 22, 2023.
[63] The AI Act. "What is the AI Act?" https://artificialintelligenceact.eu/. Accessed August 22, 2023.
[64] U.S. Copyright Office Fair Use Index. "2013 Joint Strategic Plan on Intellectual Property Enforcement." https://www.copyright.gov/fair-use/. Accessed August 22, 2023.
[65] Vokinger K. Gasser U. "Regulating AI in medicine in the United States and Europe." "https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7611759/. Accessed August 22, 2023.
[66] AMA PolicyFinder. Augmented Intelligence in Health Care H-480.939. Accessed August 22, 2023.
[67] AMA PolicyFinder. Augmented Intelligence in Health Care H-480.940. Accessed August 22, 2023.
[68] AMA PolicyFinder. Augmented Intelligence in Medical Education H-295.857. Accessed August 22, 2023.
[69] AMA PolicyFinder. Professionalism in Health Care Systems: Augmented Intelligence E-11.2.1. Accessed August 22, 2023.
[70] AMA PolicyFinder. Assessing the Potentially Dangerous Intersection Between AI and Misinformation H-480.935. Accessed August 22, 2023.

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,

president and CEO of the ABMS, was invited by the Council to attend its fall 2022 meeting to provide an update on the new Standards for continuing certification. He also presented to the AMA on April 5, 2023, co-hosted by the Academic Physician Section and Young Physician Sections, to further discuss the new Standards as well as share related concerns from physicians and the ABMS response to those concerns. Dr Hawkins also discussed structural changes to ABMS governance and the organization's collaboration with associate members. He clarified current misinformation. Further, the Council invited Dr. Hawkins to attend their assembly during the 2023 Annual Meeting. Dr. Hawkins shared that they've received largely favorable feedback on the new Standards. Boards are working on their implementation plans given that the Standards take effect January 1, 2024; the Council asked that ABMS consider challenges faced by physicians in independent private practice. Also, Dr. Hawkins reported on their collaboration with ACGME on CBME and attentiveness to equity in assessment. He shared concerns regarding alternative certifying bodies, specifically the National Board of Physicians and Surgeons, citing how they fall short of the norms set by the ABMS as publicly addressed in their July 2022 statement.[9] Lastly, Dr. Hawkins shared that ABMS is looking into ways continuing certification can promote well-being and decrease burnout.

In addition, the Council will proffer a report at the 2023 Interim Meeting that provides an overview of several entities that provide board certification including the ABMS, AOA Bureau of Osteopathic Specialists (BOS), National Board of Physicians and Surgeons (NBPAS), American Board of Physician Specialties (ABPS), and American Board of Cosmetic Surgery (ABCS) and how their standards for board certification differ. It is important to note that while there are different ways to achieve continuing board certification, it is debatable whether they produce the same outcomes for patients.

Relevant AMA policies

AMA policy related to CBC and lifelong learning can be accessed in the AMA PolicyFinder database. Policies most relevant to CBC are provided in Appendix B and are listed here:

- H-275.924, "Continuing Board Certification
- D-275.954, "Continuing Board Certification"
- H-275.926, "Medical Specialty Board Certification Standards"
- D-275.957, "An Update on Maintenance of Licensure"

CONCLUSION

The AMA will continue to monitor the evolution of CBC and provide updates, as directed by this House of Delegates. The Council is grateful to ABMS and AOA for their contributions to the creation of this report. Following this report, the Council will provide further updates in the form of issue briefs as pertinent information arises. In the event of significant changes to CBC impacting practicing physicians, the Council will consider initiating a report to the House of Delegates. Reports and issue briefs are posted to the Council's report webpage and promoted through various AMA medical education communications. Reports can also be found via the AMA Council Report Finder search tool.

Fiscal note: $500

APPENDIX A: ANNOTATED BIBLIOGRAPHY

Berland LL, Mary Jo Tarrant, Heitkamp DE, Beavers K, Lewis CS. Maintenance of Certification in Radiology: Eliciting Radiologist Preferences Using a Discrete Choice Experiment. Journal of The American College of Radiology. 2022 Sep 1;19(9):1052–68.

Bradley S, Lindquist LA, Jones E, Rowe T, O'Brien K, Dobschuetz D, et al. Development and evaluation of a simulation-based mastery learning maintenance of certification course. Gerontology & Geriatrics Education. 2021 Feb 25;43(3):397–406.

Driscoll SW, Raddatz MM, Sabharwal S, Francisco GE, Nguyen V, Kinney CL. American Board of Physical Medicine and Rehabilitation Diplomate Customization Choices on the Longitudinal Assessment for Physical Medicine and Rehabilitation. American Journal of Physical Medicine & Rehabilitation. 2022 Jul 1;101(7):S21–5.

Faulkner LR, Juul D, Thomas CR, Anzia JM, Lewis SL, Schor NF, et al. An Article-Based Format for Medical Specialty and Subspecialty Maintenance of Certification. Journal of Continuing Education in the Health Professions. 2022 Feb 17;Publish Ahead of Print.

Fraundorf S, Caddick Z, Rottman B, Nokes-Malach T, Swanson D, Bazemore A, et al. Conceptual Foundations for Designing Continuing Certification Assessments for Physicians [Internet]. American Board of Medical Specialties. [cited 2022 Jul 27]. Available from: https://www.abms.org/wp-content/uploads/2022/07/conceptual-foundations-continuing-certification-assessments-for-physicians.pdf

Hawkins RE, Ogrinc G, Ramin SM. American Board of Medical Specialties and New Standards for Continuing Certification. JAMA. 2022 May 3;327(17):1645.

Hendricks JJ, Theis R, Mann KJ, Turner AL, Filipp SL, Leslie LK, et al. Exploring paediatricians' experiences with performance improvement modules and quality improvement. BMJ Open Quality [Internet]. 2022 May 1 [cited 2022 Jul 22];11(2):e001674. Available from: https://bmjopenquality.bmj.com/content/11/2/e001674.abstract

Lyness JM, McMahon GT. The Role of Specialty Certification in Career-Long Competence. Academic Medicine. 2023 Jul 4.

Main PAE, Anderson S. Evidence for continuing professional development and recency of practice standards for regulated health professionals in Australia: protocol for a systematic review (Preprint). JMIR Research Protocols. 2021 Mar 8.

Norcini JJ, Weng W, Boulet J, McDonald F, Lipner RS. Associations between initial American Board of Internal Medicine certification and maintenance of certification status of attending physicians and in-hospital mortality of patients with acute myocardial infarction or congestive heart failure: a retrospective cohort study of hospitalisations in Pennsylvania, USA. BMJ Open. 2022 Apr;12(4):e055558.

Sheth BP, Schnabel SD, Beth Ann Comber, Martin B, McGowan M, Bartley GB. Relationship Between the American Board of Ophthalmology Maintenance of Certification Program and Actions Against the Medical License. American Journal of Ophthalmology. 2023 Mar 1;247:1–8.

Siegel RD, Garrett-Mayer E, Lipner RS, Kozlik MMP, Vandergrift JL, Crist STS, et al. Relationship Between Participation in ASCO's Quality Oncology Practice Initiative Program and American Board of Internal Medicine's Maintenance of Certification Program. JCO Oncology Practice. 2022 Apr 1.

Sliwa JA, Sherilyn Whately Driscoll, Robinson LR, Walker ML, Garrison CJ, Kinney CL. Improving Patient Safety and Quality in Physical Medicine and Rehabilitation Through Participation in the American Board of Physical Medicine and Rehabilitation Continuing Certification Program. American Journal of Physical Medicine & Rehabilitation. 2022 Jul 1;101(7):S10–4.

Peterson LE, Johannides J, Phillips RL. Physicians' Choice of Board Certification Activity Is Unaffected by Baseline Quality of Care: The TRADEMaRQ Study. The Annals of Family Medicine. 2022 Mar;20(2):110–5.

Tanoue LT, Evans L. Maintaining Your Certification in Pulmonary Disease and Critical Care Medicine. Chest. 2023 May 1;163(5):1020–2.

Ward RC, Baker KA, Spence D, Leonard C, Sapp A, Choudhry SA. Longitudinal Assessment to Evaluate Continued Certification and Lifelong Learning in Healthcare Professionals: A Scoping Review. Evaluation & the Health Professions. 2023 Mar 24;016327872311643-016327872311643.

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.

REFERENCES

1. American Board of Medical Specialties. [cited 2023 Jun 16]. Available from: https://www.abms.org/

2. Continuing Board Certification: Vision for the Future Initiative Selects Commission Members [Internet]. American Board of Medical Specialties. [cited 2023 Jun 16]. Available from: https://www.abms.org/newsroom/continuing-board-certification-vision-for-the-future-initiative-selects-commission-members/

3. Continuing Board Certification: Vision for the Future Commission, Final Report [Internet]. American Board of Medical Specialties. [cited 2023 Jun 16]. Available from: https://www.abms.org/wp-content/uploads/2020/11/commission_final_report_20190212.pdf

4. Standards for Continuing Certification [Internet]. American Board of Medical Specialties. [cited 2023 Jun 16]. Available from: https://www.abms.org/board-certification/board-certification-standards/standards-for-continuing-certification/

5. An Update on Continuing Board Certification (CME 2-A-22) [Internet]. American Medical Association. Council on Medical Education; [cited 2023 Jun 17]. Available from: https://councilreports.ama-assn.org/councilreports/downloadreport?uri=/councilreports/CME_Report_02_A_22_final.pdf

6. Board Certification Report 2021-2022 [Internet]. American Board of Medical Specialties. [cited 2023 Jun 17]. Available from: https://www.abms.org/abms-board-certification-report/

7. Strategic Plan 2023-2028 [Internet]. American Board of Medical Specialties. [cited 2023 Jun 17]. Available from: https://www.abms.org/newsroom/abms-strategic-plan-2023-2028/

8. Strategic Plan 2023-2028, Executive Summary [Internet]. American Board of Medical Specialties. [cited 2023 Jun 17]. Available from: https://www.abms.org/wp-content/uploads/2023/05/abms-strategic-plan-2023-2028-executive-summary-external.pdf

9. The ABMS Response to National Board of Physicians and Surgeons' Assertion of Certifying Body Equivalency [Internet]. American Board of Medical Specialties. 2022. Available from: https://www.abms.org/newsroom/abms-response-to-nbpas-assertion-of-certifying-body-equivalency/

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 expanhding 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

proposals to revoke the flexibilities for POHs that service greater numbers of Medicaid patients, to increase the agency's regulatory authority to grant or deny exceptions to expansion, and to expand the scope of community input. The AMA believes these proposals limit the capacity of POHs to increase competition and choice in communities throughout the country and more significantly, limit patients' access to high-quality care. The AMA believes that in the proposed rule, CMS provides a one-sided rationale to support its proposals restricting POHs. CMS' own study in 2003 found a number of factors that account for the high performance of POHs, including specialization, improved nursing staff ratios and expertise, patient amenities, patient communication and education, an emphasis on quality monitoring, and clinical staff perspectives on physician ownership.[18] Unfortunately, CMS published the Final Rule in August 2023 and moved forward with enacting restrictions on POHs. An excerpt from the Final Rule states:

> "As we have stated in previous rulemakings, we are concerned that, when physicians have a financial incentive to refer a patient to a particular entity, that incentive can affect utilization, patient choice and competition. Physicians can overutilize by ordering items and services for patients that absent a profit motive, they would not have ordered. A patient's choice is diminished when physicians steer patients to less convenient, lower quality, or more expensive providers of health care just because the physicians are sharing profits with, or receiving renumeration from, the quality, service, or price." (80 FR 41926 and 81 FR 80533)[19]

The AMA has recently provided comments to the U.S. Senate Finance Committee,[20] the U.S. House Committee on Ways and Means,[21] and the U.S. House Committee on Energy and Commerce[22] all in support of physician-owned hospitals and repealing the existing ban. Additionally, in July 2023, the AMA supported a sign-on letter to Congress in support of the Patient Access to Higher Quality Health Care Act (S. 470/H.R. 977) which supports repealing the ban on physician-owned hospitals.[23]

CONCLUSION

Longstanding AMA policy supports the repeal of the ban on POHs, and the AMA has been actively advocating for the repeal as recently as 2023. The AMA's June 2023 letter of support for the Patient Access to Higher Quality Care Act of 2023 underscores that POHs have been shown to provide high-quality care to the patients they serve. The Council believes that not only does limiting the viability of the POHs reduce access to quality medical care, but it also reduces competition in hospital markets to the detriment of the communities these hospitals serve.

One of the strongest opponents of POHs is the American Hospital Association (AHA). In a comment letter to Congress on H.R. 977/S.470, the AHA claims that POHs "provide limited or no emergency services, relying instead on publicly funded 911 services when their patients need emergency care." However, the majority of POHs are generally equipped with several hundred beds and large emergency departments similar to community hospitals. A report by CMS in 2005 found that physician-owned cardiac hospitals resembled full-service hospitals with emergency departments, whereas orthopedic hospitals and general surgical specialty hospitals more closely resemble Ambulatory Surgery Centers (ASCs) which focus on outpatient services or cases with a reasonable expectation of limited hospitalizations. For example, POHs with specialty care, like cardiac care, closely resemble full-service hospitals with emergency departments, while POHs that specialize in orthopedic care closely resemble other outpatient facilities or ASCs. The differences are driven by services provided to patients and are not driven by the ownership structure of the hospital.[24]

Additionally, in their comment letter, the AHA claims that "physician self-referral also leads to greater utilization of services and higher costs." The Council believes that this is also a misrepresentation. CMS studied referral patterns associated with specialty hospitals among physician owners relative to their peers and ultimately stated: "We are unable to conclude that referrals were driven primarily based on incentives for financial gain." Several studies looking at the effect of hospital ownership on health care utilization have concluded that physician ownership does not lead to an increased volume of surgeries being performed, suggesting that any evidence of increased utilization is at best mixed.[25]

Finally, the AHA claims that "physician-owned hospitals tend to cherry-pick the most profitable patients, jeopardizing communities' access to full-service care." To the contrary, evidence indicates that physician-owned hospitals do not "cherry-pick" patients. For example, CMS studied referral patterns associated with specialty hospitals among physician owners relative to their peers and were unable to conclude that referrals were driven primarily based on incentives for financial gain. Importantly, new economic research also finds strong evidence against "cherry-picking" in POHs.[26]

While the Council recognizes the challenges of a partnership with POHs, we believe there are potential benefits to collaborating with interested stakeholders to promote the benefits that POHs can provide to a community.

The IPPS Final Rule issued by CMS in August 2023 will make it more difficult for existing POHs to expand and will not allow for new POHs to open. Even facilities deemed high Medicaid facilities will not be able to expand beyond 200 percent of their baseline facility capacity, must locate all approved expansion facility capacity on their main campus, and may not request an expansion exception earlier than two calendar years from the date of the most recent decision by CMS approving or denying the hospital's most recent expansion request. The Final Rule changes the process for community input when considering a POH's request to expand, including doubling the length of time for initial community input, as well as doubling the length of time for hospital rebuttal if a request is denied.[27]

The AMA believes that POHs provide high-quality care to patients and needed competition in hospital markets. The AMA supports competition between health care providers and facilities as a means of promoting the delivery of high-quality, cost-effective health care. Providing patients with more choices for health care services stimulates innovation and incentivizes improved care, lower costs, and expanded access.

The CMS Final Rule mischaracterizes physicians and POHs by incorrectly assuming that physicians misuse resources and steer patients to use excess services and are solely driven by profit motives. In contrast, POHs would increase competition and provide valuable resources to many communities, including those in rural areas. CMS' own study of physician referral patterns found no evidence of "cherry-picking" or steering patients. Lifting the ban on POHs could allow physicians to acquire hospitals and better enable them to implement alternative delivery and payment models in an effort to control hospital costs and supervise the overall health care product.

The Council believes the AMA has clear policy to advocate for the repeal of the ban on physician-owned hospitals as evidenced by recent AMA advocacy activities. The Council presents this report for the information of the House and will continue to monitor this issue.

Fiscal Note: Less than $500.

REFERENCES

[1]Physician-Led Healthcare for America. Physician-Led Hospitals: The Patient-Physician Relationship. Accessed: July 21, 2023. https://physiciansled.com/physician-owned-hospitals/#:~:text=Beginning%20in%20the%20early%202000s,owned%20and%20operated%20by%20physicians
[2]Miller, Brian J., et al. Reversing Hospital Consolidation. Health Affairs. April 12, 2021. https://www.healthaffairs.org/content/forefront/reversing-hospital-consolidation-promise-physician-owned-hospitals
[3]*Ibid*
[4]CMS.gov. Physician-Owned Hospitals. Accessed: July 20, 2023. https://www.cms.gov/medicare/fraud-and-abuse/physicianselfreferral/physician_owned_hospitals
[5]*Supra*. Note 2.
[6]Bryant, Meg. ACA is taking a toll on physician-owned hospitals. Healthcare Dive. July 11, 2017. https://www.healthcaredive.com/news/aca-is-taking-a-toll-on-physician-owned-hospitals/446761/
[7]Kane, Carol K. Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice Towards Larger Practice Size Continue through 2022. American Medical Association. 2023. https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf
[8]*Ibid*
[9]Henry, Tanya Albert. Physician-Owned Hospitals Seize their Moment. Journal of the Missouri Medical Association. July-August 2013. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6179879/
[10]*Supra*. Note 2.
[11]NDP Analytics. The Economic and Social Benefits of Physician-Led Hospitals. September 2022. https://physiciansled.com/wp-content/uploads/2022/09/Economic-Impact-Report-2022-1.pdf
[12]*Supra*. Note 2.
[13]Mandelberg, Matthew C., et. al. Hospital Competition and Restrictions on Physician-Owned Hospitals. February 5, 2023. https://ssm.com/abstract=4350105
[14]AMA Comment Letter to Centers for Medicare & Medicaid Services in Response to 2024 Inpatient Prospective Payment Systems Proposed Rule. June 9, 2023. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfcmt.zip%2F2023-6-9-Letter-to-Brooks-LaSure-re-2024-IPPS-Comments-v4.pdf
[15]*Supra.* Note 13.
[16]AMA Comment Letter to U.S. House of Representatives in Support of H.R. 977. June 1, 2023. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfcsot.zip%2F2023-6-1-Letter-to-House-re-PAHQHCA-Physician-Owned-Hospitals-Bill.pdf
[16]AMA Comment Letter to U.S. Senate in Support of S. 470. June 1, 2023. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfcsot.zip%2F2023-6-1-Letter-to-Senate-re-PAHQHCA-Physician-Owned-Hospitals-Bill.pdf
[17]Department of Health and Human Services – Centers for Medicare & Medicaid Services. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership; and Medicare Disproportionate Share Hospital (DSH) Payments: Counting Certain Days Associated with Section 1115 Demonstrations in the Medicaid Fraction. Federal Register. 42 CFR Parts 411, 412, 419, 489, and 495. August 1, 2023. https://public-inspection.federalregister.gov/2023-16252.pdf
[18]*Supra.* Note 13.
[19]AMA Statement to the U.S. Senate Finance Committee. Consolidation and Corporate Ownership in Health Care: Trends and Impacts on Access, Quality, and Costs. June 8, 2023. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfcsot.zip%2F2023-6-8-Senate-Finance-Comm-Statement-for-the-Record-Testimony-on-Consolidation-Corp.pdf
[20]AMA Statement to the U.S. House Committee on Ways and Means – Subcommittee on Health. Why Health Care is Unaffordable: Anticompetitive and Consolidated Markets. May 17, 2023. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfcsot.zip

%2F2023-5-17-WMs-Health-SubCmt-Statement-for-the-Record-on-Anticompetitive-and-Consolidated-Markets-v2.pdf

[21]AMA Statement to the U.S. House Committee on Energy and Commerce – Subcommittee on Health. Lowering Unaffordable Costs: Examining Transparency and Competition in Health Care. March 28, 2023. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fstmnt.zip%2FEC-Statement-For-the-Record-on-Transparency-and-Competition-X.pdf

[22]Sign-on Letter – Physician-Led Hospitals Coalition. July 27, 2023. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfsolg.zip%2F2023-7-27-Sigend-On-Coalition-Letter-re-Physician-Led-Hospitals.pdf.

[23]Swanson, A. "Physician investment in hospitals: Specialization, selection, and quality in cardiac care." Journal of Health Economics 80. 2021.

[24]*Supra*. Note 14.

[25]*Supra*. Note 13.

[26]*Supra* Note 13.

[27]*Supra*. Note 17.

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 Kyllo, MD
- Lisa Bohman Egbert, MD, Speaker, Ohio
- John H. Armstrong, MD, Vice Speaker, American College of Surgeons

BACKGROUND

Members of the RMTF were sent background material related to the current resolution process in the House (Appendix A). The task force subsequently met on August 27 to assess the resolutions process, identify potential areas for improvement, and develop a list of topics to discuss at the open forum scheduled to be held at Interim 2023 at 10 am on Sunday, November 12, 2023. The task force will subsequently develop its report with recommendations to be presented at Annual 2024 as directed in resolution A-22-604.

At their initial meeting, the task force stated, "The RMTF seeks to develop efficient processes that allow for all business before the House to be equally reviewed by all delegates with the ultimate goal of the best policy being developed for our AMA." Subsequent discussion focused on identifying current "roadblocks" to achieving this goal and considering potential solutions. Following is the list of topics with brief synopsis for discussion at the I-23 open hearing as shared by the task force. This list is not intended to be exclusive and also does not imply that the task force has reached a conclusion on any specific topic.

ITEMS FOR CONSIDERATION

Unequal Time for Delegates to Evaluate Items of HOD Business

The task force identified unequal time for delegates to evaluate the individual items of House of Delegates (HOD) business as a significant barrier to creating a better process for the development of our policy. Unequal time to evaluate the business can be further divided into two broad areas: increased volume of business and variable definition of "on time" resolutions.

Topic #1 Increased Volume of Business

The volume of business has been increased at the last three in-person meetings. This may be attributed to the backlog of resolutions from the Federation that were unable to be handled during the Special Meetings, the increasing number of delegates leading to production of more resolutions, the focus on policy making within the Sections, and the politicization of issues related to science, medicine and health. Tracking this data is challenging as all processing of resolutions at the AMA level is done "by hand." The task force encourages individual delegations to review their recent resolution production and share those numbers at the upcoming open forum.

A large volume of business inevitably leads to a large volume of policy which is challenging to manage, both from a data processing perspective (i.e. Policy Finder) and, more importantly, from AMA management and board perspectives as they are tasked with the development and implementation of our AMA strategic plan that derives from House policies.

Topic #1
Should the volume of business be limited? If so, how can this be accomplished fairly without infringing on the individual delegate's right to present business to the House? Should there be a requirement for authors to explain how resolutions correlate with our AMA strategic plan?

Topic # 2 Definition of "On-time Resolutions"

Bylaw 2.11.3.1 *Introduction of Business* sets the resolutions submission deadline as *"not later than 30 days prior to the commencement of the meeting at which it is to be considered."* It then goes on to delineate two exemptions to this rule, which are paraphrased below:

1. Resolutions from member organization's house of delegates or primary policy making body, as defined by the organization, that adjourn during the 5-week period preceding the commencement of the AMA House of Delegates meeting are allowed 7 days following the close of their meeting to submit resolutions from that meeting.
2. Resolutions presented from the business meetings of the AMA Sections held in conjunction with the HOD meeting may be presented up until the recess of the opening session of the House of Delegates.

Combined, these two exceptions account for a significant number of resolutions that are presented after the handbook has been posted. These items are not available on the Online Member Forums for review. In addition, the later the resolutions are made available, the less time for groups to meet to discuss them in advance of the reference committee hearings potentially affecting the quality of resolutions passed.

Topic #2
Should there be one firm deadline, with no exceptions, for all business presented at each meeting, with items received after that deadline treated as *late?

**Late resolutions, as defined by bylaw 2.11.3.1.3, are those received after the 30 day deadline and prior to the recess of the opening session of the House of Delegates. These resolutions are reviewed by the Committee on Rules and Credentials and can be accepted as business with a two-thirds majority vote.*
**Late resolutions are recommended for consideration by the Committee on Rules and Credentials based on two criteria: why they could not be submitted on time and the urgency of the topic and thus the need to be considered at the meeting. This would continue to apply to the currently exempted items if they became "late" by changing to one firm deadline.*

Topic #3 Avoiding Redundancy with Existing Policy

The RMTF identified the significant volume of existing policy and the potential for redundancy within that policy as another broad area that should be improved. While this is in part due to the increasing volume of business, another contributing factor is an inadequate mechanism to identify and deal with new resolutions that are not significantly different from existing policy. These issues can be further delineated as follows:

Resolution writing process

- Authors vary in their efforts and success in identifying existing AMA policy on the topics under consideration for resolutions.
- Policy Finder is not user-friendly, making searches of existing policy time-consuming and often unproductive. Updates to policy finder are ongoing but will not be completed in the short-term.
- Federation policymaking bodies are not compelled to review current AMA policy in writing resolutions for their own organizations before forwarding them to the AMA HOD. In addition, many organizations are required to forward all resolutions, as passed, to the AMA HOD, without consideration for alternative pathways to achieving their goals.

Identifying Submitted Resolutions for Reaffirmation

- Resolutions are reviewed for possible reaffirmation of existing policy by AMA staff who are content matter experts. Corporate turnover, especially during COVID-19, has resulted in the loss of long-time staff who had considerable institutional memory of AMA policy. This leaves our newer staff more dependent on Policy Finder and its inherent shortcomings.
- The Rules and Credentials Committee reviews the list produced by staff to develop their report. Note that per bylaws this committee, like all other HOD committees, cannot officially act prior to the commencement of the meeting. Their report is released in the meeting tote ("Saturday" tote) for action at the second opening session later that day, allowing limited time for review by delegations.

Pulling items off the reaffirmation consent calendar

- Current rules allow an individual delegate to pull an item off of the consent calendar.
- While there is typically a significant number of items placed on the consent calendar, half to 2/3rds are typically pulled off and sent to reference committee hearings.
- Reference committees often ultimately recommend reaffirmation of policy in lieu of many items initially recommended for reaffirmation on the Reaffirmation Consent Calendar.
- Many authors/delegations do not consider reaffirmation a "win" with regard to their resolution, despite the fact that the sunset clock is reset and the topic is noted in the proceedings.

Alternative Pathways

- G-600.060 (5) states, *"The submission of resolutions calling for similar action to what is already existing AMA policy is discouraged. Organizations represented in the House of Delegates are responsible to search for alternative ways to obtain AMA action on established AMA policy, especially by communicating with the Executive Vice President. The EVP will submit a report to the House detailing the items of business received from organizations represented in the House which he or she considers significant or when requested to do so by the organization, and the actions taken in response to such contacts."*
- While your task force is not recommending flooding the desk of our EVP, this is an underutilized alternative to writing a redundant resolution in order to stress the importance of a specific topic already in policy.

Topic #3
Can we reduce the introduction of resolutions that are redundant to existing policy? Are there ways to improve the production of the reaffirmation consent calendar? Should items identified as potential reaffirmation be so delineated on the Online Forum? Should authors of items identified as reaffirmation be asked to explain in writing to Rules and Credentials why their item is not reaffirmation? Should there be a higher bar for removal from the reaffirmation calendar? How do we encourage the use of alternative pathways for increasing awareness of given topics? How do we reframe reaffirmation as a "win"?

Topic #4 Reference Committee Process

The task force noted several concerns with the process by which resolutions move through reference committees. These can be broadly separated into two main topics: Online Member Forums and In-person Hearings.

Online Member Forum

The Online Member Forum has been underutilized by the HOD despite successful use by many Sections and component societies. This is due in large part to the inability to have all business before the House available for comment on the Forum, which in turn is due to the large number of resolutions that arrive after the posting of the initial handbook.

Policy D-600.956 *Increasing the Effectiveness of Online Reference Committee Testimony* initiated a two-year trial of the production of a preliminary reference committee document, based on

testimony in the Online Member Forum during a prescribed 14 day period, which is then intended to be used to inform the discussion at the in-person reference committee hearing. I-23 marks the conclusion of this trial. For I-23, your Speakers established an expedited deadline system to enable all items, minus the exempted items, to be included in the handbook and the forum. No addendum was produced. Multiple communications were sent to the House to encourage more robust use of the Forum, and the reference committees were directed to enhance their preliminary documents. As of the writing of this report, the effects of these changes are unknown but are hoped to stimulate better utilization of the Online Forum and that the improved preliminary documents will expedite the in-person hearings.

Topic #4
How can the Online Forum be better utilized? Should the preliminary document be more robust? Should the preliminary document include reference committee recommendations and be used as the basis for the discussion at the in-person hearing?

Topic #5 Reference Committee Hearings

Your Speakers have heard several concerns regarding reference committee hearings at our recent in-person meetings. Despite the earlier meeting start which allowed for more time for deliberation, the volume of business before the reference committee hearings caused several to run over their allotted time. Concerns have been raised that items at the end of the agenda do not receive adequate discussion due to lack of attendance and significant restrictions on debate, in one instance down to 30 seconds. This often results in more items at the end of reference committees being extracted from the consent calendar for full House deliberation. Reference committee members and particularly the chairs spend significant time following the hearings in executive session and report review. In addition, reference committee members and staff work, often without sleep, for prolonged periods in order to complete their reports. It may be that this has become such a significant time commitment that it is a reason for your Speakers having difficulty obtaining enough volunteers for the reference committees at recent meetings.

Topic #5
How can we improve reference committee hearings to allow all items to receive adequate discussion in a timely fashion? How can we decrease the time spent on report development while maintaining the quality of the reports?

CONCLUSION

The RMTF is looking forward to hearing your comments regarding the above topics at the Open Forum to be held on Sunday, November 12 at 10 am. Note that this list is not meant to be all inclusive but rather a guide to frame the discussion. The task force is open to hearing all comments or suggestions from our House regarding improving this process.

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 sunsetting 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 sunsetting 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~~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 ~~s~~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 ~~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~~ are 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 supere~~s~~sede 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.
(~~4~~6) All resolutions and reports should ~~will~~ be written to include both "MD and DO," unless specifically applicable to one or the other.
(~~5~~7) ~~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.
(~~6~~8) 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; (~~c~~d) Modify Bylaws; (~~d~~e) Rescind HOD Policy; (~~e~~f) Reaffirm HOD Policy; or (g) Directive to Take Action.
(~~7~~9) 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 s~~ 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 <u>Access</u> ~~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

Whereas, Our American Medical Association House of Delegates recently reviewed and revised the election process for officers and councils through a Speakers Task Force; and

Whereas, The process of submitting, reviewing, evaluating, reporting, and voting on resolutions in our HOD has not changed in many years; and

Whereas, For the past two years, all delegations and sections have met virtually and have been able to work asynchronously to discuss and vote on potential resolutions to submit to the AMA HOD; and

Whereas, The Saturday/Sunday tote contains a significant amount of new resolutions each year; and

Whereas, The resolutions in the Saturday/Sunday tote cannot be adequately reviewed and vetted by all delegations and delegation staff and reference committee members prior to the start of the reference committee hearings; and

Whereas, According to Bylaws 2.11.3.1.3, “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”; and

Whereas, According to Bylaws 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”; and

Whereas, The ability to meet virtually and work asynchronously was enhanced during the pandemic to the point where it is potentially more efficient and convenient for Delegations and Sections; therefore be it

RESOLVED, That our American Medical Association form a Speakers Task Force on the Resolution Process to review the entire process of handling resolutions for our AMA House of Delegates, including but not limited to definitions of on time resolutions, emergency resolutions, and late resolutions, deadlines for submission of resolutions by all sections, processing and review of reference committee reports, and use of virtual meetings so that all on time resolutions can be submitted by the same deadline (Directive to Take Action); and be it further

RESOLVED, That our AMA Speakers Task Force on the Resolution Process report back to our AMA House of Delegates by the 2024 Annual Meeting with recommendations regarding the 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