

REPORTS OF THE BOARD OF TRUSTEES

The following reports were presented by Bobby Mukkamala, MD, Chair.

1. RACIAL ESSENTIALISM IN MEDICAL EDUCATION

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

This informational report submitted to the House of Delegates summarizes American Medical Association (AMA) activities in combatting racial essentialism in medical education and is written in response to AMA Policy D-350.981, “Racial Essentialism in Medicine.”

RACIAL ESSENTIALISM IN MEDICAL EDUCATION

“Racial essentialism” is defined as the belief in a genetic or biological essence that defines all members of a racial category.^{1,2} However, this theory is grounded in fallacy, as science has proven that race is a social construct based on a human-invented classification system to define physical differences among people.³ There is ample evidence that race is a poor proxy for genetic differences and “phenotypic” features commonly referenced in discussions of race fail to correspond to discrete categories or underlying physiology.⁴ Additionally, the categorizations of race have led physicians and medical students alike to draw conclusions about the hierarchical organization of humans, which connect an individual to a larger preconceived geographically circumscribed or socially constructed group. This belief contributes to the cultivation of structural racism, which refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources.⁵

Current Manifestations of Racial Essentialism in Medical Education

Racial essentialism has been preserved in medicine and medical education in multiple ways.

Foundational scientific content and clinical teaching is based upon research that commonly lacks diverse representation among subjects. This can lead to teaching of outdated or ill-informed practices, such as race-based calculation of estimated glomerular filtration rate (eGFR). Renal function estimated glomerular filtration rate (eGFR) calculations have historically been adjusted up for Black/African American race to account for “increased muscle mass,” though no robust scientific evidence exists to support this claim, and patients have been categorized as “Black” and “non-Black.” This practice minimizes the severity of illness in Black patients, has led to the overestimation of kidney function among Black patients, and has translated to devastating consequences such as delayed referrals for treatment, disqualification for transplants, and misguided treatment and counseling. It also creates a blind spot for the treatment of others who may be inaccurately aggregated under one homogeneous “non-Black” label regardless of their genetics or biological ancestry, health profile, or social circumstances. In 2020-2021, following a review of the practice and mirroring the precedent set by Beth Israel Deaconess Medical Center, Mass General Brigham and New York City Health + Hospitals eliminated the use of race as a factor when calculating kidney function and implemented that renal function eGFR calculations would be solely based on creatinine levels, age, and sex for all patients.⁶ Additionally, the National Kidney Foundation (NKF) and the American Society of Nephrology (ASN) established the NKF-ASN Task Force on Reassessing the Inclusion of Race in Diagnosing Kidney Disease, a joint task force to examine the inclusion of race in the estimation of GFR and its implications for the diagnosis and subsequent management of patients with, or at risk for, kidney diseases. The task force released an interim report entitled “Reassessing the Inclusion of Race in Diagnosing Kidney Diseases: An Interim Report from the NKF-ASN Task Force” which detailed the process, initial assessment of evidence, and values defined regarding the use of race to estimate GFR in June 2021.⁷

Lack of diverse representation in educational practices is another challenge. There is a paucity of educational materials on non-white skin tones and the lack of curriculum devoted to the care of diverse skin and hair textures of patients demonstrates the lack of inclusion in training materials for medical students.^{8,9} A recent study of race and skin tone depicted in images in textbooks assigned at top medical schools found that while the textbooks did approximate the racial distribution of the U.S. population—62.5% white, 20.4% Black, and 17.0% Person of Color—the skin tones in the illustrations—74.5% light, 21% medium, and 4.5% dark—overrepresent light skin tone and underrepresent dark skin tone. There is also an absence of skin tone diversity at the chapter and topic level.¹⁰ The lack of training on diverse skin tones extends into patient care, and patients have expressed frustration with dermatologists who lack experience and knowledge in the care of disorders of diverse skin tones and hair textures. Fortunately, dermatology residency programs are making efforts to incorporate training on treatment of skin of color into their curriculum.¹¹ Similarly, simulations and clinical skills frequently lack diverse representation.

Perpetuation of stereotypes in the learning environment include naming of implicit bias and social elements included in clinical case vignettes and examination items. These stereotypes lead to incomplete framing of social determinants of health and presenting social determinants of health as a matter of personal choice or unfortunate personal circumstances rather than acknowledging systemic and structural drivers of those social factors. Stereotyping is a cognitive process in which individuals use a social category to acquire, process, and recall information about people. Stereotyping can both lead to and stem from unconscious bias. These processing patterns unconsciously help individuals organize complex information. The conscious effort to reduce automatic stereotyping requires considerable cognitive resources and, under heavy cognitive load—including during clinical training and decision-making—individuals rely more heavily on stereotyping to process information. Indeed, while structured clinical vignettes have long been utilized as a resource to illustrate or highlight some aspect of medicine that the clinician can use to improve one's knowledge and clinical skills, clinical vignettes are not immune from stereotypes. Evidence of unconscious bias was found in a study of emergency department physicians' treatment of pain using clinical vignettes and found that socially desirable information increased the prescribing rates by a small but statistically significant percentage.¹² Additionally, a 2019 meta-analysis of studies conducted from 1990 to 2018 found that Black patients were 40% less likely and Hispanic patients were 25% less likely to receive medication to ease acute pain compared to white patients.¹³ Equally concerning are patients' interpersonal experiences of unfair treatment while seeking care due to their race ethnicity, gender identity, sexual orientation. These experiences can lead people to delay or forgo care, and to experience adverse health consequences.¹⁴

Clinical reasoning strategies and algorithms that support clinical decision making frequently lack diverse representation. Many data repositories collect race and ethnicity data on thousands if not millions of Americans, and it is not uncommon for multivariate analyses to test whether certain patient characteristics, such as gender, age, comorbidities, race and ethnicity contribute significantly to the predictive accuracy of estimates of risks and benefits of the various preventative and therapeutic options. With race now understood as a social, not biological construct, and as proxies for non-biological factors including social determinants of health and structural racism, considerable scholarship has been focused on determining whether race and ethnicity should continue to be included in clinical algorithms and in teaching of clinical reasoning.

EFFORTS TO ADDRESS RACIAL ESSENTIALISM IN MEDICAL EDUCATION

There have been efforts to examine practices of racial essentialism in medical education at an institutional level. These efforts include review and modernization of outdated material such as slides and clinical case vignettes to mitigate bias, explicit training in health system science, structural competency, structural drivers of social determinants of health and structural racism as well as training in metacognition, implicit bias and common forms of error in clinical reasoning. Institutions are also seeking diverse representation in clinical skills training and simulation (e.g., ophthalmologic examinations). In addition, institutional efforts have strived to actively foster diversity in classroom and clinical learning environments, explicitly consider perspectives missing from any given environment and improve the diversity of the profession by promoting holistic selection into medical school and residency by providing implicit bias training to gatekeepers and supporting pathway programs.

The AMA's Accelerating Change in Medical Education initiative has led to the development and scaling of innovations influencing the full continuum of medical training. The core initiative objectives focus on competency-based approaches to medical education and individualized pathways for students; training in health systems science; and enhancing the learning environment. This initiative has been successful in stimulating change at the consortium

schools and propagating those innovations broadly, with outputs involving medical students, faculty, medical schools, affiliated health systems, and the broader educational landscape.

In 2020, this initiative conducted a 4-week series entitled “Combatting structural racism in UME and GME,” which featured interactive sessions addressing the structural racism embedded in medical educational programs. Each session was convened for 2 hours and approximately 50 medical educational programs were represented. Structural racism in both undergraduate and graduate medical education was addressed and topics of focus included “The Educational Milieu,” “Appraising Programmatic Outcomes,” and “Microaggressions.”

During the series, member schools of the Accelerating Change in Medical Education Consortium explored the AMA curricular diversity and inclusion self-study process at a high level, with each institution to develop its own plan to follow up. The outline for self-study and action plans can be found at: <https://www.ama-assn.org/system/files/2020-07/curricular-diversity-inclusion-self-study.pdf>. In addition, the series highlighted a session on “Structural racism embedded in educational materials and approaches,” which included the naming of implicit bias in training examples, incomplete framing of equity issues, biologic versus sociologic construct of race, and bias in historical clinical protocols taught in basic science and clinical training. During this series, medical schools such as the Warren Alpert Medical School of Brown University and the George Washington University School of Medicine and Health Sciences shared their struggles and strategies for shifting the curriculum from race-based medicine to race-conscious medicine as an alternative to improve health outcomes for all.

Since 2020, the AMA has also conducted the following [webinars](#) on the topic of structural racism in medical education:

- Applying systems thinking to address structural racism in health professions education
- Combating racism in med ed to address health care disparities
- Uprooting structural racism in medical education

The AMA has also hosted *Prioritizing Equity* episodes devoted to this topic, including:

- [Examining race-based medicine](#)
- [Getting to justice in education](#)
- [Moving Upstream](#)
- [The Root Cause & Considerations for Health Care Professionals](#)

These (and other) *Prioritizing Equity* episodes will be featured in the Health Equity Education Center, a new part of the AMA Ed Hub launched by the Center for Health Equity. These videos will be further supported by new educational modules developed in partnership with COVID Black, an organization that helps healthcare systems, academic institutions, non-profit organizations, and companies solve problems around racism and health by developing custom e-learning content based on modern instructional design and visual design principles to create an impactful learning experiences about race, health disparities, health equity, and medicine. The first module serves as an introduction to racism in medicine, with substantial analysis and exploration of the history of racial essentialism and the social construction of race. Modules in development for publication later in 2021 will further examine racism in other aspects of health care, from COVID vaccination inequities to maternal and child health to health communications to public health data.

CONCLUSION

The AMA remains committed to pushing for a shift in thinking from race as a biological risk factor to a deeper understanding of racism as a social determinant of health.

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APPENDIX - Relevant AMA Policy

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.

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.

H-65.952, Racism as a Public Health Threat

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental

organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them. 6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

2. POLICING REFORM (Resolution 410-NOV-20)

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 410-NOV-20 REMAINDER OF REPORT FILED

See Policies H-65.954, H-145.969, H-345.972, H-515.955 and D-65.987

INTRODUCTION

At the 2020 November Meeting, the House of Delegates referred the Third, Fourth, and Eighth Resolve Clauses of Resolution 410-NOV-20, “Policing Reform,” introduced by the Medical Student Section, which asked:

That our AMA advocate for the elimination or reform of qualified immunity, barriers to civilian oversight, and other measures that shield law enforcement officers from consequences for misconduct.

That our AMA support efforts to demilitarize law enforcement agencies, including elimination of the controlled category of the United States Department of Defense 1033 Program and cessation of federal and state funding for civil law enforcement acquisition of military-grade weapons.

That our AMA support the creation of independent, third-party community-based oversight committees with disciplinary power whose mission will be to oversee and decrease police-on-public violence.

The reference committee heard mixed testimony on these resolves, including significant support for referral to allow for a more thorough analysis. This Board report, therefore, addresses the Third, Fourth, and Eighth Resolve Clauses of Resolution 410-NOV-20, specifically, and provides background, discussion, and recommendations.

BACKGROUND

Following the well-publicized deaths of Black Americans during police encounters—including George Floyd, Breonna Taylor, and too many others—as well as the widespread protests in their aftermath, our nation is engaging in a long-overdue conversation about police violence and excess force, and how racism and systemic and structural racial injustice manifest in over-policing of Brown and Black communities. While the AMA recognizes that many who serve in law enforcement are committed to social justice in their holistic view of justice, AMA policy acknowledges the need for changes at the federal, state, and local levels to end discriminatory practices and unnecessary or excessive use of police force. The AMA has been and continues to be engaged in advocating for such changes. As noted in an AMA Viewpoint by then-Immediate Past AMA Board Chair Jesse M. Ehrenfeld, MD, MPH, and then-Immediate Past President Patrice Harris, MD, MA:

...the violence inflicted by police in the news headlines today must be understood in relation to the larger social and economic arrangements that put individuals and populations in harm’s way, leading to both premature illness and death. Police violence is a striking reflection of our American legacy of racism—a system that assigns value and structures opportunity while unfairly advantaging some and disadvantaging others based on their skin color... Importantly, racism is detrimental to health in all its forms.¹

Because of structural racism, historically marginalized and minoritized communities in the United States shoulder the unfair, unjust, and disproportionate burden of police violence, experiencing higher levels of mortality, morbidity, inequity, and intergenerational trauma. Police violence is a leading cause of death for young men in the United States.² Over their life course, about one in every 1,000 Black men can expect to be killed by police. The risk of being killed by police peaks between the ages of 20 years and 35 years for men and women and for all racial and ethnic groups. Black women and men and American Indian and Alaska Native women and men, however, are significantly more likely than white women and men to be killed by police. Latino men are also more likely to be killed by police than

are white men.³ According to the Mapping Police Violence database, Black people comprise 28 percent of those killed by police in 2020—despite being only 13 percent of the population.⁴ It is important to note that the disproportionate exposure of communities of color to fatal police violence does not correlate to crime rates.⁵ Police-related deaths have distinct causes, distributions, and consequences for population health from other forms of violence and currently number in the thousands every year.⁶

Beyond the increased rate of fatalities, research also shows that racially marginalized communities are disproportionately subject to police force, and there is a correlation between policing and adverse health outcomes. Studies have shown that, “Men, racial/ethnic minorities, young people, and those living in economically disadvantaged areas are particularly at risk, especially those at the intersection of these social stratifications.”⁷ Standardized policies, such as stop and frisk, normalize racial profiling and structural racism.⁸ An increased prevalence of police encounters is linked to elevated stress and anxiety levels, along with increased rates of high blood pressure, diabetes, and asthma—and fatal complications of those comorbid conditions—for both the victim and the community, including children.^{9,10} Racism as a driver of health inequity is also particularly evident in findings from a 2018 *Lancet* study showing that law enforcement-involved deaths of unarmed Black individuals were associated with adverse mental health consequences among Black American adults—regardless of whether the individual affected had a personal relationship with the victim or the incident was experienced vicariously. The trauma of violence in a person’s life course is associated with chronic stress, higher rates of comorbidities, and lower life expectancy.¹¹

QUALIFIED IMMUNITY

Qualified immunity is a judicially created legal principle that grants civil immunity to individual government officials performing discretionary duties within the scope of their employment. Only if a plaintiff demonstrates that the government official violated, “clearly established statutory or constitutional rights of which a reasonable person would have known” may a civil suit proceed.¹² It operates as an affirmative defense for individual government officials, barring damages even if an unlawful, unconstitutional act was committed. Though qualified immunity is often discussed as it applies to law enforcement officers, it also applies to most other executive branch officers. Importantly, qualified immunity is only applied in civil claims and only in suits against government officials individually. Criminal proceedings and suits against the government itself for damages caused by officials’ actions do not trigger the qualified immunity doctrine.

The doctrine of qualified immunity was established in 1982 by the U.S. Supreme Court and was intended to, “protect officials who are required to exercise discretion and the related public interest in encouraging the vigorous exercise of official authority.”¹³ As it applies to law enforcement officers, supporters of qualified immunity believe it is necessary to give some deference to officers making “split-second judgments—in circumstances that are tense, uncertain, and rapidly evolving—about the amount of force that is necessary in a particular situation.”¹⁴

The doctrine is often implicated in civil rights lawsuits against state and local police under 42 U.S.C. § 1983 (Section 1983), which creates an avenue to seek damages for civil rights violations in state or federal court. Over time, the Supreme Court has broadened qualified immunity and narrowed the path to proceed in a case against a government official, diminishing the protections of Section 1983. A *Reuters* analysis of appellate court records showed that lower courts have increasingly granted immunity in cases alleging excessive use of force by law enforcement officers.¹⁵

Qualified immunity is a federal doctrine, and, for that reason, it can only fully be abolished or amended by the Supreme Court or Congress. Nevertheless, some states have acted to limit the application of qualified immunity in state courts. In June 2020, for example, Colorado became the first state to explicitly limit qualified immunity for local law enforcement officers, sheriff’s deputies, and Colorado State Patrol officers. The Enhance Law Enforcement Integrity Act (the Act) creates a new “civil action for deprivations of rights” which enables state residents to sue law enforcement officers in state court for alleged violations of the Colorado Constitution. The Act also requires law enforcement agencies to indemnify their officers.

In April 2021, New Mexico enacted the New Mexico Civil Rights Act which bars the defense of qualified immunity for any state or local public official who has caused “the deprivation of any rights, privileges or immunities secured by the Constitution of New Mexico.” The New Mexico law also creates a new cause of action under which a plaintiff may sue the government employer for damages for violations of rights under the state Constitution. Whereas Colorado’s law applies only to law enforcement officers, New Mexico’s applies to all state officials. Neither state law affects federal civil rights claims filed in federal court.

Recent high-profile deaths at the hands of law enforcement have put repeal of the qualified immunity doctrine into the spotlight as a means of preventing excessive use-of-force by law enforcement officers. Many understand qualified immunity to grant too much deference and insulate law enforcement officers from the consequences of misconduct, particularly that aimed at members of minoritized and marginalized communities. In a 2018 dissent, U.S. Supreme Court Justice Sonia Sotomayor wrote that qualified immunity gives license to police to, “shoot first and think later, and it tells the public that palpably unreasonable conduct will go unpunished.”¹⁶

The rationale for abolishing qualified immunity posits that the threat of personal liability will be so great that officers will “think twice” before engaging in misconduct. Indeed, the International Association of Chiefs of Police warns that the “loss of this protection would have a profoundly chilling effect on police officers and limit their ability and willingness to respond to critical incidents without hesitation.”¹⁷ There is reason to doubt, however, that repeal of the qualified immunity doctrine would create the intended effect. Research shows that law enforcement officers are almost always indemnified by their employer and governments pay of 99.98 percent of damages recovered for violations of civil rights.¹⁸ Indemnification creates a moral hazard wherein an individual officer does not bear the full costs of his or her behavior, reducing or eliminating the incentive for individual change in behavior. If law enforcement agencies are responsible for their employee’s individual actions, however, this may compel departments to implement better policies to curb officer misconduct to avoid financial repercussions. These hypotheses are unproven, though the recently enacted laws in Colorado and New Mexico may provide the evidence needed in the future to evaluate the effectiveness of repealing qualified immunity, as a means, to curb excessive use-of-force.

In addition, incentivizing behavior change via personal liability assumes that civil rights violations are committed intentionally and that, with the right incentives or disincentives in place, an officer would choose a different course of action. While bad actors exist and intentional brutality does tragically occur, many cases result from officers, in their minds, making the best decision they could at the time. In this way, reforming the principle of qualified immunity does not address systemic failure in policing practices.

Discussion

As a physician organization, the AMA is invested in the betterment of the public health. AMA policy recognizes that policing is a social determinant of health and that inequitable law enforcement practices are a result of structural racism and have a direct, negative impact on health, particularly among historically marginalized and minoritized communities that shoulder the disproportionate burden of police violence. If the inability to hold law enforcement officers individually liable in civil court has a measurable impact on the health of our patients, then police accountability may be ripe for AMA involvement. Literature linking the application of qualified immunity for law enforcement officers to health outcomes, however, is not available and, as noted above, claims that abolishing qualified immunity would result in better policing outcomes are untested. Given that constitutional law doctrines are generally outside the scope of the AMA’s work and the lack of evidence that abolishing qualified immunity would indeed reduce police violence, the AMA’s contribution to the national conversation about policing might better be focused on a holistic approach to policing. In particular, because of the similarities between medicine and law enforcement—professionals in both fields are frequently placed in high-pressure situations in which they must make split second, life-or-death decisions—it may benefit law enforcement to borrow some of the strategies and practices that the medical profession uses to ensure that its members provide safe and effective care.

First, in medicine, reliance on evidence is a bedrock of clinical decision-making, but the same is not true in policing. The approximately 18,000 law enforcement jurisdictions set policies and procedures independently and generally without the benefit of research to inform those policies. Though efforts are underway to expand evidence-based policing through organizations like the American Society of Evidence-Based Policing, those efforts are nascent. More research is needed to understand and implement those practices and strategies that effectively control crime while maintaining the trust and confidence of the public and ending those that are harmful and result in inequitable, discriminatory treatment of marginalized and minoritized communities.

In addition, law enforcement lacks standardization. Unlike in medicine, where multiple governmental and nongovernmental entities set standards and guidelines for training and clinical practice, law enforcement entities are not required to adhere to external standards, often resulting in fragmented and inconsistent policies.¹⁹ Although accreditation alone will not prevent all negative events, it may be one tool for review and ongoing measurement. Entities like the Commission on Accreditation for Law Enforcement Agencies, Inc. (CALEA) set professional

standards for law enforcement through an accreditation program, though accreditation is voluntary, and fewer than 1,000 of the 18,000 law enforcement jurisdictions are currently accredited by CALEA.²⁰

Furthermore, application of sentinel event reviews, like those conducted in health care and aviation settings, following a negative event, such as a police shooting, provide a promising upstream approach to reform. A sentinel event review focuses not on assigning blame but bringing together key community stakeholders to conduct a root cause analysis of all factors that led to a negative outcome and reforms that can strengthen the system to prevent recurrence. Like sentinel event reviews in health care, the approach recognizes that failures are often system-wide and not the result of a single individual's actions. The goal, therefore, is to enable systems changes in practice and culture. Sentinel event reviews are an emerging effort, though the U.S. Department of Justice Sentinel Events Initiative has been encouraging and evaluating their adoption since 2014. One of the first jurisdictions to adopt a sentinel event review board (Review Board) was the Tucson Police Department, which convened in summer 2020 following two in-custody deaths of Latino men.²¹ The 15 members of the Review Board identified 32 contributing factors and agreed unanimously on 53 recommendations for the Tucson Police Department, the Tucson Fire Department, and the Tucson Public Safety Communications Department to prevent future in-custody deaths. An implementation report produced six months later found that, as a result, of the review, agencies had adopted new policies, procedures, and training to address prior failings.²²

MILITARIZED EQUIPMENT

The recent controversy over policing methods and excessive or unreasonable force has refocused attention on programs that transfer military equipment to law enforcement agencies across the country. Images during the summer protests of 2020 following the death of George Floyd in police custody that were widely broadcast by news shows and online repeatedly showed police outfitted with tactical gear, including full-body armor and in militarized vehicles, facing off with protestors. Concerns have been raised over whether law enforcement agencies have become too militarized, the use of such equipment, and the impact of the use of such equipment, particularly on communities of color.

Eligible federal, state, and local agencies, under certain circumstances, may obtain certain U.S. Department of Defense (DOD) personal property, including equipment, clothing, vehicles, aircraft, weapons, and ammunition for use in law enforcement, counterdrug, counterterrorism, border security, and/or humanitarian activities.²³ DOD's disposal of excess or surplus military equipment, through sale, transfer, donation, or reutilization, originally dates to the end of World War II. What is now known as the 1033 Program, however, was temporarily authorized by Congress through the National Defense Authorization Act (NDAA) in 1990.²⁴ It allowed law enforcement agencies to acquire excess military property for a bona fide law enforcement purpose. The original intent was to transfer military equipment in the "War on Drugs" to federal and state agencies to help assist in the fight against drug production and trafficking.²⁵ Congress officially created the 1033 Program through the Fiscal Year 1997 NDAA.²⁶ The 1033 Program allowed the transfer or donation of excess DOD property to state, local, and Tribal law enforcement agencies. Agencies that used the property for counterdrug or counterterrorism activities received preference.²⁷

The Law Enforcement Support Office (LESO) of the DOD's Defense Logistics Agency (DLA) is responsible for facilitating and managing the 1033 Program and, according to information on LESO's website, more than 8,000 law enforcement agencies to date have enrolled in the 1033 Program.²⁸ Once accepted into the 1033 Program, a law enforcement agency can review online the available excess DOD inventory that is suitable for law enforcement and make requests for property through the state coordinator. Every request for property must have a justification outlining how the property will be used, and requests must be for bona fide law enforcement purposes. Agencies do not pay for the property but must pay for shipping the items as well as potential storage costs.²⁹ A caveat of the 1033 Program included a requirement to deploy the equipment within one year of receipt which may incentivize police to use the equipment for other purposes. Agencies that do not use the equipment within the one-year timeframe are required to return the unused items.³⁰

There are two types of property that can be transferred to law enforcement under the program: controlled and uncontrolled. Controlled property consists of military items that are provided via a conditional transfer or "loan" basis; title for the property remains with DLA. Controlled property includes items such as small arms/personal weapons, demilitarized vehicles and aircraft, and night vision equipment. When a law enforcement agency no longer wants the controlled property, it must be returned to LESO. Non-controlled property, on the other hand, consists of common items DLA would sell to the general public, such as office equipment, first aid kits/supplies, hand tools, sleeping bags,

computers, and digital cameras. After one-year, general property becomes the property of the law enforcement agency. Most of the equipment transferred is non-controlled property.³¹ According to *Politifact.com*, small arms weapons such as rifles and side-arms normally make up about five percent of the total, while less than one percent of property issued is tactical vehicles.³² In order to request and receive controlled property, participating law enforcement agencies must receive the local governing authority's approval and must certify that, in addition to receiving such approval, they have adopted publicly available protocols for the appropriate use of controlled property, the supervision of such use, and the evaluation of the effectiveness of such use, including auditing and accountability policies.³³ Since the 1033 Program's beginning, more than \$7.5 billion worth of property (based on initial acquisition value) has been transferred to law enforcement agencies.³⁴

There are certain military items that are not available for transfer to law enforcement agencies through the 1033 Program. This prohibited equipment includes: any aircraft, vessels or vehicles that inherently contain weaponry, (e.g., tanks, Bradley fighting vehicles, armed drones); crew served/large caliber (.50 caliber or greater) weapons and ammunition; military uniforms; body armor; Kevlar helmets; and explosives or pyrotechnics of any kind. Also, aircraft and vehicles available in the program are "demilitarized," meaning that any specific military technology (e.g., communication equipment) are removed prior to transfer to law enforcement agencies.³⁵

There are several oversight tools that DLA uses for the program to maintain and ensure compliance with all program requirements and property accountability, including an annual certified inventory by each participating state, biennial federal level program compliance reviews, and annual state coordinator reviews of at least five percent of the law enforcement agencies that have acquired property. In addition, state coordinators and law enforcement agencies may be suspended or terminated from the 1033 Program for non-compliance.³⁶ In addition, the law was amended by Congress in 2015 to make it clear that each individual agency acquiring controlled equipment has responsibility for training its personnel in the proper use, maintenance, and repair. The law requires each law enforcement agency to certify on an annual basis that it provides annual training to relevant personnel on the maintenance, sustainment, and appropriate use of controlled property.³⁷ Additional oversight is provided through coordination between LESO and the DOJ to identify law enforcement agencies that are under DOJ investigation or under a consent decree and thus ineligible for the program.

After calls for transparency about the 1033 Program following the Black Lives Matter protests in 2014 in Ferguson, Missouri, in the aftermath of the police shooting of Michael Brown, the DOD released data about the tactical equipment it tracks through the program, and for the first time identified the agencies that received items.³⁸ Since 2016, there has been more transparency than there was during the first 20 years of the 1033 Program, when record keeping was very spotty. LESO has a public website page that links to a detailed spreadsheet, that lists all equipment issued to agencies, by state.³⁹

While the 1033 Program is perhaps the most publicly well-known program, there are additional DOD programs that allow law enforcement to purchase military-grade equipment. For example, under the 1122 Program, originally authorized in the NDAA for FY1994 (P.L. 103-160, codified at 10 U.S.C §281), the Secretary of Defense is allowed to establish procedures for state and local governments to purchase law enforcement equipment for counterdrug, homeland security, and emergency response activities. Section 885 of the FY2009 NDAA (P.L. 110-417) expanded the program to include homeland security and emergency response operations. The U.S. Army, notably, manages the 1122 Program. Moreover, another program authorizes the Secretary of Defense to sell surplus military equipment to state and local law enforcement, firefighting, homeland security, and emergency management agencies at fair market value. Authorized equipment includes pistols, revolvers, shotguns, rifles of a caliber not exceeding .30, ammunition for such firearms, gas masks, personal protective equipment, and other appropriate equipment. The equipment cannot be transferred or resold by the acquiring agency.⁴⁰

Similar to the 1122 Program, the Department of Homeland Security's (DHS) Urban Areas Strategy Initiative provides grant funds to allow police and sheriffs' departments to purchase crowd-control items such as cuffs, batons, helmets, gas masks, and other such equipment or allow them to use their own money to buy it at discounted federal prices.⁴¹ DHS also has another grant program, the State Homeland Security Program, that provides funding to state, local, and Tribal governments, for terrorism preparedness. Notably, there is less transparency about these other programs, and they do not have the same restrictions as the 1033 Program.

Following the Ferguson protests, numerous concerns were raised about the 1033 Program by members of Congress, the media, and research groups. Congressional hearings were held and in May 2015, following the recommendations

of a working group he appointed, then President Barack Obama signed an executive order that prohibited state and local law enforcement from receiving certain types of property, such as grenade launchers and weaponized aircraft, under the 1033 Program.⁴² Subsequently, former President Donald Trump rescinded the Obama-era restrictions.

More recently, in the wake of the police killing of George Floyd and the subsequent protests, a provision to place restrictions on the 1033 Program was included in the FY21 NDAA, which was passed over then President Trump's veto. Specifically, Section 1053 bars the transfer to law enforcement agencies of bayonets, lethal grenades, weaponized tracked combat vehicles, and aerial drones equipped with weapons. The provision also requires that personnel in law enforcement agencies that receive DOD equipment under the program undergo training in respect for citizens' constitutional rights and in conflict de-escalation. Finally, legislation was introduced in Congress in 2020 and again this year that includes provisions to demilitarize police departments, i.e., the "George Floyd Justice in Policing Act" (H.R. 1280, 117th Congress), which passed the House of Representatives on March 3, 2021. Section 365 of the bill would place limitations on the 1033 Program, including banning the transfer of controlled equipment (e.g., firearms, ammunition, bayonets, grenade launchers, grenades, explosives, most vehicles, drones, certain aircraft) and require more accountability and reporting from agencies receiving equipment and from DOD to Congress. This provision remains one of the stumbling blocks in negotiations on the bill in the Senate.

Discussion

Supporters of the 1033 Program, including many members of Congress and law enforcement agencies, argue that it provides an efficient way for local police agencies to obtain recycled equipment they otherwise could not afford, and was a good use of tax dollars. Law enforcement notes that there are high risk situations when use of such equipment is necessary and appropriate, such as during mass shooting events. They also point to the numbers, arguing that the 1033 Program does not contribute to militarization given that most of the transferred equipment is of general use, such as first aid kits, blankets, gym equipment, cold weather clothing, and large storage bins, while less than one percent of the equipment are tactical vehicles and only five percent are small arms.⁴³ Proponents also argue that the 1033 Program helps to increase safety in cities, particularly for law enforcement officers and the public.⁴⁴ In an evaluation of the 1033 Program published in 2018 that was conducted by the RAND Corporation and was required by the 2017 NDAA, the authors concluded that the DOD's LESO manages an efficient program that effectively reuses excess property, benefits the law enforcement community, responds diligently to oversight, and is faithful to congressional intent. The study authors acknowledged, however, that, "these efforts are unlikely to resolve perceptions that the program contributes to the militarization of police."⁴⁵

Opponents and critics, however, argue that the 1033 Program has led to an excessive militarization of local police agencies, adversely impacts police culture, erects barriers between police and local communities, and has led to an association with the use of lethal force on suspects.⁴⁶ For example, recent research has analyzed factors that increase an agency's likelihood of acquiring specific categories of equipment through the 1033 Program. One study found that agencies with "warrior" tendencies (measured through agencies' body armor policies and special units) and that use asset forfeiture were significantly more likely to acquire a mine-resistant ambush-protected (MRAP) vehicle.⁴⁷ Another study assessing the influence of violent crime rates, drug arrest rates, and proportion of minority population on agencies' participation in the 1033 Program, found that high violent crime rates and high proportion of Black population increased an agency's likelihood to obtain any equipment from the 1033 Program.⁴⁸ In a 2014 report by the American Civil Liberties Union that examined the use of SWAT teams, the authors stated that, "the use of hyperaggressive tools and tactics results in tragedy for civilians and police officers, escalates the risk of needless violence, destroys property, and undermines individual liberties."⁴⁹

In light of the different ways agencies acquire military equipment, it is difficult to assess the extent to which and whether local police agencies are militarized and how such equipment is actually used. As discussed above, there is no consensus in research studies on the actual impact of the 1033 Program on communities or on police. There is also no clear evidence that regulating or limiting the 1033 Program alone would resolve these issues given the other programs through which law enforcement agencies acquire military equipment, especially since there is less publicly available information on them. Without such evidence, it is difficult to reach conclusions on whether the AMA should support limiting or eliminating the 1033 Program or funding for additional DOD or DHS military equipment programs. And, without such evidence, it would be difficult for the AMA to impactfully advocate on such a position. Therefore, while acknowledging the concerns expressed by Resolution 410, and its sponsors and supporters, the Board determined that the AMA should defer to outside organizations that have the appropriate expertise and resources to fully examine and study these issues and encourage such endeavors.

COMMUNITY-BASED OVERSIGHT BOARDS

Community or civilian oversight boards (COBs) are entities comprised of members of the public who may review, investigate, or discipline law enforcement officer wrongdoings. They vary tremendously in terms of composition, scope, and authority, but generally follow three main models: investigation-focused models that operate separately from law enforcement; review-focused models that review the quality of completed internal affairs investigations; and auditor/monitor models that focus on large-scale systemic reform and, at times, participate in or monitor internal investigations. Currently, there are approximately 200 COBs among the 18,000 law enforcement jurisdictions in the United States, including in 24 of the 50 largest cities.^{50,51} Most COBs are created locally by cities, towns, and counties.⁵²

The movement toward modern civilian oversight, dates back, to the civil rights era when Black and Latino communities successfully advocated for civilian oversight in their communities. Since that time, many COBs have been created in direct response to high profile events and racially disparate policing. For example, the City of Chicago created its Police Accountability Task Force in response to the 2014 shooting of Laquan McDonald.⁵³ The findings from the Chicago task force investigation led to the creation of a civilian oversight body.⁵⁴ Often, COBs are created in a consent decree between the DOJ and a municipality. For instance, Albuquerque's COB was established via settlement agreement with the DOJ in 2014 following findings of patterns of excessive force by the DOJ.⁵⁵

Proponents of community oversight say that such boards improve public trust, ensure accessible complaint processes, ensure thorough investigations, increase transparency, and deter police misconduct. The push for community oversight also stems from skepticism of self-regulation by police. Proponents argue that internal investigations and disciplinary processes conducted by fellow law enforcement officers are inherently conflicted and biased, and lead to overly permissive supervision that fails to hold officers accountable for wrongdoing. Citizen-led investigatory and disciplinary processes, it is argued, are a necessary external check on police power.

However, despite their growing popularity, evidence of COBs promoting accountability, improving police-community relations, and curbing police misconduct is limited. There is some evidence that external civilian review of internal investigations is associated with a greater likelihood that misconduct complaints will be found to have merit, but, to date, COBs have been found to be largely ineffective due to political opposition, lack of authority to investigate, and lack of power to discipline.^{56,57}

Many COBs have limited authority by design. A survey conducted by the National Association for Civilian Oversight of Law Enforcement found that 63 percent of oversight boards have authority to conduct investigations that are independent of the police, but others are limited to audits or reviews of prior internal investigations. Only 40 percent had subpoena power, without which COBs cannot compel witnesses to testify or produce documents.⁵⁸ In some instances, because they are staffed by civilians, COBs are not granted access to confidential personnel records or internal investigations documents that might be relevant.⁵⁹ Further, COB findings are often advisory and non-binding. For those that can recommend disciplinary action, police chiefs or others may reject their recommendations. Only six percent have authority to discipline officers.⁶⁰ One study estimated that when COBs handle civilian misconduct complaints, only seven to nine percent of the complaints result in officer discipline.⁶¹ COBs are sometime limited in scope as well. Some can only investigate serious police violence, which puts systemic failings out of the COBs' reach. Some COBs can only investigate incidents rather than general policing policies, reinforcing the reactive, rather than proactive, approach to police misconduct.⁶²

Police unions can sometimes impede COBs. Some object to civilians, who they consider to be unknowledgeable in policing, having the power to judge police actions and argue there are other systems in place to investigate police misconduct, like internal affairs units.⁶³ Consequently, police or their unions sometimes place restrictions on what information can be released to the COBs or otherwise restrict COBs via collective bargaining agreements.

Discussion

Because of the limitations of existing COBs and limited research demonstrating their effectiveness, it is unclear if expanding civilian authority of police oversight would improve police-community relations and decrease officer misconduct. It may be that authorizing COBs to conduct independent investigations and issue binding disciplinary orders would deter police violence. The necessary attributes of an effective COB, however, remain unclear. Questions

about what form COBs ought to take, what powers it ought to be granted, and how to untangle agreements made between police unions and local governments extend beyond the scope of the AMA's expertise.

We also note that medicine has a long tradition of self-regulation that is supported by AMA policy. When a state medical board conducts an investigation or inquiry of a physician's quality of care, we believe that the standard of care must be determined, not only by a physician, but by a physician from the same specialty. Similarly, AMA policy supports peer review processes that are conducted by physicians within the same specialty. We also advocate for strict confidentiality of the proceedings of peer review processes and information reported to licensing boards. If COBs were proposed to oversee physicians' actions, physicians would undoubtedly object.

Again, policy supporting a more holistic approach to policing may be more impactful way for the AMA to advocate. Specifically, there is a movement underway towards more police coordination and engagement with communities on the front-end, which allows communities visibility and input into policing strategies, and elevates them to a meaningful partner in the production of public safety. Community policing has four important features: community-based crime prevention; reorientation of patrol activities to emphasize non-emergency servicing; accountability to the public; and decentralization of command.⁶⁴ A community-focused approach has been found to reduce citizen fear and increase citizen satisfaction, which are often linked to a citizen's perception of legitimacy of the police.⁶⁵ In a short-term study, brief interactions with the police were shown to improve attitudes towards the police and increase trust of the police.⁶⁶

"Community-oriented" policing is on the rise and quickly becoming the dominant philosophy for policing in America, with over 81 percent of agencies using some community policing approaches.⁶⁷ A 2018 report from the Policing Project at NYU School of Law, Police Foundation, and National Urban League, however, found that while most law enforcement agencies are taking steps to build community relations, more can be done. According to this 2018 report, community members desire more input into department policies and practices.⁶⁸ More community involvement on the front-end could address some of the upstream, systemic issues that lead to racially disparate policing.

In addition to community-oriented policing, improving, and expanding training on procedurally just policing has been lauded as a strategy for decreasing use-of-force and increasing citizen satisfaction with police. The "procedural justice" model of policing prioritizes transparency, explaining policing actions, and responding to community concerns.⁶⁹ In Seattle, for example, a procedural justice training program designed to "slow down" police officers' interaction with community members reduced use-of-force between 15 and 40 percent.⁷⁰ Similarly the National Academy of Sciences found that large-scale implementation of procedural justice training in Chicago led to both reduced complaints against the police by 10 percent and reduced the use of force against civilians by 6.4 percent over two years.⁷¹ Another study found that officers who attended training on procedural justice were more likely to endorse the importance of giving members of the public a voice, granting them dignity and respect, demonstrating neutrality, and trusting them to do the right thing.⁷²

We recognize, however, that procedurally just policing and community policing must be accompanied by greater police accountability. Accountability for individual police actions is essential if police are to effectively and equitably protect all citizens, and if police are to have legitimacy in the eyes of community members. As discussed above, there is currently insufficient evidence to support the widescale adoption of police accountability reform proposals that seek to decentralize disciplinary processes away from internal police mechanisms and instead empower independent actors (e.g. community boards and courts) with disciplinary authority. Research does, however, suggest that certain internal accountability mechanisms, such as written policies on use of force, greater supervision of officers by their supervisors, early intervention systems that identify officers with patterns of misconduct, and hiring practices that prevent officers who have been dismissed for misconduct from being unknowingly rehired by other departments, may be effective at changing individual police conduct.⁷³ While the AMA is not in a position to determine which reforms are preferable over others, we do recognize that greater accountability is necessary to end discriminatory practices and unnecessary or excessive use of police force.

AMA POLICY

AMA policy affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health. Policy further encourages data collections and the study of public health effects of violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities and mandatory reporting of legal intervention deaths and

law enforcement officer homicides to public health agencies (Policy H-515-955, “Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes”).

In November 2020, the AMA adopted new policy recognizing police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color and pledging to work with interested medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers. AMA policy also advocates against the utilization of racial and discriminatory profiling by law enforcement, for appropriate anti-bias training and individual monitoring, and for trauma-informed, community-based safety practices (Policy H-65.954, “Policing Reform”).

AMA policy supports 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, and federal funding to encourage increased community and law enforcement participation in crisis intervention training programs. AMA policy also supports evidence-based training programs for corrections officers on effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities (Policy H-345.972, “Mental Health Crisis Interventions”). AMA policy also encourages national standards for school resource officers to include training and certification in child psychology and development, restorative justice, conflict resolution, crime awareness, implicit/explicit biases, diversity inclusion, cultural humility, and individual and institutional safety and the development of policies that foster the best environment for learning through protecting the health and safety of those in school, including students, teachers, staff and visitors (Policy H-60.902, “School Resource Officer Qualifications and Training”).

Several AMA policies directly address law enforcement processes and procedures. AMA policy does not regard the choke and sleeper holds as casually applied and easily reversible tranquilizers, but as the use of deadly force with the potential to kill and advocates that with all incidents involving the application of choke and sleeper holds there should be timely medical surveillance of the inmate (Policy H-430.998, “Use of the Choke and Sleeper Hold in Prisons”). AMA policy recommends that law enforcement departments and agencies should have in place specific guidelines, rigorous training, and an accountability system for the use of conducted electrical devices (CEDs) and encourages evaluation, management, and post-exposure monitoring and independent research of field deployment of CEDs to better understand the risks and benefits under conditions of actual use (Policy H-145.977, “Use of Conducted Electrical Devices by Law Enforcement Agencies”). AMA policy supports expanded use of body-worn cameras for law enforcement (Policy D-160.919, “Increased Use of Body-Worn Cameras by Law Enforcement Officers”). AMA policy advocates for guidelines governing police pursuits and use of advanced technologies to reduce high-speed chases (Policy H-15.964, “Police Chases and Chase-Related Injuries H-15.964”). New AMA policy adopted in 2021 supports prohibiting the use of rubber bullets, chemical irritants, and kinetic impact projectiles to control protests and crowds that do not pose an immediate threat (Policy H-145.969, “Less-Lethal Weapons and Crowd Control”). AMA policy also recommends that law enforcement agencies have in place specific guidelines, rigorous training, and an accountability system for the use of kinetic impact projectiles and chemical irritants, as well as greater use of de-escalation techniques and the development of crowd-control techniques which pose a more limited risk of physical harm (Policy H-145.969, “Less-Lethal Weapons and Crowd Control”).

AMA policy opposes the use of the terms “excited delirium,” expresses concern about law enforcement officer use of force accompanying “excited delirium” that leads to disproportionately high mortality among communities of color, particularly among Black men, and denounces “excited delirium” solely as a justification for the use of force by law enforcement officers (Policy H-130.932, “Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting”). AMA policy opposes the use of sedative/hypnotic and dissociative agents as a pharmacological intervention for agitated individuals in the out-of-hospital setting, when done solely for a law enforcement purpose and recognizes that sedative/hypnotic and dissociative pharmacological interventions for agitated individuals have significant risks (Policy H-130.932, “Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting”). AMA policy also urges training for law enforcement and frontline emergency medical service personnel on de-escalation techniques and the appropriate use of pharmacological intervention for agitated individuals (Policy H-130.932, “Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting”). Finally, AMA policy urges medical and behavioral health specialists, not law enforcement, to serve as first responders and decision makers in medical and mental health emergencies in local communities and that administration of any pharmacological treatments in the out-of-hospital setting be done equitably, in an evidence-based, anti-racist, and stigma-free way (Policy H-130.932, “Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting”).

RECOMMENDATIONS

The Board recommends that the following be adopted in lieu of the Third, Fourth, and Eighth Resolve Clauses of Resolution 410-NOV-20, and that the remainder of the report be filed.

1. That our AMA advocate for efforts to implement evidence-based policing and the creation of evidence-based standards for law enforcement.
2. That our AMA advocate for sentinel event reviews in the criminal justice system following an adverse event, such as an in-custody death.
3. That our AMA encourage further research by subject matter experts on the issues related to the transfer of military equipment to law enforcement agencies, including the impact on communities, particularly those in minoritized and marginalized communities.
4. That our AMA support greater police accountability, procedurally just policing models, and greater community involvement in policing policies and practices.
5. That Policy H-65.954, "Policing Reform," be reaffirmed.
6. That Policy H-515.955, "Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes," be reaffirmed.
7. That Policy H-345.972, "Mental Health Crisis Interventions," be reaffirmed.
8. That Policy H-145.969, "Less-Lethal Weapons and Crowd Control," be reaffirmed.

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Appendix A: AMA Policies Recommended for Reaffirmation

H-65.954 Policing Reform

Our AMA: (1) recognizes police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color; (2) will work with interested national, state, and local medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers; (3) will advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures; and (4) will advocate for legislation and regulations which promote trauma-informed, community-based safety practices. (Res. 410, I-20; Reaffirmed: CSAPH Rep. 2, A-21)

H-515.955 Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes

Our AMA:

1. Encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement.
4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies.

5. Encourages appropriate stakeholders, including, but not limited to the law enforcement and public health communities, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers. (Res. 406, A-16; Modified: BOT Rep. 28, A-18)

H-345.972 Mental Health Crisis Interventions

Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports 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) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs; and (4) supports 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. (Res. 923, I-15; Appended: Res. 220, I-18; Reaffirmed: CSAPH Rep. 2, A-21)

H-145.969 Less-Lethal Weapons and Crowd Control

Our American Medical Association (1) supports prohibiting the use of rubber bullets, including rubber or plastic-coated metal bullets and those with composites of metal and plastic, by law enforcement for the purposes of crowd control and management in the United States; (2) supports prohibiting the use of chemical irritants and kinetic impact projectiles to control crowds that do not pose an immediate threat; (3) recommends that law enforcement agencies have in place specific guidelines, rigorous training, and an accountability system, including the collection and reporting of data on injuries, for the use of kinetic impact projectiles and chemical irritants; (4) encourages guidelines on the use of kinetic impact projectiles and chemical irritants to include considerations such as the proximity of non-violent individuals and bystanders; for kinetic impact projectiles, a safe shooting distance and avoidance of vital organs (head, neck, chest, and abdomen), and for all less-lethal weapons, the issuance of a warning followed by sufficient time for compliance with the order prior to discharge; (5) recommends that law enforcement personnel use appropriate de-escalation techniques to minimize the risk of violence in crowd control and provide transparency about less-lethal weapons in use and the criteria for their use; and (6) encourages relevant stakeholders including, but not limited to manufacturers and government agencies to develop and test crowd-control techniques which pose a more limited risk of physical harm. (BOT Rep. 10, A-21)

3. REDEFINING AMA’S POSITION ON ACA AND HEALTHCARE REFORM

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

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 went on to call 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 Healthcare 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 [“2021 and Beyond: AMA’s Plan to Cover the Uninsured.”](#) The current COVID-19 pandemic has led to many people losing their employer-based health insurance. This has only increased the need for significant improvements to the Affordable Care Act. 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 to 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 which is inversely related to income, as well as the current 3:1 age rating ratio.
- Our AMA also is advocating for an expansion of the eligibility for and increasing the size of cost-sharing reductions. Currently, individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which leads to lower deductibles, out-of-pocket maximums, copayments and other cost-sharing amounts. Extending eligibility for cost-sharing reductions beyond 250 percent FPL, and increasing the size of cost-sharing reductions, would lessen the cost-sharing burdens many individuals face, which impact their ability to access and afford the care they need.

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

Before the COVID-19 pandemic, in 2018, 6.7 million of the nonelderly uninsured were eligible for Medicaid or 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.
- Our AMA has been opposing efforts to establish Medicaid work requirements. The AMA believes that Medicaid work requirements would negatively affect access to care and lead to significant negative consequences for individuals' health and well-being.

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

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

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

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.

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

TEXAS VS. AZAR SUPREME COURT CASE

The Supreme Court agreed on March 2, 2020, to address the constitutionality of the ACA for the third time, granting the petitions for certiorari from Democratic Attorneys General and the House of Representatives. Oral arguments were presented on November 10, 2020, and a decision was expected before June 2021. The AMA filed an amicus brief in support of the Act and the petitioners in this case.

On February 10, 2021, the U.S. Department of Justice under the new Biden Administration submitted a letter to the Supreme Court arguing that the ACA's individual mandate remains valid, and, even if the court determines it is not, the rest of the law can remain intact.

This action reversed the Trump Administration's brief it filed with the Court asking the justices to overturn the ACA in its entirety. The Trump Administration had clarified that the Court could choose to leave some ACA provisions in place if they do not harm the plaintiffs, but as legal experts pointed out, the entire ACA would be struck down if the Court rules that the law is inseparable from the individual mandate—meaning that there would be no provisions left to selectively enforce.

On June 17, 2021, the Supreme Court in a 7-2 decision ruled that neither the states nor the individuals challenging the law have a legal standing to sue. The Court did not touch the larger issue in the case: whether the entirety of the ACA was rendered unconstitutional when Congress eliminated the penalty for failing to obtain health insurance.

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) 5 percent increase in the Medicaid FMAP 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 federal poverty line (FPL) for 2021 and 2022; and
- Give an option for states to provide 12-month postpartum coverage under State Medicaid and CHIP.

ARPA represents the largest coverage expansion since the Affordable Care Act. Under the ACA, eligible individuals and families with incomes between 100 and 400 percent of the federal poverty level (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, ARPA eliminated ACA's subsidy "cliff" for 2021 and 2022. As a result, individuals and families with incomes above 400 percent FPL (\$51,040 for an individual and \$104,800 for a family of four based on 2020 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 federal poverty level (133 percent and 150 percent FPL in Medicaid expansion states) now qualify for zero-premium silver plans, effective until the end of 2022. In addition, individuals receiving unemployment compensation who qualify for exchange coverage are eligible for a zero-premium silver plan in 2021.

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.

FY 2022 BUDGET RESOLUTION AND POSSIBLE EXTENSION OF ARPA PROVISIONS

The Senate and House of Representatives are working on a proposed FY 2022 Budget Resolution framework for up to \$3.5 trillion in new federal spending that may allow funding for an extension of the aforementioned ACA subsidies included within the ARPA well as provisions to close the Medicaid “coverage gap” in the States that have not chosen to expand.

The budget plan is expected to move through what is known as the budget reconciliation process. Congress must first approve budget instructions for legislation that affects spending, revenue, or debt. Under Congressional rules, the legislation can then advance on an expedited basis and pass in the Senate with a simple majority, circumventing the threat of filibuster.

ACA SPECIAL ENROLLMENT PERIOD

President Biden, during his first weeks in office, opened a new ACA special enrollment period, citing an increased need for coverage during the current economic and health crises. On March 23, 2021, the Biden administration announced its decision to lengthen the ACA special enrollment period from May 15 to August 15.

The U.S. Department of Health and Human Services (HHS) announced on July 14, 2021, that a total of 1.5 million Americans have enrolled in coverage through healthcare.gov throughout the special enrollment period, while another 600,000 signed up using the 15 state-based marketplaces. HHS subsequently launched the "Summer Sprint to Coverage" campaign as part of robust efforts to get more Americans to sign up for health coverage in the final 30 days of the special enrollment period on HealthCare.gov.

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.

INDEPENDENT PAYMENT ADVISORY BOARD REPEAL

The Bipartisan Budget Act of 2018 signed into law by President Trump on February 9, 2018, included provisions repealing 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 House of Delegates.

4. 2021 AMA ADVOCACY EFFORTS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

BACKGROUND

Policy G-640.005, “AMA Advocacy Analysis,” calls on the Board of Trustees (the Board) to provide a report to the House of Delegates (HOD) at each Interim Meeting highlighting the year’s advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The Board has prepared the following report to provide an update on American Medical Association (AMA) advocacy activities for the year. (Note: The report was prepared in August based on approval deadlines and may be updated if warranted.)

DISCUSSION OF 2021 ADVOCACY EFFORTS

While COVID-19 response efforts remain at the forefront of AMA advocacy in 2021, there has also been continuous activity on many other important issues for physicians and patients at the federal and state levels. On the COVID-19 front, our AMA is working with policymakers to address the public health aspects of the pandemic while at the same time seeking fixes for the practice issues that COVID-19 has created for physicians. The AMA is also working to quell other practice obstacles, such as payment concerns, harmful insurer practices, unwarranted scope of practice expansions, and hurdles to the appropriate use of technology in providing care. At the same time, the AMA is working on legislative and regulatory efforts to improve public health and reduce health care disparities including pursuing solutions to increased maternal mortality and drug overdose and death. Updates on these key issues follow.

COVID-19 Response

The COVID-19 pandemic has been an absolute tragedy for many Americans and their families with over 600,000 deaths and over 33 million cases reported nationwide. The global impact is astounding as well with over 4 million deaths. The physical and emotional toll will reverberate world-wide for many years to come, and it has had a significantly disproportionate impact on minoritized and marginalized communities. During this time of pandemic, the AMA has sought ways to reduce the impact of the virus and its variants. From following the science to social distancing to getting tested to wearing masks to getting vaccinated, the AMA has been out front in promoting best practices to the American public. At the same time, the AMA has been promoting policies that assist physicians in fighting the harsh financial realities their practices face due to stay-at-home recommendations, the temporary halts on elective procedures, and general patient hesitance to resuming regular care.

After the Biden administration assumed office, it established a national plan and issued executive orders to address the pandemic that included several AMA priorities: testing; health care worker safety; science as the basis for reopening schools; a COVID-19 Health Equity Task Force; urgent inventory of supplies; use of the Defense Production Act (DPA); enhanced COVID-19 data collection; strengthening public health infrastructure; requiring masks on domestic forms of transportation; and extending the pause on student loan payments. The Biden administration is also encouraging states to supply more vaccines to primary care physician offices to address immunization inequities and better reach patients who are hesitant to get vaccinated against COVID-19.

Our AMA also advocated to assist physician practices in mitigating the financial impact of the pandemic and made progress on several aspects of this concern, including:

- The Centers for Medicare & Medicaid Services (CMS) announced it will automatically hold physicians harmless from the up to 9% Merit-based Incentive Payment System (MIPS) penalties due to the significant disruptions of the COVID-19 public health emergency on physician practices' performance in 2020 and is accepting hardship exception applications from physicians who need an exemption from MIPS in 2021 due to the ongoing COVID-19 pandemic (for which the maximum performance adjustment will also be +/-9% in 2023).
- CMS also reopened the hardship exception application for group practices, virtual groups, and alternative payment model entities who missed the previous 2020 deadline.
- CMS announced that the 2020 MIPS Cost Performance Category will be reweighted to 0% of the final score even if eligible physicians or groups submitted 2020 data in other MIPS categories in light of the impact of the COVID-19 pandemic.
- Legislation has been introduced to ensure Provider Relief Fund grants do not count as taxable income.
- The American Rescue Plan Act (ARPA) included following provisions:
 - Added an additional \$8.5 billion dollars to the Provider Relief Fund;
 - Directs the utilization of the Defense Production Act to boost domestic production of personal protective equipment (PPE), vaccines, and onshore production of rapid COVID-19 tests;
 - Adds \$15 billion in new funding for Targeted Economic Injury Disaster Loan (EIDL); and
 - Grants funds to provide hard-hit, underserved small businesses with increased flexible monetary relief.
- The Biden administration nearly doubled Medicare payment for administration of the COVID-19 vaccine, including administration of vaccines requiring two doses, to \$40 per administration.

The AMA has also hosted eight webinars with federal officials on key COVID-19 developments which have been viewed by thousands of physicians. The AMA has also partnered with grassroots groups such as Made to Save that

focus on ensuring hard-hit populations have access to COVID-19 vaccines and accurate, timely information. For more information on the AMA's COVID-19 advocacy efforts, please see a full [report](#) on the AMA website.

Scope of Practice

As expected, 2021 was filled with numerous bills related to scope of practice, and the AMA worked to protect patients with 35 state medical associations and other Federation partners to help defeat scope legislation this year, including bills related to Advanced Practice Registered Nurses (APRN) (nurse practitioners, nurse anesthetists, nurse midwives, clinical nurse specialists), naturopaths, optometrists, pharmacists, physician assistants, psychologists, and podiatrists. Due to the tremendous efforts of organized medicine at all levels and physician leaders across the country there have been many wins, but some tough losses as well.

- **APRNs** – Key bills that would have significantly expanded APRN scope of practice were defeated in eight states this year, including Florida, Kansas, Kentucky, Louisiana, Maine, Mississippi, Tennessee, and Texas. Unfortunately, Delaware, Massachusetts, and Utah also enacted legislation to allow independent practice of APRNs.
- **Physician Assistants** – Physician Assistants introduced the American Academy of physician assistants (AAPA) Optimal Team Practice Act, their model independent practice legislation, in multiple states this year. Such bills were defeated in Colorado, Indiana, South Dakota, and Texas. Other states also had physician assistant legislation, but state medical associations were able to secure favorable amendments. Unfortunately, a concerning bill was enacted in Utah (S.B. 27), which replaces physician supervision of physician assistants with collaboration, requiring such collaboration with a physician only for the first 4,000 hours of practice. Oregon and Wyoming also enacted legislation replacing physician supervision of physician assistants with a weakened definition of collaboration. In addition to this legislative activity, AAPA adopted new policy at their Annual House of Delegates to change the title of physician assistants to “physician associate.” The AMA stands in strong opposition to this title change.
- **Optometrists** – Legislation that would have allowed optometrists to perform eye surgery was defeated in Alabama and Florida, while favorable amendments were secured in Texas. Unfortunately, however, legislation expanding optometrist scope of practice passed in Mississippi and Wyoming.

The AMA is working to stop a Department of Veterans Affairs (VA) initiative known as the Supremacy Project, which would develop national standards for practice for 48 health care occupations. As the name of the initiative implies, the VA is invoking the Supremacy Clause of the Constitution to preempt state laws potentially including practice laws for nonphysician health care professionals. The AMA is concerned this will have negative repercussions for both patient safety and quality of care available to our nation's veterans. The AMA also has concerns with the feasibility of developing a national standard of practice for all physicians.

Insurer Practices

The AMA continues to oppose harmful insurer practices through federal, state, and private sector efforts. Prior authorization requirements remain frustrating for physicians and detrimental to patients. The AMA conducted and released its annual [physician survey](#) to quantify the impact of prior authorization on patients and physician practices. According to the results, 94% of physicians surveyed indicated that prior authorization results in care delays; 79% reported that prior authorization can lead to care abandonment; and 30% stated that prior authorization has resulted in an adverse outcome for a patient. In addition, the survey data captured the [lack of progress](#) made on prior authorization reforms agreed to by insurers over three years ago.

At the federal level, the AMA successfully advocated for the reintroduction of the Improving Seniors' Timely Access to Care Act, which would require Medicare Advantage plans to abide by many of the key prior authorization reforms outlined in the 2018 Consensus Statement. The AMA has also been closely monitoring federal rulemaking on prior authorization and submitted extensive [comments](#) on a proposed rule issued late last year that would require Medicaid, CHIP, and federally facilitated health plans to automate medical services prior authorization using technology embedded in physicians' EHRs. At the state level, it has been a busy year for prior authorization legislation as well, with new legislation enacted in Georgia, Texas, and Illinois, and many other state legislative efforts underway. Many state prior authorization bills are based on the AMA's [model legislation](#) on this issue. The AMA continues to build its grassroots advocacy campaign with its dedicated [FixPriorAuth](#) website and associated social media presence. One of

the newer features to the website is an employer-oriented track, which seeks to educate and engage this new and important audience.

The AMA is also heavily engaged on the surprise billing issue at the federal and state levels as well. The [Consolidated Appropriations Act](#) signed into law on Dec. 27, 2020, included “No Surprises Act” provisions that allow for price transparency, more accurate provider directories, and patient financial protections against surprise medical bills or unexpected gaps in health insurance coverage. The final provisions reflect significant advocacy by the AMA and Federation groups, including an independent dispute resolution provision. In 2021, the Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury (Tri-Agencies), along with the Office of Personnel Management (OPM) released an interim final rule with comment period (IFR) entitled the [Requirements Related to Surprise Billing; Part I](#) implementing many of the provisions of the NSA. The IFR clarifies the Qualified Payment Amount (QPA) by specifying cost sharing calculations for emergency services provided by out-of-network emergency facilities and out-of-network providers, and certain non-emergency services furnished by out-of-network providers at certain in-network facilities. In addition, the IFR clarifies certain notice and consent requirements for health care providers and facilities. The AMA is closely reviewing the IFR after submitting [comments](#) to the Tri-Agencies on the implementation and calculation of the QPA and the QPA audit process, among other provisions, as well as [comments](#) on the Independent Dispute Resolution Process and prepared a [detailed summary](#) to help physicians with this topic.

Meanwhile, states continue to evaluate the impact of the new federal law on state regulation of surprise medical bills and determine their options. It seems that most comprehensive state laws will continue to apply to fully insured plans, and those states can establish opt-ins for self-insured ERISA plans. (Georgia enacted such an opt-in earlier this year.) Several states that have not taken action or have laws that do not meet the NSA requirements are considering if legislating during the NSA implementation is a worthwhile effort or if a wait-and-see approach allows for less confusion for patients, physicians, and plans. Most medical societies are advocating for the latter.

The AMA also released the [National Managed Care Legal Database](#) in 2021, which pulls in over 1,000 patient and physician protections passed at the state and federal levels and seeks to empower physicians, patients and their advocates in their dealings with health insurers and to inform policymakers, legislators and regulators about key issues—e.g., surprise billing—involving health insurers, physicians and patients. The AMA is holding Federation-wide webinars to alert state medical and national specialty societies about the Database.

In response to strong advocacy by the AMA, state medical associations, and national medical specialty medical societies, UnitedHealthcare (UHC) made positive changes to several problematic programs/policies:

- Optum Pay™ modified its electronic payment program to offer downloadable remittance information, up to 13 months of payment data for UHC claims, and unlimited users for each account at no cost through its basic service option. Previously, Optum Pay had required enrollment in its premium program, which assessed a 0.5% per payment fee, to continue access to these critical revenue cycle functionalities.
- UHC announced an implementation delay for its emergency department coverage policy, under which it could retroactively deny claims deemed nonemergent, through at least the end of the COVID-19 national public health emergency. The AMA will continue to advocate for complete rescission of this dangerous policy that could discourage patients from appropriately seeking emergency care.
- UHC modified its Designated Diagnostic Provider (DDP) program for outpatient laboratory services from a strict coverage/no-coverage model to a tier-based system, under which UHC patients pay lower cost shares for labs performed by DDPs. In response to AMA and Federation concerns, UHC also is launching extensive educational outreach to both physicians and patients about the DDP program.

Finally, the AMA joined the All Copays Count Coalition and signed onto model legislation to prohibit insurers’ copay accumulator programs. More than a dozen bills based on Coalition’s model have been introduced in the states, with Alaska, Kentucky, and Oklahoma, enacting new laws.

Medicare/MIPS

In addition to the COVID-19 payment relief cited earlier in this report, Congress also enacted legislation that provided relief from the 2% Medicare sequester payment cut through 2021. The AMA led a grassroots effort in support of this legislation that garnered over 5,400 emails to Congress and over 50,000 engagements. Congress also enacted a one

year [3.75% increase in Medicare payments](#) to offset the impact of a budget neutrality adjustment required by law to offset the costs in fee schedule policy changes largely related to evaluation and management (E/M) services.

CMS released the proposed rule for the 2022 Medicare physician fee schedule in July 2021. AMA staff continue to analyze the rule and have developed a [summary](#) of the 1,700+ page proposal, it is important to highlight that the 2022 Medicare conversion factor would be reduced by approximately 3.75% from \$34.8931 to \$33.5848. This is largely a result of the expiration of a 3.75% increase to the conversion factor at the end of calendar year 2021, as averted for 2021 by Congressional action. The AMA will strongly advocate that Congress avert this significant cut and extend the 3.75% increase for 2022. The AMA developed a [chart](#) (pages 10-11) to show the proposed rule's specialty impact with and without the 3.75% cut to use in AMA advocacy efforts.

On another front, the AMA and the Physicians Foundation funded novel research about [how much time and money it costs to participate in MIPS](#) and [physicians' perspectives about whether MIPS improves patient care](#). On average, practices spent \$12,800 per physician per year on MIPS and 200 hours per physician per year on MIPS during the 2019 MIPS performance period. Regarding perceptions of MIPS, physician practices are conflicted about whether it improves care but overwhelmingly agree that MIPS is overly burdensome, and that the costs of successful participation generally outweigh any payment incentives received. The findings are based on interviews with small, medium, and large physician practices in primary care, general surgery, and multispecialty groups across the U.S. The AMA will use these concerning findings to bolster advocacy to reduce burden and improve the clinical relevance of MIPS for physicians in every specialty, practice size, and location.

Telemedicine

During the pandemic, telehealth services emerged as a critical tool to provide care to patients while supporting physical distancing efforts and reducing the spread of COVID-19 and other infectious diseases by avoiding unnecessary in-person patient encounters. In response, Congress acted to temporarily expand access to Medicare covered telehealth services to all Medicare beneficiaries by authorizing HHS to waive outdated statutory restrictions on where telehealth services may be provided. Stories poured in from all over the country from physicians and patients alike about the positive effects of expanded telehealth benefits. It has continued to allow physicians to provide high-quality care using new digital tools.

The AMA is now strongly advocating for enactment of legislation introduced in both the House and Senate that, if passed, would make the expanded access to telehealth services permanent. The Telehealth Modernization Act of 2021 (H.R. 1332/S. 368) would lift the rural-only restriction and add any site where a patient is located as a potential originating site and ensure all Medicare patients may receive covered Medicare telehealth benefits, including at home and via mobile technologies as appropriate. The CONNECT for Health Act (H.R. 2903/S. 1512) would provide HHS with permanent authority to waive these restrictions, similar to the authority the agency has for the duration of the COVID-19 public health emergency (PHE). The success of telehealth technology adoption during the COVID-19 PHE has made it abundantly clear that Medicare covered telehealth benefits should be available to all Medicare patients regardless of where they live or how they access telehealth services.

The AMA has also been advocating that CMS maintain Medicare coverage and payment for the many services that were temporarily added to the Medicare telehealth list during the PHE for two years after the PHE ends. The COVID-19 PHE was most recently renewed in July 2021 and is expected to continue through the end of 2021. In the Medicare physician payment schedule proposed rule, CMS has proposed to continue paying for services placed temporarily on the telehealth list through the end of 2023, consistent with the AMA's recommendation to provide a glide path to evaluate whether the services should be permanently added to the telehealth list following the COVID-19 PHE.

Telehealth continues to be a priority for state medical associations and legislators across the country as states seek opportunities to make permanent policies expanding coverage, payment, and access to care provided via telehealth. While there has been overwhelming support of telehealth generally, issues around payment, establishment of patient physician relationships via telehealth, acceptable modalities, prescribing via telehealth, and licensure continue to be topics of debate. The AMA worked closely with 18 states reviewing legislative or regulatory language, providing data and additional resources to help states enact strong telehealth laws aligned with AMA policy.

The AMA is also engaged with multiple national organizations developing model state telehealth legislation. We have provided written comments to the National Conference of Insurance Legislators (NCOIL) Health Insurance and Long-

Term Care Issues Committee, regarding its draft Telemedicine Authorization and Reimbursement Model Act. In addition, the AMA serves as an official observer to the Uniform Laws Commission drafting committee on telehealth.

Finally, with the increased mobility of physicians and patients and increased utilization of telehealth, the ability of physicians to provide care to patients across state lines has become increasingly important as has the ability of physicians to expeditiously gain licensure in multiple states. The Interstate Medical Licensure Compact (IMLC) continues to gain steam with three more states (Delaware, Ohio, and Texas) enacting legislation to join the IMLC, bringing the total number of IMLC members to 35 (33 states plus DC and Guam). Four states still have legislation pending.

Maternal Mortality

The AMA is committed to tackling the issues surrounding maternal mortality and morbidity. The U.S. has the highest maternal mortality rate among developed countries. A 2019 report by the Centers for Disease Control and Prevention (CDC) found that Black women are 3-4 times more likely to die from pregnancy-related causes than White women. The AMA understands that there are a multitude of considerations necessary to address this epidemic, including lack of insurance or inadequate coverage prior to, during, and after pregnancy; closures of maternity units in many rural and urban communities; and a lack of inter-professional teams trained in best practices. There are concrete actions that should be taken to reduce and prevent rising rates of maternal mortality and serious or near-fatal maternal morbidity in the U.S. The AMA urges policymakers to:

- Expand Medicaid and CHIP coverage to 12-months postpartum;
- Increase support for Maternal Mortality Review Committees;
- Implement equitable standardized data collection methods;
- Expand access to medical and mental health care and social services for post-partum women;
- Continue to develop a health care workforce that is diverse in background and experience;
- Address shortcomings in our institutions; and
- Adopt standards to ensure respectful, safe, and quality care before, during, and after delivery.

So far in 2021, HHS approved a [postpartum Medicaid expansion](#) for Georgia, Illinois, and Missouri. Fifteen state legislatures have also enacted legislation to seek federal approval for coverage expansions for postpartum women. The AMA has also successfully sought introduction of the “[Mothers and Offspring Mortality and Morbidity Awareness Act](#),” also known as the MOMMA Act which would extend coverage for postpartum care from the existing 60 days to 12 months under Medicaid and CHIP and would also support training clinicians on implicit bias and health equity issues. The AMA also supports the Connected Maternal Online Monitoring Act which would require CMS to identify barriers to coverage of remote physiologic devices under state Medicaid programs to improve maternal and child health outcomes for pregnant and postpartum women.

Drug Overdose and Death

The AMA remains engaged in fighting the drug overdose and death epidemic. Recent statistics have shown that the epidemic has worsened during the COVID-19 pandemic, but significant progress has been made on the advocacy front on these issues in 2021:

- The Biden administration [adopted policies](#) to address overdose and substance use disorder in ways that will reduce stigma, [more effectively prevent overdose deaths](#), and remove barriers to treatment—and in ways that are consistent with AMA policy recommendations.
- The Biden administration is waiving burdensome administrative requirements so that all physicians will be able to [prescribe buprenorphine](#) for their patients with opioid use disorder.
- Using national principles and working with coalition partners, the AMA supported five state laws directing opioid litigation funds to be earmarked for public health uses.
- As part of a national coalition, the AMA helped support six new state mental health and substance use disorder parity laws that will help enhance oversight and enforcement to protect patients. Our AMA also helped secure a [new rule](#) in Colorado that will be the nation’s first to meaningfully measure substance use disorder network adequacy and provide regulators with actionable information to help hold insurers accountable for inadequate networks.

- Developed a new issue brief focused on [actions employers can take](#) to help improve access to evidence-based care for opioid use disorder and pain, as well as to support harm reduction efforts; worked with the Milken Institute and the DEA to present highlights of the issue brief at multiple regional DEA-sponsored events.
- Held a national webinar with Manatt Health featuring medical, legal and public health experts identifying ways to remove barriers to evidence-based treatment for opioid use disorder in justice-involved settings; a second webinar with Manatt Health focused on evidence-based initiatives to support harm reduction efforts, including the first overdose prevention site in the nation.
- Highlighting [physician advocacy efforts](#) to help their patients with a substance use disorder or chronic pain and detailed the effects of COVID-19 on physicians and patients with respect to barriers to care for patients with as well as physicians' uptake of new federal telemedicine and other flexibilities.
- AMA Immediate Past President Susan R. Bailey, MD, provided a keynote address on the AMA's advocacy efforts to end the overdose epidemic at the [National Rx Drug Abuse and Heroin Summit](#) and to the American Bar Association.

The AMA also urged advisers to the Centers for Disease Control and Prevention Injury Center to recommend an overhaul of the agency's problematic guideline on opioid prescriptions. Mirroring recommendations of the Opioid Workgroup, the AMA urged the removal of arbitrary thresholds to restore balance and support comprehensive, compassionate care, noting that the opioid epidemic has become more lethal due to illicit rather than prescribed drugs. States and insurers have turned the existing guidelines into laws and unbending regulations that prevent physicians from treating patients as individuals with specific needs, including patients with cancer and sickle cell disease, as well as those in hospice care.

Competition in Health Care

The AMA is continuing to monitor key health care mergers and acquisitions for their effects on physicians and patients. On July 9, President Biden signed a new [executive order](#) aimed at limiting anticompetitive actions and promoting competition in several sectors, including health care. The "Promoting Competition in the American Economy" executive order includes directives to several federal departments and agencies, including HHS, Food and Drug Administration (FDA), and Federal Trade Commission (FTC), that could potentially impact issues such as prescription drug pricing and access, hospitals, and insurer mergers, use of non-compete clauses in employment contracts, and occupational licensing. Broadly, the order notes its opposition to consolidation in any industry and specifically notes concerns about monopoly and monopsony powers in health care markets. Specifically, the order directs the FTC to curtail the use of non-compete agreements and other clauses that may limit employee mobility and to address the use of "unfair occupational licensing restrictions." The order also includes several directives to HHS, FDA, and CMS to promote competition in the prescription drug space aimed at decreasing prescription drug costs and increasing access to generics and biosimilars. The AMA will review forthcoming agency activity on these issues and provide AMA recommendations as appropriate. Further, the AMA initiated engagement with U.S. Department of Justice, asking for a more thorough investigation, of the proposed merger of United/Optum and Change Healthcare and its potential effects on the U.S. health system.

The AMA also continues to help state medical associations with respect to legislation that improves competition in health care. For example, the AMA worked closely with the Nevada State Medical Association on a piece of legislation that was enacted that, in part, limits the ability of large health care systems to use their market power to injure competition, raise consumer prices, and reduce health care quality.

Access

Access to health care remains a priority for the AMA in its advocacy work. Positive developments in 2021 include the Biden administration starting the process of [lifting the Title X "gag clause"](#) rule. It is also repealing approvals of state Medicaid work requirements. The [American Rescue Plan Act \(ARPA\)](#) contained provisions to extend postpartum coverage under Medicaid and CHIP, increase premium subsidies for ACA marketplace plans, and invest in trust and treaty obligations to provide essential safety-net programs that serve Native American communities. The American Families Plan announced by the President on April 28 would make ARPA's Affordable Care Act (ACA) subsidy enhancements permanent. Finally, a special enrollment period for the ACA was opened in 2021 to expand access to coverage. Based on this, 2 million Americans have signed up for coverage.

Anti-racism Efforts

As the AMA continues to focus on anti-racist and social justice policies, it was pleased that the CDC recognized racism as a “[serious public health threat](#).” The AMA also supported the Asian American and Pacific Islander federal [hate crime legislation](#), which was signed into law on May 20 after widespread reports of violence against this community. The AMA also successfully opposed state legislation that would have barred state-funded entities from conducting trainings on diversity and inclusion. Moving forward, AMA advocacy efforts will incorporate elements of the [AMA’s strategic plan to embed racial justice and advance health equity](#) as it promotes AMA health equity policy at the federal and state levels.

LGBTQ+ Health

The AMA was very active in supporting LGBTQ+ health in 2021. Efforts include endorsing H.R. 5, the [Equality Act](#), passed by the House, which prohibits discrimination based on sex, sexual orientation, and gender identity in areas including public accommodations and facilities, education, federal funding, employment, housing, credit, and the jury system. The Biden administration withdrew a Trump Administration proposal restricting transgender people in homeless shelters. It also announced it would [provide protections](#) against discrimination in health care based on gender identity and sexual orientation, reversing a rule issued by the previous administration that allowed discrimination against transgender individuals. The AMA strongly opposed the previous policy and had urged the Biden Administration to reverse it. The AMA was also pleased that the new administration withdrew the previous administration’s proposed rule that would have weakened the Equal Access Rule which ensures that all individuals—regardless of sexual orientation or gender identity—have equal access to the Office of Community Planning and Development programs, shelters, other buildings and facilities, benefits, services, and accommodations. The AMA also contributed to the defeat of harmful anti-transgender legislation in over a dozen states that would have criminalized the provision of medically necessary gender-affirming care to minor patients. The AMA also sent a letter to the National Governors Association urging the nation’s governors to reject legislation that would discriminate against transgender individuals.

Gun Violence

Gun violence is a public health crisis, and the AMA remains committed to finding solutions that help reduce the impact it has nationwide. Some positive steps occurred in 2021. The Biden administration issued rules to [require](#) background checks for “ghost guns.” The House of Representatives passed two bills supported by the AMA that would close the so-called “Charleston Loophole” by extending the time period the FBI has to determine whether a buyer is qualified to purchase a gun and to expand the existing background check system to cover all firearm sales, while providing exceptions for law enforcement and family and friend transfers. The AMA also helped to successfully secure FY 2021 federal appropriations of \$25 million for the National Institutes of Health and \$25 million for the Centers for Disease Control and Prevention for research on gun violence.

Immigration

In 2021, the AMA promoted its policy on immigration issues. There were several beneficial developments under the new administration. First, it delayed implementation of a problematic Department of Homeland Security (DHS) final rule regarding cap-subject H-1B visa petitioners. The Biden administration also continued the policy to defer the removal of certain undocumented immigrants who were brought to the United States as children, have obeyed the law, and stayed in school or enlisted in the military (DACA). Also consistent with AMA advocacy, the Biden administration lifted the immigration ban on Muslim countries and rescinded rules that would deem immigrants inadmissible on public charge grounds. The AMA is currently advocating for a broad range of immigration and border security policy changes, including those that would ease visa restrictions for foreign-born physicians seeking to train or practice in the U.S.

Restrictive Covenants

Pursuant to AMA House of Delegates action at the AMA’s 2020 Special Meeting, the AMA developed a 60+ page, comprehensive legislative template on restrictive covenants to help the Federation develop legislative proposals that would address concerns that restrictive covenants raise while, at the same time, be cognizant of the interests of physicians who own their own practices and may view the use of reasonable restrictive covenants as a means of protecting their practices’ financial viability and their relationships with their patients, and making it easier to bring

new physicians into the practice. The AMA also continues to assist individual state medical associations with analyzing and drafting restrictive covenant legislative language.

State Medical Liability Efforts

2021 was a very busy year for state medical liability legislative proposals. These proposals gave qualified immunity from medical liability for physicians, health care professionals, and health care facilities for care that they provided during, or as a result of, the COVID-19 pandemic. Thus far, over half of the states have enacted some form of medical liability immunity legislation. The AMA provided comprehensive resources to state medical associations working on this issue to help them advocate for enactment of liability immunity laws. The AMA also proactively contacted all state medical associations working on this issue to provide support. The AMA helped state medical associations analyze and draft medical liability immunity legislation that became law. Aside from medical liability immunity advocacy, the AMA helped persuade the Illinois Governor to veto legislation that would have imposed prejudgment interest in medical liability cases starting on the day the alleged liability occurred and supported the New Mexico Medical Society in reaching a successful result concerning amendments to its MLR law. The AMA also published the 2021 edition of [MLR NOW!](#).

CONCLUSION

Our AMA has made significant progress on a challenging group of advocacy issues so far in 2021 and will continue to advocate powerfully for physicians and patients in the second half of the year. The situation is somewhat fluid with the Delta variant becoming the dominant COVID-19 strain in the U.S. and hitting unvaccinated pockets of the country very hard. However, the AMA will continue to stress “following the science” in its COVID-19 response. And the AMA will seek to make further progress on the other issues confronting physicians and patients.

5. TERMS AND LANGUAGE IN POLICIES ADOPTED TO PROTECT POPULATIONS FROM DISCRIMINATION AND HARASSMENT

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

HOUSE ACTION: RECOMMENDATIONS ADOPTED REMAINDER OF REPORT FILED

See Policy H-65.950

Policy G-600.067, “References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment,” instructs the American Medical Association (AMA) to:

- (1) undertake a study to identify all discrimination and harassment references in AMA policies and the code of ethics, noting when the language is consistent and when it is not;
- (2) research language and terms used by other national organizations and the federal government in their policies on discrimination and harassment; and
- (3) present the preliminary study results to the Minority Affairs Section, the Women’s Physician Section, and the Advisory Committee on LGBTQ Issues to reach consensus on optimal language to protect vulnerable populations including racial and ethnic minorities, sexual and gender minorities, and women, from discrimination and harassment; and
- (4) produce a report within 18 months with study results and recommendations.

BACKGROUND

Original Resolution 9-A-19 observes that while the “concept of protection against discrimination or harassment is not controversial . . . generally accepted, standard language for protected classes or groups does not exist among national organizations.”

Federal law establishes a variety of characteristics as defining “protected classes”: race; color; religion or creed; national origin or ancestry; sex, including gender, pregnancy, sexual orientation, and gender identity; age; physical or mental disability; veteran status; genetic information; citizenship; and military status. Relevant laws are as follows:

Title VII of the Civil Rights Act of 1964 (42 U.S.C. § 2000e) prohibits discrimination based on race, color, sex—including amendments by the Pregnancy Discrimination Act and Civil Rights Act of 1991, national origin, and religion. Title I and Title V of the Americans with Disabilities Act (42 U.S.C. §§ 12101-12113) prohibits discrimination based on disability—including amendments by the Civil Rights Act of 1991 and the Americans with Disabilities Act Amendments Act. The Rehabilitation Act (29 U.S.C. §§ 791, 793, 794, and 794a) prohibits discrimination based on disability in federal employment by employers with federal contracts or subcontracts that exceed \$10,000 and by employers that receive federal funds. The Age Discrimination in Employment Act (29 U.S.C. §§ 621-634) prohibits discrimination based on ages 40 and over. The Genetic Information Nondiscrimination Act (42 U.S.C. § 2000ff) prohibits discrimination based on genetic information. The Uniformed Services Employment and Reemployment Rights Act (38 U.S.C. § 4311) prohibits discrimination based on past, current, or prospective military service. Section 1981 of the Civil Rights Act of 1866 (42 U.S.C. § 1981) prohibits discrimination based on race, color, and ethnicity in contracts, including most employment arrangements. The Equal Pay Act (29 U.S.C. § 209(d)) prohibits sex-based wage discrimination against men or women performing substantially equal work in the same establishment. The Immigration Reform and Control Act (Pub. L. 99-603, 100 Stat. 3359 (1986)) prohibits citizenship discrimination, national origin discrimination by certain employers, and over-documentation in the employment eligibility verification process [[PracticalLaw](#)].

States may extend protections more broadly – for example, California protects individuals against discrimination on the basis of “marital status”; includes “childbirth, breastfeeding, and/or related medical conditions” within the protected category of “sex”; and explicitly prohibits discrimination on the basis of request for family care leave or for an employee’s own serious medical condition [[CA State Senate](#)].

CURRENT AMA POLICY

A search of AMA’s policy compendium (PolicyFinder) using the terms “discrimination” and “harassment” returned 73 results, covering AMA Bylaws and governance policy, the AMA *Code of Medical Ethics*, and directives and policies of the AMA House of Delegates. After eliminating duplicate entries and excluding policies that did not address discrimination on the basis of personal or practice characteristics the remaining 54 policies were reviewed for the characteristics they delineate (Appendix I).

Of these, 10 adopt at least four of the “protected classes” recognized in law. However, no two policies adopt precisely the same set of characteristics or express them in precisely the same language. Thus Bylaw 1.4 prohibits denying membership in AMA on the basis of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, “or for any other reason unrelated to character, competence, ethics, professional status or professional activities.” Opinion 9.5.4, “Civil Rights & Medical Professionals,” in the *Code of Medical Ethics* enumerates a fundamentally similar, but nonetheless not identical set: race, color, religion, creed, ethnic affiliation, national origin, gender or gender identity, sexual orientation, age, family status, and disability, but uses the same language to qualify its guidance: “or for any other reason unrelated to character, competence, ethics, professional status, or professional activities.”

H-140.837, “Policy on Conduct at AMA Meetings and Events,” delineates yet a further, albeit related, set of characteristics: race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship “or otherwise.” While H-65.965, “Support for Human Rights and Freedom,” prohibits discrimination on the basis of “sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin or age” or “any other such reprehensible policies.” H-310.919 opposes questioning residency or fellowship applicants about “marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion” as discriminatory, yet H-65.978, “Nondiscrimination Toward Residency Applicants,” calls on the Accreditation Council for Graduate Medical Education to amend institutional requirements to prohibit discrimination based on the more limited set of age, sex, race, creed, national origin, gender identity and sexual orientation.

As Appendix I details, the remaining policies address discrimination in reference to fewer of the characteristics that define protected classes or to other characteristics entirely:

| Characteristic | No. of Policies |
|---|-----------------|
| Sex/gender (including gender identity) | 8 |
| National origin (more specifically, IMG status) | 6 |
| Genetic information | 4 |
| Disability | 2 |
| Race/ethnicity | 1 |
| Religion | 1 |
| Age | 1 |
| Other | 14 |

The “other” characteristics set out in various policies included status as an international medical graduate; enrollment in a physician health program, osteopathic or allopathic training; and status as a living organ donor. Table 1 presents the specific choices made across AMA policies on discrimination.

POLICY OF OTHER ORGANIZATIONS

For purposes of comparison, publicly available policies or position statements relating to discrimination were retrieved for 27 organizations: four federal agencies, 13 major specialty societies in the AMA House of Delegates, and 10 academic institutions (Appendix II).

Not surprisingly, public statements of nondiscrimination by the Office for Civil Rights of the Department of Education, the Equal Employment Opportunity Commission (EEOC) of the Department of Labor, the Department of Health and Human Services, and the Office of Fair Housing and Equal Opportunity of the Department of Housing and Urban Development employ the protected classes as defined in federal law.

The federal protected classes form the foundation in policy and position statements reviewed from professional medical organizations. These policies nonetheless differ significantly in how finely they parse the universe of possible personal characteristics or social categories to identify those they deem most pertinent to nondiscrimination policy. Policy of the American Academy of Family Physicians, for example, recognizes not only “socioeconomic status” as a protected feature, but also “body habitus,” while the American Heart Association condemns discrimination on the basis of zip code and primary language, as well as on traditional grounds for protection. The American Academy of Pediatrics (AAP) extends its policy to prohibit discrimination based on the patient’s disability or “the disability of the patient’s parent(s) or guardian(s).” Among the 18 characteristics set out in the statement on nondiscrimination of the American College of Emergency Physicians are socioeconomic status, immigration status, and language preference. Characteristics set out in policy of the American Academy of Hospice and Palliative Medicine include education, political opinion and professional experience.

Using various language, several policies extend protection to “any other characteristic prohibited by applicable federal, state, or local law” (American Urological Association). The National Association of Medical Examiners, in contrast, condemns discrimination based on delineated characteristics and “any other human condition or choice.”

Like the medical professional society policies reviewed, sample policies of academic institutions that prohibit discrimination—among students, faculty, staff, and, where relevant, patients—are grounded in the protected classes of federal law, but also delineate a wider or more nuanced range of protected characteristics. For example, “order of protection status” and “unfavorable military discharge” (University of Illinois at Chicago); “genetic information or family medical history” (University of Alabama); “associational preferences” (University of Iowa Hospitals & Clinics); “serious medical condition” (University of New Mexico); “family status and responsibilities,” “political affiliation,” “matriculation,” and “unemployed status” (Howard University). Vanderbilt University adopts “sexual orientation” as a protected characteristic but goes on to define it more specifically as “a person’s self-identification as heterosexual, homosexual, bisexual, asexual, pansexual, or uncertain.” In keeping with many others, policies sampled from academic institutions are often open ended in that they specifically defer to “other protected classes” (or “any other legally protected basis” (University of Alabama).

| Table 1. AMA policies | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--------------|-------|-----------|-----------|-----------|-----------|-----------|----------|-----------|-----|-----------|-----------|-----------|-----------|----------|----------|-----------|-----------|-----------|------|-------|-----------|--------|-----------|-----------|----------|----------|----------|----------|----------|-----------|-----------|---|--|--|
| | AMA Policies | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| categories/characteristics cited | B-1.4 | 9-5.4 | H-140.837 | H-225.985 | H-225.985 | D-145.981 | H-310.919 | H-65.985 | H-225.989 | 8-5 | H-140.950 | H-310.976 | H-525.998 | H-525.998 | H-65.981 | H-60.919 | H-225.986 | H-225.978 | H-225.988 | 41.3 | 7-3.7 | H-315.983 | 65-989 | H-310.923 | H-310.923 | H-25.996 | H-20.914 | D-98.991 | D-88.881 | D-88.984 | H-275.949 | H-270.985 | | | |
| age | x | x | x | x | x | x | x | x | x | | | | | | | | | | | | | | | | | | x | | | | | | | | |
| ancestry | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| appearance | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| body habitus | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| citizenship | | | x | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| color | x | x | x | | | x | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| creed | x | x | | | | | | | | x | | | | | | | | | | | | | | | | | | | | | | | | | |
| disability | x | x | x | x | | x | | x | | | | | | | | | | | | | | | | | | | | | x | | | | | | |
| education | | | | | | | | | | | | | | | | | | | | | | | | | | | | | x | | | | | | |
| ethnic origin | x | x | | x | x | | | x | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| family status | | x | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| gender | | x | | | | | | x | | x | x | x | | | x | | | | | | | | | | | | | | | | | | | | |
| gender identity | x | x | x | x | x | x | | x | x | | | | | | | x | | | | | | | | | | | | | | | | | | | |
| gender expression | | | | | | | | | | | | | | | | | x | | | | x | | | | | | | | | | | | | | |
| genetic information | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| health/health status | | | | | | | x | | | | | | | | | | | | | | | | x | x | x | x | | | | | | | | | |
| immigration status | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| language preference | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| marital status | | | x | | x | | x | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| medical condition | | | | | | | | | | | | | | | | | | | | | | | | | | | | x | | | | | | | |
| military/veteran status | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| national origin | x | x | x | | | x | x | x | x | | | | | | | | | | | | | | | | | | | | | | | | | | |
| pregnancy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| race | x | x | x | x | x | x | x | x | x | | | | | | | | | | | | | | | | | | | | | | | | | | |
| religion | x | x | x | x | x | x | x | x | | | | | | | | | | | | | | | | x | | | | | | | | | | | |
| sex | x | | x | x | x | x | | x | x | | | | x | x | | | | | | | | | | | | x | | | | | | | | | |
| sexual orientation | x | x | x | x | x | x | x | x | | | | | | | | x | | | | | | | | | | | | | | | | | | | |
| social status or condition | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| socioeconomic status | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| other basis prohibited by law | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| other protected group/category/characteristic | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| other personal category | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| other social category | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| other human condition or choice | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| other legally protected basis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| other | x | x | x | | | x | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| affiliational preferences | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| country of education or origin | | | | | | | | | | | | | | | | | x | | | | | | | | | | | | | | | | | | |
| culture | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| degree of medical dependency | | | | | | | x | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| dependent status | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| drug abuse | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| employment status | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | x | | |
| expected length of life | | | | | | | x | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| future plans for marriage or children | | | | | | | | x | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| international medical graduate | | | | | | | | | | | | | | | | | | x | x | | | | | | | | | | | | | | | | |
| living donor status | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | x | | |
| order of protection status | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| participation in a PHP | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | x | | |
| political opinion | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| present or predicted disability | | | | | | | x | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| professional experience/profession | | | | | | | | x | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| quality of life | | | | | | | x | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| zip code | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Table 2 presents the specific choices made across the non-AMA policies reviewed.

THE GOAL OF A COMMON LANGUAGE

Several of the position statements reviewed were triggered by recent events and the impact of the COVID-19 pandemic. For example, the American College of Surgeons' statement indicates that it responds, at least in part, to "reports of racial and ethnic discrimination during the COVID-19 pandemic," and is offered as condemnation of such behavior. So too, the statement by the National Academy of Medical Examiners "strongly denounces injustice and racism in all its forms" as a prelude to condemning discrimination on the basis of characteristics the statement then enumerates.

Academic institutions have a clear duty to comply with federal nondiscrimination law, as policy of Vanderbilt University explicitly indicates. The University of Washington grounds its responsibility to provide "equality of

| | Non-AMA Institutions/Organizations | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|------------------------------------|------|-----|-------|----------|-----|-----|-----|-----|-------|-----|------|------|---------|------|-----|-----|----------------|------------|------|-----------------|-----------------|----------|------------|--------|------|------|------|--------|
| categories/characteristics cited | ACEP | AAFP | AMA | AAHPM | AAO-HNSF | AAP | ACS | AGS | AOA | ASCRS | SVS | AUA* | NAME | Depr Ed | EEQC | HHS | UIC | U-JA Hlth Care | U-JH Uchil | Caro | Harvard College | Harvard Medical | Stanford | Vanderbilt | U-Balt | U-WA | U-NM | U-AL | Howard |
| age | * | * | * | * | * | * | | | * | * | | | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * |
| ancestry | * | | | | * | | | | | | * | | | | | | * | | | * | * | | | | * | * | * | | * |
| appearance | | * | | | | | | | | | * | | | | | | | | | | | | | | | | | | * |
| body habitus | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| citizenship | * | | | | | | | | | | | | | | | | | | | | | | | * | | | | | |
| color | * | * | | * | | | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * |
| creed | * | | | | | | | * | | | | | | | | | | * | | * | * | * | * | * | | | | | |
| disability | * | * | | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * |
| education | | | * | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ethnic origin | * | * | * | | * | * | | | | | | * | * | | | | | | (*) | | | | (*) | | * | | | | |
| gender | | * | * | | * | * | * | | | | * | * | | | | | | | | | | | | | | * | | * | |
| gender identity | | * | * | * | * | | (*) | * | | | * | | | (*) | | (*) | * | * | * | * | * | * | * | * | * | * | ** | * | * |
| gender expression | | | | * | * | | | | | | * | | | | | | | | | | | | | (*) | (*) | | * | | |
| genetic information | | | | | | | | | * | | | | | * | | * | * | * | | | | | * | * | * | * | * | * | |
| health | | * | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| immigration status | * | | | | * | | | | | | | | | | | | | | | | | | | | | * | | * | |
| language preference | * | * | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| marital status | | | | * | * | | | | | | | | | | | | * | | | | | | | * | * | | * | * | |
| medical condition | * | | | | | | | | | | | | | | | | | | | | | | | | * | | * | * | |
| military/veteran status | * | | | * | * | | | | * | * | | | | | | | * | * | * | * | * | * | * | * | * | * | * | * | * |
| national origin | * | * | * | * | * | * | * | * | * | * | | | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * |
| pregnancy | | | | (*) | | | * | | | | | | | (*) | | | | * | | * | * | * | * | * | * | * | * | * | * |
| race | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * |
| religion | * | * | * | * | * | * | | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * |
| sex | * | * | | | | | | * | * | * | * | | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * |
| sexual orientation | * | * | | * | * | * | (*) | * | * | * | * | * | * | (*) | | * | * | * | * | * | * | * | * | * | * | * | * | * | * |
| social status or condition | * | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| socioeconomic status | * | * | * | * | | | | | | | | | | | | | | | | | | | | | | | | | |
| other basis prohibited by law | | | | * | | | | | * | | | | | | | | | | | | | | | | | | | | |
| other protected group/ category/ characteristic | | | | | | | | | | * | * | | | | | | | * | * | * | | | | | | | | | |
| other personal category | | * | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| other social category | | * | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| other human condition or choice | | | | | | | | | | | | * | | | | | | | | | | | | | | | | | |
| other legally protected basis | | | | | | | | | | | | | | | | | | | | | | | | | | * | | | |
| other | | | | | | | | | | | | | | | | | | * | * | * | * | * | * | * | * | * | * | * | * |
| affiliational preferences | | | | | | | | | | | | | | | | | | * | * | | | | | | | | | | |
| family | | | | | | | | | | | | | | | | | | * | | | | | | | | | | | * |
| status/responsibilities | | | | | | | | | | | | | | | | | | | | | | | | | | | | | * |
| matriculation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | * |
| order of protection status | | | | | | | | | | | | | | | | * | | | | | | | | | | | | | |
| political opinion/affiliation | | | * | | | | | | | | | | | | | | | | | | | | | | | | | * | * |
| professional experience | | | * | | | | | | | | | | | | | | | | | | | | | | | | | | * |
| unemployed status | | | | | | | | | | | | | | | | | | | | | | | | | | | | | * |
| zip code | | * | | | | * | | | | | | | | | | | | | | | | | | | | | | | |

opportunity and an environment that fosters respect for all members of the University community,” on the fact that as an institution it is “established and maintained by the people of the state.”

What the statements and policies reviewed demonstrate is that there is no single, agreed on way to speak to discrimination and promote nondiscrimination. In themselves, these materials offer no specific insight into why a particular set of characteristics was adopted or why particular language was used to express those characteristics.

Federal, state, and local law establish a baseline, identifying the minimum constellation of characteristics with respect to which discrimination should not be tolerated, based on the history of discrimination in the U.S. At the same time, policies among medical professional organizations, including those of the AMA, suggest that beyond that baseline it may be appropriate to focus nondiscrimination policy—and tailor the language used—to the salient issues of the context(s) in which policy is intended to apply. As statements of aspiration for conduct at all times and in all places, policies should be encompassing. As guides for action, they may need to be, and responsibly could be, more narrowly focused.

For example, in light of the distinctive responsibilities physicians and parents/guardians must negotiate in caring for pediatric patients, there is strong rationale for the AAP to oppose discrimination on the basis of the disability status of a patient's parent(s) or guardian(s). That insight perhaps should inform other health care contexts in which decision making involves multiple parties, but whether the disability status of participants should universally be specifically addressed in nondiscrimination policy is considerably less clear.

The policies reviewed further suggest that how a nondiscrimination policy expresses or describes salient characteristics is also worthy of thoughtful consideration. The majority of documents in the current, admittedly limited sample, for example, most often refer simply to “disability,” or in some instances “physical or mental disability,” as a characteristic of concern. The University of Chicago, however, refers to “status as an individual with a disability,” using “person-first language.” AMA policy has elsewhere recommended the use of such language (H-440.821).

In some circumstances, “context sensitivity” of the sort evidenced in AAP's nondiscrimination policy might argue for more granular distinctions with respect to a protected characteristic, replacing the broadest designation of the relevant characteristic with a set of more nuanced features. Much as Vanderbilt University's policy offers secondary interpretation of the characteristic “sexual orientation” as a range of specific self-identifications. As, indeed, the policies reviewed suggest is the case in the emerging preference for “gender identity” coupled with “gender expression” over a monolithic—and increasingly ethically, scientifically, and socially problematic—characteristic of “gender.”

Perhaps the most important consideration for any policy or position statement is the goal it is intended to serve. Arguably, as the nondiscrimination policy of the University of Iowa eloquently puts it, the goal is to prevent discrimination on the basis of any classification “that deprives the person of consideration as an individual.” Seen through an equity lens, that means disrupting the historical chain of actions that have the effect of discriminating against, marginalizing, or minoritizing individuals on the basis of actual, perceived, or ascribed characteristics. Words do matter, but there is not necessarily one and only one vocabulary that can accomplish the goal.

These results were circulated to the Governing Councils of the Minority Affairs Section, Women Physicians Section, LTBTQ Advisory Committee, International Medical Graduate Section, and Senior Physicians Section. The wide variation in language used across policies of the AMA, other professional medical organizations, and health care institutions argues that further thoughtful reflection should be given to deciding what terms will best express AMA's commitment to equity and nondiscrimination across our policy compendium, as reflected in the recommendation that follows.

RECOMMENDATION

In keeping with these considerations, your Board of Trustees recommends that G-600.067, “Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment,” be rescinded, the following be adopted, and the remainder of this report be filed:

That our AMA recommend preferred terminology for protected personal characteristics to be used in AMA policies and position statements.

Appendix I: AMA Policies

AMA Bylaws & governance policy

B-1.4

Discrimination

Membership in the AMA or in any constituent association, national medical specialty society or professional interest medical association represented in the House of Delegates, shall not be denied or abridged **because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age,**

| | |
|--|--|
| <p>Cross-referenced by B-7.1 Resident/Fellow Section B-7.3 Medical Student Section</p> | <p>or for any other reason unrelated to character, competence, ethics, professional status or professional activities.</p> <p>7.1.4.1 National Resident and Fellow Organizations. National resident and fellow organizations that meet the following criteria may be considered for representation in the Resident and Fellow Section Assembly: c. Membership in the organization must be available to all residents or fellows, without discrimination.</p> |
| <p>G-600.014 Constituent Associations G-600.020 Specialty Organizations</p> | <p>7.3.3.4.1 Criteria for Eligibility. National medical student organizations that meet the following criteria may be considered for representation in the Medical Student Section Business Meeting: c. Membership in the organization must be available to all medical students, without discrimination.</p> <p>(1) The organization must not be in conflict with the Constitution and Bylaws of our AMA with regard to discrimination in membership;</p> |
| <p><i>AMA Code of Medical Ethics</i> 9.5.4 Civil Rights & Medical Professionals</p> | <p>Opportunities in medical society activities or membership, medical education and training, employment and remuneration, academic medicine and all other aspects of professional endeavors must not be denied to any physician or medical trainee because of race, color, religion, creed, ethnic affiliation, national origin, gender or gender identity, sexual orientation, age, family status, or disability or for any other reason unrelated to character, competence, ethics, professional status, or professional activities.</p> |
| <p><i>Directives and policies of the House of Delegates</i> H-140.837 Policy on Conduct at AMA Meetings and Events</p> <p>H-295.865 Discrimination Against Patients by Medical Students H-295.955 Teacher-Learner Relationship In Medical Education</p> <p>D-185.981 Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act</p> | <p>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. Our AMA opposes the refusal by medical students to participate in the care of patients on the basis of the patient's race, ethnicity, age, religion, ability, marital status, sexual orientation, sex, or gender identity.</p> <p>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.</p> <p>Our AMA will work with state medical societies to ensure that no health carrier or its designee may adopt or implement a benefit design that discriminates on the basis of health status, race, color, national origin, disability, age, sex, gender identity, sexual orientation, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.</p> |

[H-310.919](#)

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process

Our AMA:

1. opposes questioning residency or fellowship applicants regarding **marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;**

[H-65.965](#)

Support of Human Rights and Freedom

Our AMA:

(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, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies;**

[H-65.978](#)

Nondiscrimination in Responding to Terrorism

Our AMA:

(2) opposes discrimination or acts of violence against any person on the basis of **religion, culture, nationality, or country of education or origin** in the nation's response to terrorism.

[H-295.969](#)

Nondiscrimination Toward Residency Applicants

Cross-referenced by H-310.943, Closing of Residency Programs

Our AMA urges the Accreditation Council for Graduate Medical Education to amend its Institutional Requirements to read: "In assessing and selecting applicants for residency/fellowship programs, ACGME-accredited programs must not discriminate on the basis of **sex, age, race, creed, national origin, gender identity, or sexual orientation.**"

Appendix II: Professional associations – universities – health centers

Professional Medical Associations

[American College of Emergency Physicians](#)

The American College of Emergency Physicians (ACEP) acknowledges that implicit and explicit biases, attitudes, or stereotypes affect our understanding, actions, and decisions. These factors are further magnified in the emergency department where cognitive load, rapid and abbreviated interactions, and high stress can leave patients and staff vulnerable to pre-conceived notions and biases. In order to reduce biases and improve health equity, it is crucial to be mindful of their pervasiveness and to employ critical reflection, training, and education geared to address and disarm them. ACEP advocates for the respect and dignity of each individual, opposes all forms of discrimination and harassment, and supports anti-discrimination and anti-harassment practices protected by local, state, or federal law. Discrimination and harassment **may be based on, but are not limited to, an individual's race, age, religion, creed, color, ancestry, citizenship, national or ethnic origin, language preference, immigration status, disability, medical condition, military, or veteran status, social or socioeconomic status or condition, sex, gender identity or expression, or sexual orientation.**

[American Academy of Family Physicians](#)

Patient: The AAFP opposes all discrimination in any form, including but not limited to, **that on the basis of actual or perceived race, color, religion, gender, sexual orientation, gender identity, ethnic affiliation, health, age, disability, economic status, body habitus or national origin.**

Physician: Equal Opportunity--The AAFP strongly supports the principle that hiring, credentialing and privileging decisions for physicians should be based solely on verifiable professional criteria.

[American Heart Association](#) [American College of Cardiology](#)

(1.4)1. Principles of Professionalism) Social justice. The medical profession must promote justice in the healthcare system, including the fair distribution of healthcare resources. Physicians should work actively to eliminate discrimination in health care, **whether based on race, sex, socioeconomic status, ethnicity, religion, or any other social Category.**

(2.2) 4. The existence and **perpetuation of bias and structural racial, ethnic, sex, and other inequities** throughout the cardiovascular community must be recognized and acknowledged as a problem, and change must be embraced and incentivized as vital to mission.

[American Academy of Hospice and Palliative Medicine](#)

(2.4) 6. Clinicians should review their own practices at least once per year for possible differential treatment of patients by **race and ethnicity, zip code, and primary language**. Systemic racism undermines public health and poses a barrier to achieving our vision that all patients, families, and caregivers who need it will have access to high-quality hospice and palliative care.

[American Academy of Otolaryngology—Head and Neck Surgery](#)

We have made the following pledges to achieve Diversity, Equity and Inclusion
Build a community and field that is **diverse across many dimensions, including but not limited to age, gender, gender identity, ability, education, ethnicity, nationality, political opinion, professional experience, race, religion, sexual orientation, and socioeconomic status**.

The AAO-HNS/F is opposed to discrimination against people **on the basis of, but not limited to, race, color, national origin, religion, sex (including pregnancy), age, sexual orientation, gender identity and expression, marital status, disability, veteran status, or any other basis prohibited by federal, state, or local law**. This applies to all aspects of medical practice and training, practice administration, and academic settings.

[American Academy of Pediatrics](#)

THE MISSION OF the American Academy of Pediatrics (AAP) is “to attain optimal physical, mental, and social health and well-being for all infants, children, adolescents and young adults.”¹ In support of this mission, therefore, the AAP is opposed to discrimination **in the care of any patient on the basis of race, ethnicity, ancestry, national origin, religion, gender, marital status, sexual orientation, gender identity or expression, age, veteran status, immigration status, or disability of the patient or patient’s parent(s) or guardian(s)**. In addition, the AAP supports the right of pediatricians, pediatric medical subspecialists, pediatric surgical specialists, and other specialist physicians who care for pediatric patients in both educational and practice settings **to participate in the delivery of health care without discrimination on the basis of race, ethnicity, ancestry, national origin, religion, gender, marital status, sexual orientation, gender identity or expression, age, veteran status, immigration status, or disability**. Physicians with disabilities who maintain the ability to perform the essential functions of their jobs with or without “reasonable accommodation,” as defined by the Americans with Disabilities Act (ADA),² should not be hindered from participating in such activities.

[American College of Surgeons](#)

The American College of Surgeons (ACS) is aware of reports of racial and ethnic discrimination during the COVID-19 pandemic. Since this outbreak started, Asian members of both our own surgical community and the public at large continue to experience bias. We strongly condemn these actions.

COVID-19 does not discriminate. It **affects all people, regardless of gender, race, ethnicity, age, sexual orientation, or geographic location**. Discrimination of any kind is antithetical to the mission of any health care professional. We were drawn to this profession to serve all patients.

The ACS supports all health care personnel who provide essential services in our communities at this time and maintains that they should be able to continue to do so without the specter of hatred and violence resulting from xenophobia, racism, and bigotry. We also encourage you to discuss any discriminatory acts you witness at any time to your institution’s leadership and to the ACS.

[American Geriatrics Society](#)

The American Geriatrics Society (AGS) opposes **discrimination against healthcare professionals or older people based on race, color, religion, gender (including gender identity, sexual orientation, and pregnancy), disability, age, or national origin**. We believe that such discriminatory practices can have a negative impact on public health, especially the health of older Americans and vulnerable older people.

We oppose any federal order or legislation that unfairly singles out or targets health professionals and other members of the healthcare workforce because of race, color, religion, gender (including gender identity, sexual orientation, and pregnancy), disability, age, or national origin. Additionally, we oppose discrimination or disparate treatment of any kind in any healthcare setting because of race, color, religion, gender (including gender identity, sexual orientation, and pregnancy), disability, age, or national origin.

[American Osteopathic Association Code of Ethics](#)

Section 3. A physician-patient relationship must be founded on mutual trust, cooperation, and respect. The patient, therefore, must have complete freedom to choose her/his physician. The physician must have complete freedom to choose patients whom she/he will serve. However, the physician should not refuse to accept patients **for reasons of discrimination, including, but not limited to, the patient’s race, creed, color, sex,**

national origin, sexual orientation, gender identity, or disability. In emergencies, a physician should make her/his services available.

Section 3 does not address a patient's discriminating against a physician based on the physician's race, creed, color, sex, national origin, sexual orientation, gender identity or disability; and a patient may express a desire to not be treated by a particular physician or by a physician with certain characteristics.

Therefore, the AOA interprets section 3 of its code of ethics to permit but not require an osteopathic physician to treat a patient when the physician reasonably believes the patient is experiencing a life- or limb-threatening event, even though the patient may have previously expressed a desire to not be treated by a physician based on the physician's race, creed, color, sex, national origin, sexual orientation, gender identity or disability. (July 2014)

[American Society of Colon and Rectal Surgeons](#)

The American Society of Colon and Rectal Surgeons does not discriminate **on the basis of race, color, religion, national origin, sex, sexual orientation, age, genetics information, disability, status as a protected veteran, or on any other basis violative of law.**

[Society for Vascular Surgery](#)

The Society for Vascular Surgery® (SVS) is committed to providing a work environment in which all individuals are treated with respect and dignity. Harassment of any kind, including sexual harassment, is prohibited and will not be tolerated. The Society has zero tolerance of harassment of any kind by anyone, including managers, co-workers, members, vendors, clients, customers, or any other third party.

Harassment consists of unwelcome conduct or behavior, whether verbal, physical, or visual, that is based on a person's protected status, including **sex, race, color, religion, national origin, age, gender, sexual orientation, physical or mental disability, military status, or any other protected group status.**

[American Urological Association](#)

The American Urological Association (AUA) and the Urology Care Foundation are committed to promoting a productive work environment that is free from discrimination, harassment or disruptive activity. As such, neither the AUA nor Urology Care Foundation will tolerate verbal or physical conduct by an employee, member, vendor or other that discriminates, harasses, disrupts or unreasonably interferes with another's work performance or creates an intimidating, hostile or offensive working environment.

No form of discrimination or harassment will be tolerated **based on a person's age, race, color, religion, gender identity and expression, disability, sexual orientation or any other characteristic protected by applicable federal, state and local laws and ordinances.**

[National Association of Medical Examiners](#)

The National Association of Medical Examiners strongly denounces injustice and racism in all forms. Forensic pathologists are committed to truth, mutual respect for all, listening objectively and understanding between people. Historically, forensic pathologists have stood for truth in Attica, and denounced genocides and many other wrongs flamed by hate and discrimination. We publicly condemn racism, injustice, and discrimination of any kind. We are appalled at the deaths of George Floyd and others before him, murdered and missing indigenous women, attacks on LGBTQ and any attack, injustice or discrimination **based on race, gender, ethnicity, sexuality, religious or spiritual beliefs, appearance or any other human condition or choice.** We stand united against these terrible injustices. As forensic pathologists and physicians, we are committed to the betterment of humanity, and respect for all people regardless of **race, gender, sexuality, ethnicity, religious affiliation, place of birth or economic standing.**

6. MITIGATING THE EFFECTS OF RACISM IN HEALTH CARE: “BEST PRACTICES”

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At its November 2020 Special Meeting the House of Delegates of the American Medical Association (AMA) adopted three policies directed toward the ongoing impact of racism in medicine: [D-350.981](#), “Racial Essentialism in Medicine,” [H-65.952](#), “Racism as a Public Health Threat,” and [H-65.953](#), “Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice.”

These policies variously direct AMA to take action to address racism and racial essentialism as they manifest in medical education, clinical practice, and the development and use of new medical technologies, notably clinical algorithms. Staff from the Center for Health Equity and AMA’s Health, Science & Ethics group tasked with co-implementing these directives realized that three key themes cut across individual policies: identifying best practices to respond to the effects of racism, addressing algorithmic bias and race-corrected algorithms, and collaborating with key stakeholders to address how medical education perpetuates mistaken beliefs about race as a biologic risk factor. Staff concluded that the most effective approach to accomplishing the goals of these policies would be to engage these cross-cutting themes as organizing rubrics for three separate reports on best practices, clinical algorithms, and medical education, respectively.

The working group concluded that the most effective approach for responding to the HOD’s directives would be to engage these cross-cutting themes as its organizing rubric in a series of reports, rather than speak to individual directives policy by policy.

The present report responds to the directive to “identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations” ([H-65.952](#)).

The broad scope of this directive requires distinguishing best practices first, at the level of institutionalized or structural racism as well as the level of “personally mediated” racism,¹ and second, doing so across multiple contexts of practice, from small private offices to large integrated health systems. As evidenced below, the complexity of the task and the problem(s) to be addressed argue against defining any single set of “best” practices. Rather, this report seeks to identify essential features of strong anti-racist practice applicable across multiple levels and settings as they emerge in anti-racism declarations made by public health departments and local/state governments and in equity and anti-racism initiatives being undertaken by health care institutions across the country.

To that end, in addition to literature review, as discussed below preliminary reviews were carried out of (a) declarations regarding racism as a public health crisis posted to the American Public Health Association’s online database, and (b) publicly available descriptions of programs and initiatives on the part of health care institutions to address racism and health equity.

DECLARATIONS ON RACISM AS A PUBLIC HEALTH CRISIS

The American Public Health Association maintains a [database of declarations of racism as a public health crisis](#) or emergency. Submissions to the database are crowd-sourced; thus, it certainly does not include every existing anti-racism declaration. As of May 18, 2021, the database included 208 declarations from city/town governments (102 declarations), county boards (51), state governments (7), public health organizations (44), and educational organizations (4). The working group evaluated a randomly chosen sample of 19 declarations, which surfaced three core themes focused around declaring entities’ commitments to acknowledge racism, address racism, and mitigate racism.

Acknowledge Racism

All but one of the nineteen declarations reviewed explicitly named and condemned systemic racism (one used the term “endemic racism”). Declarations gave examples of historical and present-day government sanctioned colonization, genocide, and racism in housing, including redlining and segregation; voting rights; immigration; incarceration; as

well as hiring, promotion, compensation, and retention practices. Thirteen acknowledged historical, intergenerational, or contemporary racial trauma; none provided an apology for their role in creating or perpetuating it.

For example, the declaration from Multnomah County, Oregon included the following statement:

Multnomah County recognizes that the entirety of Multnomah County rests on the homelands, villages and ceded territories of the Indigenous Tribal nations. We acknowledge the genocide, forced removal, and systemic erasure of Indigenous peoples that have allowed us to ignore and deny this history and our responsibility to Indigenous people. Further, the state of Oregon was founded on the notion of creating a white utopia, and around the functional and implicit removal, exploitation and/or exclusion of BIPOC individuals and communities. From Black exclusion laws and restrictions that barred Black and Chinese people from voting to a steady stream of discriminatory laws and the practice of redlining in Portland, the legacies of Oregon's founding ideals continue to perpetuate harm, oppression, and marginalization within communities of color today. Racism is codified into our laws and institutions, which were created on a foundation of the ideology of white supremacy; it upholds systems, structures and policies that were created to advantage white people while neither serving nor benefiting people of color.²

Address Racism

All but four of the examined declarations included specific anti-racism actions the organization was committing to. Among the actions at the individual, institutional, and community level set out by the 15 organizations that included them are commitments to:

- Providing anti-racism training for all staff, students and volunteers.
- Instituting anti-racism policies and practices in Human Resources; building a workplace culture that promotes racialized repair.
- Developing policies and practices to ensure equity and incorporating anti-racism principles in budgets and contracting; using an equity lens in vendor selection processes.
- Using racial impact assessments in the development of all policy resolutions and ordinances; expanding documented equity decision-making frameworks that are transparent to the public.
- Conducting research, analyzing and collecting data, and monitoring progress to ensure policy approaches are data driven and have built-in accountability measures; improving data systems in order to disaggregate health data by race, ethnicity, gender, transgender, age, sexual orientation and income and facilitate data-informed decision-making processes to address health inequities.
- Sharing power in partnering with community organizations; systematically lifting up the voices of community members; applying an anti-racism lens to government outreach with all communities.
- Seeking upstream solutions to address health inequities at the population level, recognizing that racism is a social determinant of health outcomes; working to mitigate housing and job displacement from driving further racial and income segregation by developing strategic initiatives such as land use and affordable housing finance regulations and housing stability programs.

Mitigate the Effects of Racism

The declarations reviewed gave significantly less attention to addressing activities to mitigate the effects of racism. None committed to a strategy for making reparations. Many did not acknowledge the need for additional funding or resources to support mitigation. Of those that did, only two promised specific dollar amounts, while the remainder simply advocated in general for additional funding.

ANTI-RACISM INITIATIVES AMONG HEALTH CARE INSTITUTIONS

Launched in 2016, the Healthcare Anchor Network is a collaboration among now 60 hospitals and health systems committed to serving as “anchor institutions”³ in their communities. Network members recognize that

Hospitals and health systems are critical local economic engines and mission-driven organizations inextricably linked to the long-term well-being of those we serve—because of this, we as healthcare leaders, are uniquely positioned and incentivized to play a more active role in supporting our local economies. We have an opportunity

and obligation to improve health and well-being outcomes in the communities we serve and confront economic and social instability in our nation that remain obstacles to that goal.⁴

Collectively, Network members called for action to address racism as a public health crisis, pledging as institutions to:

- Re-examine institutional policies with an equity lens and make policy changes that promote equity and opportunity.
- Improve access to primary and specialty care.
- Continue to focus on helping our communities overcome chronic conditions like diabetes, heart disease, and asthma.
- Continue to advocate for investments that create innovative solutions to achieve enduring improvements in access, quality, and health outcomes for our communities.
- Commit to hiring locally and promoting and retaining leaders of color.
- Renew and expand the organizations' commitment to providing anti-racism and unconscious bias training for our administrators, physicians, nurses, and staff.
- Advocate for increased funding for social needs, social services and programs that promote social justice.⁵

Members have further “co-created the Anchor Institution Reporting Standard to develop a shared set of national metrics for anchor strategies.”

In 2015 the American Hospital Association's Institute for Diversity and Health Equity (IFDHE) launched the #123forEquity Campaign to eliminate health care disparities, which to date has received a total of 1,771 organizational pledges, with 1,711 being hospitals and health systems. The campaign encourages hospital and health system leaders to:

- Increase the collection and use of race, ethnicity, language preference and socio-demographic data.
- Increase cultural competency training.
- Increase diversity in leadership and governance.
- Improve and strengthen community partnerships.⁶

The goal of the campaign is to ensure every person in every community receives high-quality, equitable and safe care.

The working group delved into the declarations and strategic plans of 11 health systems among these two initiatives: [Rush University Medical Center](#), [Health Partners](#), [Ohio State University Wexner Medical Center](#), [MetroHealth](#), [Ascension](#), [Kaiser Permanente](#), [Mass General Brigham](#), John Hopkins Medicine, UC Davis Health, Yale New Haven Health, and RWJBarnabas Health.

Themes among these materials include:

- Recognizing the need to understand the historical context of the institution and its community, to embed equity in the institution's strategic plan, promote diversity among leadership and staff and adopt equitable processes for decision making that do not perpetuate racism and inequity.
- Commitment to:
 - ensuring equitable policies and practices for recruiting and managing personnel; adopting zero-tolerance policy with respect to racism, harassment and discrimination within the institution; and providing a living wage and equitable benefits; and
 - providing anti-racism and implicit bias training and cultivating a safe environment in which staff are comfortable addressing racism.
- Promoting quality improvement activities to eliminate variations in care and outcomes.
- Funding research to address and eliminate racism.
- Designing data systems that are able to collect, stratify, and report data on race, ethnicity, language, sexual orientation, and gender identity.
- Identifying community health assets and needs and building partnerships to address those needs and social determinants of health.
- Centering the most marginalized/minoritized communities within and outside the institution in designing solutions to address community needs.

- Building coalitions with other health care and community institutions to create resources and opportunities and redistribute power to further the interests and well-being of the local community.
- Advocating on behalf of and supporting community members in advocating for themselves.

The Institute for Healthcare Improvement's (IHI) Pursuing Equity initiative also brings together some twenty institutions committed to addressing the needs of marginalized and minoritized communities to improve health. (Several institutions are members of both the IHI initiative and the Healthcare Anchor Network.) The IHI's *Framework to Improve Health Equity* focuses on the need to make health equity a priority, build infrastructure to support health equity, address the multiple determinants of health, eliminate racism and other forms of oppression, and partner with the community to improve health equity.

The IHI identifies five strategies for eliminating racism:⁷

- Understanding the historical context for racism and other forms of oppression nationally, locally, and within the institution itself, including:
 - gaining understanding of the historically marginalized populations in the community where the institution is located; and
 - committing to ongoing learning and transformation regarding race, racism, and inequity.
- Addressing institutional racism and its impact on health equity by:
 - normalizing discussion about racism, oppression, advantage and power,
 - identifying institutional racism as a root cause of inequities;
 - setting organizational priorities to explicitly address racism; and
 - listening to patients, partners, and communities to understand their experiences and partner on solutions.
- Establishing policies and practices to promote workforce diversity and racial equity by:
 - setting specific targets for workforce diversity at all levels; and
 - ensuring that organizational policies and practices promote diversity.
- Implementing business policies and practices that support and promote racial equity by:
 - developing or revising policy through a racial equity lens; and
 - investing in the community.
- Improving clinical processes and outcomes to narrow equity gaps and improve equity for all:
 - building data systems that can identify and track equity gaps in clinical outcomes;
 - using quality improvement to narrow equity gaps and improve care for all; and
 - breaking down silos between departments to motivate clinical teams to work together to reduce equity gaps.

ADDRESSING “PERSONALLY MEDIATED RACISM”

Although addressing prejudice and discrimination in the behavior of individuals can never be a sufficient response to racism in health care, it is nonetheless essential for promoting strong anti-racist practice. Differential assumptions about individuals' abilities or intentions based on race and differential action toward individuals based on race both reflect and help to perpetuate structural inequities.

Prejudice or discrimination by health care personnel toward patients, family members, or fellow health care workers runs counter to the norms of the healing professions and undermines efforts on the part of the institution to mitigate the effects of racism. This has led to calls for providing training to all staff in implicit bias and “cultural competence,” or more properly, cultural humility and structural competence. are needed? are appropriate?

Prejudice on the part of patients or families toward health care personnel also presents a challenge for health care institutions, which have a responsibility to support and protect the dignity and well-being of personnel. Strong practice includes ensuring a safe and respectful working environment by setting clear expectations for the behavior of all parties during health care encounters and ensuring that those expectations are upheld.

Analogous to institutions' responsibility to collect data on inequities in access to care and outcomes, institutions should collect and analyze data on incidents of prejudiced or discriminatory behavior by health care personnel and patients or families to better understand how such incidents arise and inform efforts to improve the institution's response. Moreover, institutions have a responsibility to reflect critically on how they treat their staff, how they permit staff to treat one another and members of the community, and how they permit members of the community to interact with health care personnel and align policies and practices to foster compassion and respect for all stakeholders.⁸

AMA ENGAGEMENT

The AMA Center for Health Equity is designing and launching large-scale national initiatives to advance a more equitable and healthy society in which physicians use their individual, institutional, and collective power to advance health equity and public health (upstream approaches). These initiatives are focused on three key levels of action: cross-sector engagement, health care institutions, and health care professionals.

Cross-Sector Engagement. Coordinate across sectors—including public health, social care, health care, and beyond—to promote people- and community-centered, collective action addressing social and structural drivers of health, and dismantling intersecting systems of oppression. The Center’s *IHI-AMA Equity Campaign*, a two-and-a-half-year initiative, will engage individuals, health systems, payers, biotech/pharma, and professional societies to transform the health care ecosystem to promote optimal health for historically marginalized populations. The *AMA-ACGME Racial Justice and Equity Grand Rounds* will launch a national lectureship and practice lab focused on amplifying high-impact strategies and practices in racial justice and equity across sectors to promote people- and community-centered collective action to address the social and structural drivers of health, and to dismantle intersecting systems of oppression.

Health Care Institutions. Eliminate harmful variation in health care delivery, access, and outcomes, by embedding equity in the DNA of hospital operations, including quality, safety, data, and education; and promoting a place-based, equity-focused anchor mission strategy that centers community and marginalized voices. The *AMA-BWH Q&S For Impact in Racial Justice an Equity Peer Network* is designed to equip all participating U.S. health care delivery systems with the knowledge and tools to address root causes of inequities by systematically incorporating equity into the operational DNA of healthcare delivery—by leveraging equity-informed high-performance quality and safety practices and technologies that will address structural and social drivers of health and advance equity for patients, staff, and local communities.

Health Care Professionals. Develop a pipeline of health care leaders equipped with anti-racist, structural justice praxis capable of redesigning health care for social health.

LESSONS LEARNED

Defining a single set of “best” practices to respond to the challenge of racism in health care is an illusory goal. Best practices can be effective tools for responding to problems that are (relatively) circumscribed in nature and scope, affect a limited set of readily definable stakeholders, and are amenable to reasonably straightforward solutions. Racism and its effects on patients, physicians and other health care personnel, and the institutions and communities within which they live and work, is of a different order. Racism is deeply rooted historically and pervasive across U.S. society, manifest in entangled policies, practices, institutions, and habits of mind among multiple stakeholders who bring diverging values and goals to the table and for whom different “solutions” can carry significantly different implications.

The responses to systemic racism discussed above don’t delineate a set of “best practices.” Rather, they suggest features that will be common to strong solutions across the board, however different those solutions may be in their details. These initiatives indicate that at minimum, effective efforts to mitigate the impact of racism will explicitly name the problem for what it is, will engage both institutional and interpersonal racism, and will pair commitment with specific policies and concrete practices to create change.

Strong solutions will acknowledge and respond to the unique intersecting local histories of racism within the institution, the community, and their constituent populations. They will partner with the community to identify local values, needs, and assets and develop concrete, actionable plans to meet the full range of needs among the populations served. They will secure additional resources as needed to build local capacity. And they will adapt as the needs of the community change over time.

As essential partners in initiatives to mitigate racism, health care institutions will align institutional mission and strategic planning with the needs and values of the local community and populations served. They will promote and provide resources to support critical self-reflection and transformation on the part of the institution and its staff. Institutions will collaborate with the community and local populations served to design and implement meaningful measures of success and hold the institution accountable for meeting those measures. And they will ensure that at all

levels of the institution policies are equity focused, actionable, and aligned with the institution's community-informed values and mission.

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7. IMPROVING CLINICAL ALGORITHMS: MOVING BEYOND RACE AND ETHNICITY

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At its November 2020 Special Meeting the House of Delegates of the American Medical Association (AMA) adopted three policies directed toward the ongoing impact of racism in medicine: [D-350.981](#), “Racial Essentialism in Medicine,” [H-65.952](#), “Racism as a Public Health Threat,” and [H-65.953](#), “Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice.”

These policies variously direct AMA to take action to address racism and racial essentialism as they manifest in medical education, clinical practice, and the development and use of new medical technologies, notably clinical algorithms. Staff from the AMA's Center for Health Equity and Health, Science & Ethics group tasked with co-implementing these directives realized that three key themes cut across individual policies: identifying best practices to respond to the effects of racism, addressing algorithmic bias and race-corrected algorithms, and collaborating with key stakeholders to address how medical education perpetuates mistaken beliefs about race as a biologic risk factor. Staff concluded that the most effective approach to accomplishing the goals of these policies would be to engage these crosscutting themes as organizing rubrics for three separate reports on best practices, clinical algorithms, and medical education, respectively.

The present report responds to directives to “promote antiracist strategies to mitigate algorithmic bias in medicine” [[H-65.952\(6\)](#)] and “innovative health technologies” [[H-65.953\(5\)](#)] and, importantly, to “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” [[D-350.981\(4\)](#)].

BACKGROUND

With the advent of longitudinal clinical registries, electronic health record systems, and other large repositories of clinical data, many specialty societies, health systems, health plans, researchers, patient-facing organizations, government entities, and others have used the data to develop or support development of algorithms to inform the clinical care of individual patients and populations. As constructs based on real-world data and using mathematical and statistical methods such as multivariate analysis, these algorithms have been widely adopted, in part based on their implied or explicit promise to objectively synthesize and interpret data and offer clinical decision support that circumvents the potential biases of human decision makers.¹ Yet as is increasingly clear, much more remains to be done if clinical algorithms are to come closer to achieving that promise.

Clinical algorithms are only as good as the data on which they are trained and operate and can be subject to bias arising from several directions and due to many causes: limitations in the geographic origins and ancestral representativeness of data collection; missing data; small sample sizes; the implicit biases and inaccurate or inexperienced judgments of clinicians; or differential care delivered in different clinical settings to different populations of patients.¹ As a result, technical solutions to mitigate bias before, during, or after an algorithm processes data may not be sufficient to ensure that an algorithm benefits patients as intended.^{2,3,4}

Collection of data to identify and describe individuals is ubiquitous, and often required, in clinical health care settings and research. In addition to name, address, and date of birth, health care organizations, clinicians, and researchers often collect information on gender, co-morbidities, race, ethnicity, and other characteristics that they believe contribute or may contribute significantly to the predictive accuracy of estimates of the risks and benefits of the various preventive, diagnostic and therapeutic options considered and discussed, recommended or advised against, and offered or not offered in clinical care settings. With race and ethnicity now understood as social, not biological constructs, and as proxies for nonbiological factors such as social determinants of health and structural racism, considerable scholarship has been focused on what “race” and “ethnicity” mean as descriptive or explanatory categories in clinical care and research, and what role, if any, data on race and ethnicity should play in clinical algorithms.⁵

CONGRESSIONAL INTEREST

AMA is not alone in recognizing and responding to the imperative to come to terms with racism endemic in American society, which manifests in stark health inequities among members of marginalized and minoritized communities compared to white patients. Understanding and redressing how clinical algorithms create, perpetuate, or exacerbate those inequities is essential. A growing body of literature reveals the way in which race corrections, intended to enhance the accuracy of predictive models, can in fact systematically disadvantage patients of color and contribute to differential outcomes.⁶

In September 2020, Congressman Richard E. Neal, chairman of the Committee on Ways and Means of the U.S. House of Representatives, directed a request to a number of medical professional societies and other entities, asking them to describe how they are addressing the challenges that can be associated with use of clinical algorithms that incorporate race and ethnicity data, among other factors.⁷ The organizations’ responses indicate that there is considerable variation within the professional community with respect to what ways and how far along different organizations are in their journey to address these issues.

Although respondents differed in the scope of their efforts to address the challenges associated with the use of race and ethnicity data in clinical algorithms, several shared concerns emerged:

- The need for guidelines on the *appropriate* use of race/ethnicity in research and clinical care.
- The need to identify and pay for, race-neutral well-validated biomarkers, if available, to improve estimates of risk of particular outcomes (e.g., use of cystatin to estimate a race-neutral creatinine clearance).
- The need for transparency on the part of algorithm developers, in particular:
 - information about the population(s) studied and the extent to which algorithms have been tested in different populations,
 - the extent to which algorithmic estimates predict outcomes and differences in outcomes that are important to people, and
 - the confidence intervals, or degree of uncertainty, associated with algorithmic estimates of outcomes of an intervention or no intervention, and
 - How algorithmic estimates change with inclusion or exclusion of race and ethnicity.
- The need to encourage and pay for collection and reporting of granular population data to identify and address inequities.
- The need to develop guidelines and opportunities for medical education about:
 - race and racism,
 - implicit bias, and
 - AI technologies.
- The need to establish and apply antiracist practices and policies throughout the total lifecycle of a clinical algorithm from conceptualization to implementation in practice.
- The need for federal support of research to advance the science of algorithm development, and identify and advance solutions that recognize racism, rather than race, as the driver of racial health inequities.

- The need for clear accountability and metrics of equitable access to care.

AMA ENGAGEMENT

The need for collaboration emerged as a dominant theme among respondents to the Committee on Ways and Means, one that AMA, with its power to convene, is well-positioned to address. As part of its larger mission to improve health equity nationwide, AMA is exploring opportunities to engage stakeholders across multiple domains.

Initiatives under development by the AMA Center for Health Equity provide an overarching framework for AMA engagement. Notably, collaboration with the Institute for Healthcare Improvement (IHI) will address issues at the level of health care institutions and health systems. The AMA-IHI Equity Campaign is designed to help institutions build equity and racial justice into their operations in all domains, from quality, safety, data, and education to place-based equity-focused anchor mission strategies that center community and marginalized voices.

Going forward, clinical algorithms must address the fact that in health datasets, race and ethnicity are proxies, not for ancestry or genetics, but for nonbiological causal factors such as social determinants of health and the effects of systemic racism. This has led to calls, such as those that surfaced in responses to the Committee on Ways and Means, to replace race/ethnicity with more appropriate data elements in EHRs, registries, and research datasets.

Further, race/ethnicity data currently available are problematic in that they are in some instances self-reported by patients and in others ascribed to patients by researchers and clinicians, with the latter approach more subject to error than the former. Furthermore, the options offered to reporters have varied as societal perspectives on race and ethnicity have changed over time. Some early data systems and evidence reports have limited choices or analyses to White and non-White, where systems today may offer 90 or more options, including giving individuals the opportunity to self-identify as multi-racial and to decline to report.⁸ Arriving at a meaningful consensus on how race and ethnicity should be defined and reported in clinical care and research is fundamental.

AMA's [Integrated Health Model Initiative](#) (IHMI) is in a position to address these data issues, in particular, to introduce and advocate for appropriate data elements to replace race/ethnicity where they have served as proxies for biological risk factors. IHMI is a founding member of [The Gravity Project](#), a consensus-building community that "seeks to identify coded data elements and associated value sets to represent social determinants of health data documented in EHRs" for screening, diagnosis, planning, and intervention.

Input from the medical specialty societies and other organizations that have expertise and direct experience in developing and using clinical algorithms will be key to understanding the range of algorithms currently in use and to identifying if and where bias and racism exist in these tools as a first step to ensuring that they do not adversely affect health and access to care among marginalized and minoritized communities.

Following the publication of "Hidden in Plain Sight: Reconsidering the Use of Race Correction in Clinical Algorithms" in the *New England Journal of Medicine* more than a year ago,² the AMA communicated with the American College of Cardiology and the leadership of its National Cardiovascular Data Registry and the American College of Obstetricians and Gynecologists, as well as the Society of Thoracic Surgery (STS) and leadership of the STS Database and, subsequently, other stakeholder organizations, to gauge interest in convening a work group to address issues surfaced in the article.

AMA looks to engage specialty societies within the Federation, as well as clinical registry stewards and subject matter experts within and outside AMA, more broadly in 2022 to map more completely existing clinical algorithms and stakeholders' understandings of the challenges and opportunities they pose. We intend to provide a collaborative space in which stakeholders can share expertise and insights, regardless of their current or previous level of engagement with clinical algorithms, toward identifying key principles for antiracist design and implementation of clinical algorithms.

To be clear, it is not the intent of the AMA to eliminate the collection of race and ethnicity data. AMA recognizes that there is value in that data as it strives to overcome U.S. medicine's history of bias based on race and ethnicity. Absent such collection, it may be impossible to know if progress is being made and to what approaches such progress can be attributed. The AMA intends to convene organizations that are committed to making such progress and to sharing their expertise and experience and best practices, to make recommendations in support of equitable health outcomes.

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8. IMPROVED ACCESS AND COVERAGE TO NON-OPIOID MODALITIES TO ADDRESS PAIN (Alternate Resolution 218-A-19)

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED ALTERNATE RESOLUTION 218-A-19 NOT ADOPTED REMAINDER OF REPORT FILED

INTRODUCTION

At the 2019 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted an alternate resolution to Resolutions 218, which is now AMA Policy H-120.922, “Improved Access and Coverage to Non-Opioid Modalities to Address Pain.”

The following resolves were referred:

That although our AMA supports all interventional pain interventions and therapies in general, due to current issues with limitations in coverage and noncoverage, in particular, spine and large joint radiofrequency ablation and other arbitrarily limited non-covered interventional pain management procedures, by private insurance carriers, third party reviewing agencies, Medicare and Medicaid contractors, and Medicare Advantage Plans, the AMA supports coverage of these medically necessary procedures in particular, at this time; and

That our AMA supports coverage of evidence-based spinal cord stimulation trials and implantation, and peripheral nerve stimulation trials and implantation (as both CPT code sets are linked to their respective ICD10 codes as outlined in the AMA CPT Manual) by private insurance carriers, third party reviewing agencies, Medicare and Medicaid contractors, and Medicare Advantage Plans.

Original Resolutions 218 and 235 from the 2019 AMA HOD Annual Meeting contained highly specific information relating to specific medications and medical conditions. Resolution 218 asked that the AMA, “petition the Centers for Medicare and Medicaid Services (CMS) to allow reimbursement for off label use of medications like gabapentin or lidocaine patches at the lowest copayment tier for the indication of pain so that patients can be effectively treated for pain and decrease the number of opioid prescriptions written.” Resolution 235 asked that the AMA, “encourage the U.S. Food and Drug Administration (FDA) to consider approving other indications in addition to post-herpetic neuralgia for transdermal lidocaine patches.”

During HOD testimony, it became clear that physician delegates had many concerns about a wide range of non-opioid pain care treatment options in addition to the ones listed in the original resolutions. There also was concern raised

about ensuring that AMA advocacy to CMS and FDA was focused on actions that CMS and FDA could reasonably be expected to take rather than asking them to take actions beyond their regulatory scope.

As a result of the detailed testimony, the reference committee suggested an alternate “omnibus” resolution to provide for AMA support for a broad range of non-opioid pain care treatment options for coverage and access, as well as placement on a payer’s lowest cost-sharing tier. The alternate resolution received support from the Board of Trustees primarily due to the fact that the comprehensive nature of support for patients with pain would augment ongoing AMA advocacy in support of patients with pain and the physicians who provide pain care. After a robust discussion, the HOD adopted the reference committee’s “omnibus” recommendation, which is now AMA Policy H-120.922, “Improved Access and Coverage to Non-Opioid Modalities to Address Pain,” which states:

Our AMA will: (1) advocate for increased access and coverage of non-opioid treatment modalities including pharmaceutical pain care options, interventional pain management procedures, restorative therapies, behavioral therapies, physical and occupational therapy, and other evidence-based therapies recommended by the patient’s physician; (2) advocate for non-opioid treatment modalities being placed on the lowest cost-sharing tier for the indication of pain so that patients have increased access to evidence-based pain care as recommended by the HHS Interagency Pain Care Task Force; and (3) encourage the manufacturers of pharmaceutical pain care options to seek DEA approval for additional indications related to non-opioid pain management therapy.

On their face, the referred resolves involve the same type of highly specific medical procedures and payer responsibilities for those procedures that were at issue in original Resolutions 218 and 235. This report will provide background on the issues presented, discuss relevant AMA policy and provide recommendations.

DISCUSSION

One of the most common elements of the nation’s opioid epidemic has been for policymakers and public health officials to largely bypass the fact that improving pain care for America’s patients is integral to ending the nation’s opioid epidemic. The AMA has long called for the balance needed between policymaking intended to address the opioid epidemic with medical evidence, policy and patient compassion—alongside the reality that there are millions of patients in pain, and that the opioid epidemic has fully shifted to one driven by illicitly manufactured fentanyl, fentanyl analogs, heroin, cocaine and methamphetamine. While policymakers have almost entirely focused on opioid prescribing, physicians and other health care professionals on a national level began to make more judicious opioid prescribing decisions in 2012-13. Part of that decision-making process, however, must not discount the clinical experience that opioid therapy works for many patients. It also must not discount the practical reality faced by physicians and patients daily that if opioid therapy is not the preferred course of treatment, patients must have access to affordable, available non-opioid treatment options supported by medical evidence.

These overarching principles and concerns have guided the AMA in calling for pain-related policies and practices that do more than simply promote, prioritize or pay for minimizing prescription opioid prescribing. Such restrictive policies not only run the risk of undertreating pain, but they may lead to sub-optimal outcomes, increased stigma and ongoing barriers to care.¹ AMA advocacy, therefore, strongly supports efforts focused on health insurance plans, PBMs and other payer policies to be changed and aligned to support comprehensive multimodal, multidisciplinary and restorative pain care. This includes removing administrative and financial barriers (e.g., prior authorization, inappropriate specialty tiering in formularies, prohibitive cost-sharing), as well as supporting payment policies that will promote optimal pain care. Despite recognition among the medical and patient community, these barriers remain pervasive and harm patients.

The U.S. Department of Health and Human Services (HHS) Interagency Pain Care Task Force reported in 2019 that, “multidisciplinary, multimodal approaches to acute and chronic pain are often not supported in time and resources, leaving clinicians with few options to treat often challenging and complex underlying conditions.”² The report also found that:

The recent advent of retail pharmacies limiting the duration of prescriptions, making changes to dosage, amounts, or placing restrictive barriers to obtaining properly prescribed pain medications has had the unintended consequence of limiting access to pain care. Without access to sufficient pain care, many patients face unnecessary medical complications, prolonged suffering, and increased risk for psychiatric conditions.

The AMA is deeply concerned that corporate and retail pharmacy and PBM practices are having the unintended consequence of limiting access to pain care—leading to medical complications, heightened stigma and increased pain. These combined payer, pharmacy chain and PBM policies need further investigation and rescission to help ensure patients with pain can receive the type of comprehensive, multidisciplinary, multimodal care that pain experts support, and patients deserve. This applies to a broad range of evidence-based restorative therapies, interventional procedures, behavioral health approaches and complementary and integrative health strategies. More than 90 percent of pain medicine specialists said that they have been required to submit a prior authorization for non-opioid pain care—with them and their staff spending hours per day on these requests.³

The AMA Opioid Task Force (Task Force) broadly supports access to the treatments prescribed and recommended by a patient's physician for pain-related care. The Task Force included, among its first recommendations, support for physicians who treat patients with pain. The Task Force recommended support for patients' and physicians' access to comprehensive, affordable, compassionate treatment, including a comprehensive, multidisciplinary, multimodal approach to pain management. The Task Force emphasized that, "[t]his means that payers and employers need to improve access to non-opioid and non-pharmacologic treatment for pain."⁴

The Task Force furthered its 2015 recommendation on comprehensive pain care in 2019, urging additional action by policymakers. The recommendation emphasized the need to, "[r]emove administrative and other barriers to comprehensive, multimodal, multidisciplinary pain care and rehabilitation programs."⁵ In part, the 2019 recommendation responded to the fact that physicians had reduced opioid prescribing by 33 percent between 2013-18, but many patients receiving opioid therapy—and part of stable, ongoing care—found themselves subject to payer, chain pharmacy, PBM and state legislative policies that either strongly encouraged or required quantity and/or dosage restrictions on opioid analgesics.

The AMA Pain Care Task Force (PCTF) was formed in 2018 with a goal of identifying a set of priorities for improving pain care that are actionable and that will potentially provide opportunities for collaborative action. The PCTF has prepared a manuscript for publication later this year that describes many of the barriers to effective, high quality and evidence-informed care for patients with pain. Policy and payer issues, workforce and training challenges, legal issues, research challenges, stigma and patient beliefs and expectations all contribute to the barriers physicians and patients experience and are explored in the document. The PCTF also has documented principles for evidence-informed pain management. Additionally, the PCTF continues to be engaged in conversations related to education of physicians along their continuum on issues relevant to the intersection of pain care, opioids, and addiction.

There is no question that the nation's physicians have reduced opioid analgesic supply—both in volume and dose strength—but there has not been a concomitant increase in access to or affordability of evidence-based non-opioid alternatives. This includes medication, including non-opioid pain relievers, anticonvulsants, antidepressants, musculoskeletal agents, anxiolytics, as well as opioid analgesics when appropriate. It includes restorative therapies such as physical therapy, occupational therapy, physiotherapy, therapeutic exercise, osteopathic manipulative therapy (OMT) and other modalities such as massage and therapeutic ultrasound. It also includes interventional procedures, such as neuromodulation, radio frequency ablation, peripheral nerve stimulation, central and peripheral nerve ablation, spine surgery and steroid injections and other emerging interventional therapies as part of the multimodal pain care plan.

The Board notes that these are among the therapies pain specialists use but are routinely subject to prior authorization and other utilization management protocols imposed by payers.⁶ In urging the U.S. Centers for Disease Control and Prevention to help reduce payer-imposed barriers to comprehensive pain care, AMA Executive Vice President and CEO, James L. Madara, MD, explained that, "[i]t is challenging for physicians to be directed by the federal government to increase access to nonopioid pain care options when payers and PBMs make that difficult, to impossible, to achieve."⁷

As the above discussion makes clear, the AMA already strongly supports broad access to the types of therapies called for under both the original resolutions and the referred resolves. The Board notes that the policy approved by the HOD at A-19 were a direct response to avoiding having AMA policy focus too narrowly on one type of therapy. The Board is concerned that in focusing too intently on one type of therapy, it potentially raises the risk of excluding other types of non-opioid pain care as part of AMA advocacy. For example, if a payer decided to remove prior authorization and other barriers to the therapies in the referred resolves, they could argue that they have satisfied AMA policy without enhancing access to the much more robust areas of non-opioid pain care used by physicians.

In addition to the overly narrow focus on specific therapies in the referred resolves, the Board also is concerned by the overly vague nature of “coverage,” as it is presented in the referred resolves. It is not clear from the testimony or the language of the resolves referred precisely what is meant by “coverage” as that is a term of art used by CMS. Specifically, CMS has processes for the development of National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), both of which require extensive levels of evidence and consideration by CMS.⁸ There also is separate CMS policy and processes for trials of a particular service. It is far beyond the scope of this report to delve into whether the procedures named in the referred resolves have the requisite levels of outcomes data, evidence and other criteria needed by CMS as part of the NCD, LCD or other coverage determination. Thus, while the Board supports the underlying intent of the original resolutions and the referred resolves to help ensure patients have access to the therapies recommended by their physician, and the Board would almost certainly support actions by CMS to remove barriers to those therapies, the Board is not aware that CMS has been presented with applications or other information as part of an NCD or LCD. It is challenging, to say the least, to suggest that the AMA should support an NCD or LCD without having access to the data and other information required by CMS. This is not to suggest that the AMA does not support patients receiving those therapies, but it is premature to suggest AMA support for a specific NCD or LCD for a specific therapy at this time.

The Board’s recommendation to not adopt the referred resolves does not limit AMA advocacy for increasing access to non-opioid pain care. This is due to the fact that the policies adopted by the HOD in lieu of original resolutions 218 and 235 encompass the underlying intent of the referred resolves. This is also due to the fact that additional AMA policies outlined below, as well as ongoing AMA advocacy, demonstrate AMA already advocates for a broad range of non-opioid pain care access for patients. The AMA does not and should not favor one evidence-based option over another, which is what the referred resolves are asking the AMA to do. Accordingly, to help ensure AMA advocacy and programmatic efforts continue to support all physicians who treat patients with pain, it is recommended that the resolves referred be not adopted.

AMA POLICY

As discussed thoroughly above, AMA has comprehensive policy in support of ensuring patients have access to the pain care therapies and modalities recommended by their physician. This includes advocating for, “increased access and coverage of non-opioid treatment modalities including pharmaceutical pain care options, interventional pain management procedures, restorative therapies, behavioral therapies, physical and occupational therapy, and other evidence-based therapies recommended by the patient’s physician,” as well as, “non-opioid treatment modalities being placed on the lowest cost-sharing tier for the indication of pain so that patients have increased access to evidence-based pain care as recommended by the HHS Interagency Pain Care Task Force. (Policy H-120.922, “Improved Access and Coverage to Non-Opioid Modalities to Address Pain”)

Similar AMA policy stresses, “ensuring access to multiple analgesic strategies, including non-opioid options and interventional approaches when appropriate, with a focus on achieving improvement in function and activities of daily living.” (Policy H-185.931, “Workforce and Coverage for Pain Management”) Notably, AMA policy supports, “health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits.” (Policy H-185.931, “Workforce and Coverage for Pain Management”)

Interventional chronic pain management means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing sub-acute, chronic, persistent and intractable pain. The practice of pain management includes comprehensive assessment of the patient, diagnosis of the cause of the patient's pain, evaluation of alternative treatment options, selection of appropriate treatment options, termination of prescribed treatment options when appropriate, follow-up care, the diagnosis and management of complications and collaboration with other health care providers.

When AMA policy does discuss invasive pain management procedures or techniques—unlike the referred resolves—AMA policy appropriately provides for a wide range, including but not limited to “ablation of targeted nerves; procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves, including percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics, steroids, and analgesics, in the spinal column under fluoroscopic guidance or any other radiographic or imaging modality; and surgical techniques, such as laser or endoscopic discectomy, or placement of intrathecal infusion pumps, and/or spinal cord stimulators.” (Policy H-410.950, “Pain Management”)

RECOMMENDATION

The Board recommends that the referred resolves in Alternate Resolution 218-A-19 not be adopted and the remainder of the report be filed.

REFERENCES

1. The Board notes that the AMA Opioid Task Force has received hundreds of emails and other communication from patients who have been nonconsensually tapered from their current opioid analgesic regimen. The communications also include patients who have not been able to find a physician willing to prescribe opioid analgesics due to fear from investigation or prosecution. In all cases, it is clear to the Board that patients across the country face increased pain and suffering due to misapplication of opioid sparing policies, stigmatization of chronic pain and fear of providing opioid-based pain therapy.
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7. AMA letter to Deborah Dowell, MD, MPH, Senior Medical Advisor/Chief Medical Officer, Division of Unintentional Injury Prevention, U.S. Centers for Disease Control and Prevention. James L. Madara, MD. October 29, 2019. Available at <https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2019-10-29-Letter-to-Dowell-Compton-Giroir.pdf>
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9. MEDICAL MARIJUANA LICENSE SAFETY (Resolution 219-A-19)

Reference committee hearing: see report of Reference Committee B.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 219-A-19
REMAINDER OF REPORT FILED
*See Policy D-95.959***

INTRODUCTION

At the 2019 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 219-A-19, “Medical Marijuana License Safety,” introduced by the Oklahoma delegation, which asked:

That our American Medical Association draft model state legislation to amend states’ prescription drug monitoring programs to include a medical marijuana license registry.

Testimony on Resolution 219 raised numerous issues, including increasing legalization of medical and recreational cannabis; concerns about cannabis use by patients with—or without—a physician’s knowledge; how medical marijuana license registries function in select states; and the potential intersection with and appropriate role(s) of a state prescription drug monitoring program (PDMP). This report provides relevant background and discussion, a review of relevant AMA policy and makes policy recommendations.

BACKGROUND

It is likely that any patient who sees a physician will be asked for a current list of any medications, supplements, herbal remedies or other substances being taken. This information is essential to ensure the physician has complete and accurate information that may be relevant to a patient's diagnosis and treatment options for any given ailment or disease.

The U.S. Food and Drug Administration (FDA) is charged with, among other things, reviewing new drug applications, including making recommendations about a drug's scheduling. The U.S. Drug Enforcement Administration (DEA) receives that recommendation and is charged with determining the drug's schedule or changing an existing drug's schedule. Cannabis (also referred to as marijuana or marihuana by DEA), contains the active ingredient delta-9-tetrahydrocannabinol (THC) and is a Schedule I controlled substance.¹ This means that under federal law, there is "no currently accepted medical use in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse." Other Schedule I substances include heroin, LSD, peyote, methamphetamine and Ecstasy.²

In testimony to Congress earlier this year, Douglas Throckmorton, MD, Deputy Director, Center for Drug Evaluation and Research, FDA, explained that the FDA has approved four products containing cannabinoids: Epidiolex (standardized, plant derived cannabidiol (CBD)), Marinol (dronabinol, synthetic THC), Syndros (dronabinol), and Cesamet (nabilone, a synthetic THC derivative). These approved drug products are only available with a prescription from a licensed health care provider. Importantly, FDA has not approved any other cannabis, cannabis-derived or CBD products.

According to the National Conference of State Legislatures, more than 30 states allow for marijuana use by persons with certain medical conditions and an additional 14 states allow for recreational use of marijuana by adults.³ In the "medical marijuana"⁴ states, 29 states provide for the establishment of a patient registry and/or identification card, three states' provisions are pending and Washington does not have such a provision.⁵ With respect to patient registries in "medical marijuana" states, it is common for states to require a considerable amount of personally identifiable information and other information, which may be made available to law enforcement and others. For example:

- California established a voluntary, web-based registry to allow law enforcement and the general public to verify the validity of a medical marijuana identification card for a patient. The registry is maintained by the California Department of Public Health.⁶
- Colorado's web-based registry allows patients to apply for an identification card as well as allows so-called "medical marijuana centers" to check whether a card has been revoked. It also has functionality to allow law enforcement to verify a card's validity among other features.⁷
- Ohio patients seeking medical marijuana must first have a certified physician submit information to the registry—after which the patient will receive an email prompting the patient to complete their application and pay a \$50 fee.⁸
- North Dakota's patient registry requires patients to apply online, including uploading a photo, in which the state requires eyes to be open and indicates further that applicants should, "[a]void wearing dark, tinted glasses, hats or head coverings when taking the photo."⁹

These examples are not meant to be representative of all patient registries. Most patient registries also include information about whether the patient has a qualifying medical condition, which might include AIDS, amyotrophic lateral sclerosis, Alzheimer's disease, cancer, chronic traumatic encephalopathy, Crohn's disease, epilepsy or another seizure disorder, fibromyalgia, glaucoma, hepatitis C, inflammatory bowel disease, multiple sclerosis, pain that is either chronic and severe or intractable, Parkinson's disease, positive HIV status, post-traumatic stress disorder, sickle cell anemia, spinal cord disease or injury, Tourette's syndrome, traumatic brain injury and/or ulcerative colitis.

Nearly every state has a PDMP¹⁰ that includes information about controlled substances dispensed to patients, as well physicians' and other health care professionals' controlled substances prescribing history. The pharmacist (or other dispenser) is typically required to submit certain information to the PDMP, as well. This typically includes a patient's name, date of birth, address, contact information, physician's DEA registration or National Provider Identifier, dose and quantity of the prescription and potentially a wide variety of information ranging from the site from which the prescription was issued, type of identification and whether the prescription was for a human or animal subject.¹¹

Nearly every state has the ability to share PDMP data across state lines.¹² Nearly all PDMPs are administered by the state board of pharmacy. While there is some variation in state law and policy, most state PDMPs contain Schedule II-V information. This information is generally viewed as helpful clinical information for health care professionals. Encouraging physicians to register for and use state PDMPs when clinically indicated was one of the first recommendations of the AMA Opioid Task Force (the Task Force) in 2015.¹³

DISCUSSION

Most physicians agree that PDMPs have the capability to provide relevant clinical information for physicians and other health care professionals as part of the clinical decision-making process. The Task Force identified many of the useful features of a state-based PDMP in its first recommendations in 2015.¹⁴ The Task Force emphasized the need for PDMPs to be integrated into clinical workflow, including having the PDMP data easily accessible in the electronic health record (EHR) without having to perform multiple clicks, enter multiple passwords, close and open multiple screens and other time-consuming barriers to PDMP use. While this has occurred in some settings, and is improving in others, it is not the norm.

Despite the barriers to PDMP use, registration and use of state-based PDMPs has significantly increased. Registration increased to nearly 2 million physicians and other health care professionals in 2019—almost a 300 percent increase from 2014; and PDMP queries have increased more than 1,100 percent during the same time period to more than 739 million.¹⁵ It is worth noting that while most states now have a legislative mandate to use a PDMP in certain circumstances, voluntary PDMP registration and use began to increase prior to those mandates taking effect.

What is less clear, however, is whether the increased registration and use has led to improved patient outcomes, reduced opioid- and drug-related mortality, an increase in referrals for treatment of a substance use disorder or any other potential benefits of a PDMP.¹⁶ It is also not clear whether any state PDMP already includes information regarding cannabis use. As noted above, with only four exceptions, cannabis, cannabis-derived and cannabinoid products remain Schedule I controlled substances and are not included in any state PDMP law. Resolution 219-A-19 is accurate in the assumption that state laws would need to be changed to allow for a Schedule I controlled substance to be part of the information captured into a state PDMP.

Another possibility is to somehow merge the information that is contained in a medical marijuana patient registry with a state PDMP. The technical aspects of such an endeavor are beyond the scope of the report, but even a cursory review of state PDMPs and medical marijuana patient registries reveals that the underlying software development and database management appear to be different in most states, including the fact that the state pharmacy board is typically not the state agency that administers the medical marijuana patient registry.

In addition, it is not clear if merging PDMPs and medical marijuana patient registries would further allow law enforcement to make inquiries into a state PDMP. Not only does this raise potential conflicts with AMA policy as detailed below, but it is unclear what precisely would be entered into the PDMP. Proponents of including medical marijuana registry information suggest that physicians should have information that a patient has registered for and received authorization to possess, obtain or purchase medical marijuana. On the surface, this sounds like a reasonable position.

Data does not exist, however, on how law enforcement currently uses medical marijuana patient registry information. Data also does not exist on what physicians might do with this information. The AMA Board of Trustees (the Board) is concerned that adding more information to a state PDMP without appropriate safeguards to ensure patient privacy could expose patients' personal health information to law enforcement in ways that could be detrimental. The mere existence of a patient's registration for medical marijuana should not be used as pretext for law enforcement to conduct unfettered searches in a patient's or physician's PDMP record.¹⁷

In addition to the concerns around increased law enforcement access to a PDMP, the Board notes that the existence of opioid prescriptions in a patient's PDMP report has resulted in myriad complications for patients, including non-consensual tapering, reports of physicians no longer prescribing opioids to such patients and patients subsequently not being able to find a physician willing to provide opioid therapy. Given that use of a legitimate medical prescription has become subject to intense scrutiny, stigma and negative consequences, the Board is concerned that adding information about a patient's authorization to use a Schedule I controlled substance could lead to similar negative consequences.

The other side to this argument is that medical diagnosis, treatment and management of disease are improved when the physician has access to all relevant information about his or her patient. This certainly includes whether a patient is using cannabis for medicinal or recreational use, as well as whether a physician has certified that a patient has one or more of the medical conditions that a state has determined qualify the patient to use cannabis for medicinal purposes. Data is not clear as to whether a patient's primary care physician is the one who is typically certifying the patient. If not, what happens when the primary physician—if reviewing new medical marijuana patient registry data—newly discovers that the patient has been certified for a serious medical condition? What effect(s) would this have on the patient-physician relationship? In addition to the above concerns, the Board notes that there is nothing currently preventing a physician from asking about these issues and that a fully functioning EHR could help resolve incomplete information about the patient's medical history.

While EHRs continue to improve, full integration with PDMPs remains a work-in-progress. In addition, the challenges with data integration would likely be increased significantly given that medical marijuana patient registry data are housed in agencies separate from those administering state PDMPs. It also is not clear what data would be integrated into a state PDMP from the registry. What would law enforcement's access be? Do the potential unintended consequences of listing patient's certification for medicinal cannabis outweigh the potential benefits for the physician and other health care professionals knowing that a patient has been certified? These are among the many questions for which clinical experience, medical evidence and objective data do not exist. Therefore, while the Board supports efforts to ensure physicians have all relevant information about their patients' potential use of cannabis for medicinal use, based on the above discussion and potential unintended consequences, it is premature to recommend developing model legislation.

AMA POLICY

AMA policy on the use of cannabis for medicinal use provides well-established balance for patient safety, autonomy and assurances for free and unfettered communication between the patient and his or her physician (Policy D-95.969, "Cannabis Legalization for Medicinal Use").

With appropriate patient privacy safeguards, the AMA also has strongly advocated in support of PDMPs sharing information on prescriptions for controlled substances among states (Policy H-95.947, "Prescription Drug Monitoring to Prevent Abuse of Controlled Substances"). This includes strong support for having PDMPs administered by, "a state agency whose primary purpose and mission is health care quality and safety rather than a state agency whose primary purpose is law enforcement or prosecutorial," to help ensure the information "is protected from release outside of the health care system" (Policy H-95.946, "Prescription Drug Monitoring Program Confidentiality").

The AMA has advocated for the benefits of PDMPs and "supports the voluntary use of state-based prescription drug monitoring programs (PDMP) when clinically appropriate." Recognizing the workflow challenges, however, AMA policy simultaneously, "encourages states to implement modernized PDMPs that are seamlessly integrated into the physician's normal workflow, and provide clinically relevant, reliable information at the point of care" (Policy H-95.939, "Development and Promotion of Single National Prescription Drug Monitoring Program").

RECOMMENDATIONS

The Board recommends that the following be adopted in lieu of Resolution 219-A-19 and the remainder of the report be filed.

1. That our American Medical Association (AMA) support efforts to include medical cannabis license certification in states' prescription drug monitoring programs when consistent with AMA principles safeguarding patient privacy and confidentiality.
2. That our AMA continue its monitoring of state legislation relating to the inclusion of cannabis and related information in state PDMPs.
3. That our AMA review existing state laws that require information about medical cannabis to be shared with or entered into a state prescription drug monitoring program. The review should address impacts on patients, physicians and availability of information including types, forms, THC concentration, quantity, recommended usage, and other medical cannabis details that may be available from a dispensary.

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3. State Medical Marijuana Laws. National Conference of State Legislatures. Last updated Oct. 16, 2019. Available at <https://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx>
4. Disclaimer: While AMA policy makes a clear distinction between cannabis for medicinal use and the recreational use of marijuana, for the purposes of this report, “medical marijuana” will be used throughout as it is how state policy commonly uses the term to refer to cannabis for medicinal use.
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7. Colorado Department of Health & Environment. Medical Marijuana Registry. Available at <https://www.colorado.gov/pacific/cdphe/medicalmarijuana>
8. Ohio Medical Marijuana Control Program “How to obtain medical marijuana.” <https://www.medicalmarijuana.ohio.gov/>
9. North Dakota Medical Marijuana Program. Patient Application Instructions. Available at <https://mmregistration.health.nd.gov/static/web/InstructionsPatients.pdf>
10. While Missouri (at the time of this report was written) does not have a statewide PDMP, St. Louis County operates a PDMP that was “launched in 2017 with 14 participating jurisdictions. Currently, 75 jurisdictions are participating in the program, and these 75 jurisdictions cover 85% of the state’s population.” Last accessed February 14, 2020. <https://pdmp-stlcogis.hub.arcgis.com/>
11. See, for example, Appendix A of the “Michigan Automated Prescription System Data Submission Guide for Dispensers.” Available at https://www.michigan.gov/documents/lara/MI_Data_Submission_Dispenser_Guide_v2.3_656381_7.pdf
12. National Association of Boards of Pharmacy PMP Interconnect®. <https://nabp.pharmacy/initiatives/pmp-interconnect/>
13. See AMA Opioid Task Force fact sheet. “Thinking of prescribing an opioid? Did you check your state prescription drug monitoring program? 2015. Available at <https://www.end-opioid-epidemic.org/wp-content/uploads/2017/05/15-0398-opioid-one-physician.pdf>
14. AMA Opioid Task Force. “Thinking of prescribing an opioid? Did you check your state prescription drug monitoring program?” 2015. Available at <https://www.end-opioid-epidemic.org/wp-content/uploads/2017/05/15-0398-opioid-one-physician.pdf>
15. Fact sheet: Physicians’ and health care professionals’ use of state prescription drug monitoring programs surpass 739 million queries—more than 10 times the queries in 2014. AMA Opioid Task Force. <https://end-overdose-epidemic.org/wp-content/uploads/2020/07/AMA-Fact-Sheet-PDMP-use-and-registration-increase-2014-2019-FINAL.pdf>
16. It is beyond the scope of this report to detail the research, data and other information concerning effects of PDMPs, but this is an area well-discussed in previous BOT reports, including BoT Report 30-A-19; BoT Report 7-I-18; BoT Report 12-A-18; BoT Report 13-A-17; and BoT Report 3-I-16
17. See, for example. CMA tells California Supreme Court it must protect patient data in CURES. November 2, 2015. November 02, 2015. <https://www.cmadoes.org/newsroom/news/view/ArticleId/27453/CMA-tells-California-Supreme-Court-it-must-protect-patient-data-in-CURES>. The AMA joined CMA in filing an amicus brief emphasizing that patients have a basic right to privacy of their medical information and records. The AMA and CMA argued that access to PDMPs by non-health care individuals should be limited to those instances in which there is probable cause that an unlawful act or a breach of the standard of care may have occurred.

10. PHYSICIAN ACCESS TO THEIR MEDICAL AND BILLING RECORDS (Resolution 226-A-19)

Reference committee hearing: see report of Reference Committee B.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 226-A-19
REMAINDER OF REPORT FILED
*See Policy D-315.971***

INTRODUCTION

At the 2019 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) considered Resolution 226, “Physician Access to their Medical and Billing Records,” introduced by the New York Delegation, which asked:

1. The American Medical Association (AMA) advocate that licensed physicians must always have access to all medical and billing records for their patients from and after date of service including after physician termination.
2. The AMA press for legislation or regulation to eliminate contractual language that bars or limits the treating physician's access to the medical and billing records such as treating these records as trade secrets or proprietary.

The HOD heard positive testimony that the AMA has strong policy regarding physician access and management of medical records. Also, testimony was given that the AMA has model state legislation regarding physician employment including a provision that a "physician is entitled to copies of patient charts and any other records relating to the physician's provision of physician services." The Council on Legislation (COL) testified, however, that the COL is currently examining issues surrounding data ownership and stewardship. AMA policy is limited in scope to the physician-patient relationship and a paradigm shift is occurring where patient information is being viewed as a patient-centered concept and information from outside of the physician-patient relationship is growing. Additionally, the COL testified that the first resolve is too broad because a patient may not want a physician to have access to or share all of the patient's medical and billing information for unrelated care that occurs outside of a specific physician-patient relationship. As a result, Resolution 226 was referred.

DISCUSSION

Resolution 226 raises very significant concerns regarding potential physician liability for non-compliance with federal and state laws regarding claims for payment submitted on behalf of the physician. For example, as the Office of the Inspector General of the U.S. Department of Health and Human Services stated, "Physicians should remember that they remain responsible to the Medicare program for bills sent in the physician's name or containing the physician's signature, even if the physician had no actual knowledge of a billing impropriety."¹ Accordingly, AMA policy states that: "Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct."² A physician's inability to access billing records and associated medical records sufficient to monitor compliance with legal and other requirements can potentially expose the physician to severe penalties.

Resolution 226 First Resolve

Given the importance of the issues that Resolution 226 raises, the Board of Trustees (Board) believes that the AMA should engage in advocacy that addresses these issues, with a few qualifications. One qualification concerns the breadth of the advocacy to which the first resolve would commit the AMA. As reference committee testimony noted, the first resolve would require the AMA to advocate that physicians have access to all of a patient's medical and billing records. A patient may not want a physician to have access to or share all of their medical and billing information for unrelated care that occurs outside of a specific physician-patient relationship. The Board agrees with this testimony. Accordingly, the Board recommends that the AMA advocate that physicians have access to their billing records and associated patients' medical records, but not that physicians have access to *all* of those records. The records should also include any billing records submitted under the physician's name, regardless of whether the physician directly provided the item or service.

Although the Board obviously believes that physicians must always have immediate access to the medical records of patients under their care, the Board does not recommend that the AMA advocate that physicians must always have access to their billing records and associated medical records. Instead, the Board recommends that, following Medicare reassignment regulations, the AMA should advocate that physicians have "unrestricted access" to their billing records and related medical records. Medicare reassignment regulations require an entity, e.g., physician practice or hospital, that submits claims on a physician's behalf give the physician unrestricted access to those claims.³ The Board recommends this approach for two reasons.

First, while the Centers for Medicare and Medicaid Services (CMS) has provided at least some informal guidance concerning what "unrestricted access" means, the first resolve does not define "always." Taken literally, if the HOD adopted the first resolve as written, "always" could be read to require the AMA to advocate that entities, e.g., physician practices, must give employed and contracted physicians immediate access to their billing records and associated medical records at all times. Such an access requirement would likely impose a significant and unnecessary

administrative burden on at least some physician practices or other physician-led entities. In contrast, CMS informally interprets “unrestricted access” to mean that an entity may not reasonably refuse or delay access to billing records. CMS has declined to define how quickly an entity must give the physician access to his or her billing records after receiving a request, or when an entity may reasonably refuse to provide access, e.g., when a physician already has the records.⁴ Instead, CMS suggests that entities use “common sense.”⁵ Although CMS’ interpretation of “unrestricted access” may not be highly specific, it does appear to provide more direction for AMA advocacy than “always,” allows for flexibility and is thus not as likely to impose as great an administrative burden on physician practices or other physician organizations as the undefined term “always” might have.

Second, requiring the AMA to advocate for an access standard other than “unrestricted access” could subject physician practices to an additional administrative burden. Medicare’s “unrestricted access” requirement has been in place for independent physician contractors since 2004 and physician employees since 2006.⁶ Physician practices and other physician-led organizations may have long-standing policies and procedures in place delineating how their organizations comply with the unrestricted access requirement. Asking the AMA to advocate for an access different from the Medicare’s regulation could require some practices and physician-led organizations to rewrite long-standing policies and procedures that have worked well for many years.

Finally, the first resolve asks the AMA to advocate that licensed physicians always have access to all medical and billing records for their patients...including after termination. The Board does not believe that the AMA should advocate that entities like physician practices and physician-led organizations incur the administrative burden of an unlimited obligation to provide billing records to physicians after employment or an independent contract has ended, e.g., merely upon request of the physician. Instead, the Board recommends that the AMA adopt policy stating that, after termination of employment or other contractual arrangement, physicians should be given access to their billing records and associated medical records analogous to AMA policy with regard to post-termination access to patient medical records. Policy H-225.950 “AMA Principles for Physician Employment,” states in part:

Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician’s defense in malpractice actions, administrative investigations, or other proceedings against the physician.⁷

Absent state law or a patient request, Policy H-225.950 does not state that after termination, the physician should be given access to all of his or her patients’ medical records. Instead, the physician should be given patient medical records when necessary for the physician’s defense in malpractice actions, administrative investigations or other proceedings against the physician. The Board recommends adopting new policy taking a similar approach, namely, that a physician employer or other entity that bills on behalf of an employed or contracted physician should, post-employment or contract, be obligated to provide the physician with his or her billing records when necessary to defend malpractice actions, administrative investigations or other proceedings against the physician. Taking this approach would reduce the burden that an open-ended obligation might create for physician-owned or led entities and be consistent with existing AMA policy.

Resolution 226 Second Resolve

With regard to the second resolve, the Board agrees that the AMA should advocate that medical records and billing records should not be kept from a physician on the grounds that those records are proprietary or constitute trade secrets. This is particularly true given the physician’s need to ensure compliance with fraud and abuse laws, which outweigh any countervailing concerns regarding privilege or secrecy.

Model State Legislation

The Board has adopted state model legislation entitled the “Physician Access to Medical and Billing Records Act” to advocate as outlined in this board report. Any AMA member can access this model bill by e-mailing arc@ama-assn.org.

AMA POLICY

The AMA has several policies addressing issues that Resolution 226 raises. Policy H-190.971, “Physicians’ Right to Receive Billing and Remittance Information,” states that all physicians are entitled to receive detailed itemized billing and remittance information for medical services they provide, and that the AMA develop strategies to assist physicians who are denied such information. Policy H-225.950, “AMA Principles for Physician Employment,” advises that employers should indemnify, defend and save harmless, employed physicians with respect to any violation of law or regulation, or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee. Policy H-385.939, “Hospital Billing on Behalf of Physicians,” requires that our AMA: (1) advocate that personnel performing diagnostic and procedural coding of physicians' services provide that information, including itemized billing information, collection rates, procedures, and remittance information, to those physicians providing the coded services; (2) urge physicians to participate in the processes used by entities submitting claims for and receiving payment on behalf of physicians; (3) urge that any entity billing for physicians' services ensure that, when a physician's choice of CPT code has been changed, the physician be so notified and the recoder identified before submission of a bill; (4) encourage physicians to carefully evaluate their billing procedures upon selling their practice or contracting for billing services; (5) encourage physicians to establish billing practice policies and billing compliance programs that include monitoring and reviewing billing accuracy; and (6) encourage physicians who sell their practice or contract out billing services to establish a mechanism for continually reviewing the collection methods and procedures of the billing entity.

RECOMMENDATIONS

In light of these considerations, the Board recommends that the following be adopted in lieu of Resolution 226-A-19 and the remainder of this report be filed:

1. That our AMA advocate that licensed physicians have unrestricted access to all their patients’ billing records and associated medical records during employment or while under contract to provide medical or health care items or services. The records should also include any billing records submitted under the physician’s name, regardless of whether the physician directly provided the item or service.
2. That our AMA advocate that, where physician possession of all his or her billing records is not already required by state law, the employment or other contractual arrangement between a physician and entity submitting claims on behalf of the physician should specify that the physician is entitled to copies of his or her billing records subsequent to the termination of employment or contractual arrangement, when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.
3. That our AMA advocate for legislation or regulation to eliminate contractual language that bars or limits the treating physician’s access to his or her billing records and associated medical records, such as treating these records as trade secrets or proprietary.

REFERENCES

1. Federal Register 65:194 (October 5, 2000) pages 59447- 59452
2. AMA Principles for Physician Employment H-225.950
3. 2 CFR § 424.80(d)(2)
4. Federal Register 71:231 (December 1, 2006) page 69689
5. Id.
6. Federal Register 69:219 (November 15, 2004) pages 66314-66318; Federal Register 71:231 (December 1, 2006) pages 69688-69689
7. AMA Policy H-225.950 AMA Principles for Physician Employment (3)(d)

RELEVANT AMA POLICY

Policy H-190.971, “Physicians' Right to Receive Billing and Remittance Information”

AMA policy is that all physicians are entitled to receive detailed itemized billing and remittance information for medical services they provide, and that the AMA develop strategies to assist physicians who are denied such information.

Policy H-225.950, “AMA Principles for Physician Employment”

1. Addressing Conflicts of Interest

- a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
- b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.
- c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
- d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
 - (i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and
 - (ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.
- e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession

- a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
- b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting

- a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.
- b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.
- c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.
- d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.
- (e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.

(f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.

(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.

(h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.

b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.

c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.

b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.

c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.

d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.

e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.

(f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:

i. The agreement is for the provision of services on an exclusive basis; and

ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and

iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements

a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

The AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

Policy H-385.939 "Hospital Billing on Behalf of Physicians"

The AMA:

- (1) advocates that personnel performing diagnostic and procedural coding of physicians' services provide that information, including itemized billing information, collection rates, procedures, and remittance information, to those physicians providing the coded services;
- (2) urges physicians to participate in the processes used by entities submitting claims for and receiving payment on behalf of physicians;
- (3) urges that any entity billing for physicians' services ensure that, when a physician's choice of CPT code has been changed, the physician be so notified and the recoder identified before submission of a bill;
- (4) encourages physicians to carefully evaluate their billing procedures upon selling their practice or contracting for billing services;
- (5) encourages physicians to establish billing practice policies and billing compliance programs that include monitoring and reviewing billing accuracy; and
- (6) encourages physicians who sell their practice or contract out billing services to establish a mechanism for continually reviewing the collection methods and procedures of the billing entity.

11. NATIONAL GUIDELINES FOR GUARDIANSHIP (Resolution 17-A-19)

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

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 17-A-19
REMAINDER OF REPORT FILED**
See Policies H-25.998, H-515.961 and D-515.984

At the 2019 Annual Meeting, the House of Delegates (HOD) referred Resolution 17-A-19, "National Guidelines for Guardianship" to the Board of Trustees for report. Resolution 17-A-19, introduced by the Medical Student Section, asked that our American Medical Association (AMA) collaborate with relevant stakeholders to advocate for federal creation and adoption of national standards for guardianship programs, appropriate program funding measures, and quality control measures.

The reference committee heard limited testimony related to this resolution. One speaker lauded the intent of the resolution but expressed concern regarding the complexity of the issue and the need for further study. Testimony was also heard characterizing the resolution as too non-specific in its request. The reference committee recommended that Resolution 17-A-19 be referred.

The resolution raises vital issues regarding adult guardianship and protection of the elderly. This report presents the current federal and state regulatory framework for laws governing guardianship proceedings, the existing funding and support for programs and education, investigations of suspected elder abuse, and the agencies, associations and commissions that champion these issues. This report analyzes the existing body of AMA policy and *Code of Medical Ethics* opinions and evaluates the adequacy of existing governmental and non-governmental initiatives.

DISCUSSION

The resolution focused on the need to assure accountability, safety and transparency in the guardianship process in order to reduce the potential for abuse. Jurisdiction over the guardianship process is within the purview of each state's court system and relevant state social services and administrative agencies. The obstacles for health care providers in seeking guidance in a patchwork of state laws are evident. However, numerous programs address these obstacles, and several are discussed here.

The “Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act”

The most ambitious and effective effort to address the inconsistency in state guardianship laws has been undertaken by the National Conference of Commissioners on Uniform State Laws, also known as the Uniform Law Commission (the ULC). The ULC drafted the “Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act” (the [Act](#)). Drafted and recommended by the ULC for enactment in all states, the Act has been adopted in 49 states.

The Act provides states with non-partisan, well-conceived model legislation that brings consistency and stability to this critical area of state law. Jurisdiction of guardianship statutes requires clarity, and the Act addresses the problems of multiple jurisdictions, transfer across state lines, out of state recognition of proceedings and interstate enforcement. In addition, the Act facilitates monitoring of guardian relationships by requiring the court’s ability to monitor the guardian as a criterion when adjudicating a guardianship matter. The Act also establishes registration procedures to aid in notification and monitoring of abuse, facilitates cross-border court communication and authorizes a court to order an investigation in another state. Not only does the Act provide a national standard for guardianship programs, it also serves to reduce elder abuse by facilitating improved court monitoring and enforcement guidelines.

The Department of Justice and the American Bar Association Commission on Law and Aging

In 2001, the U.S. Department of Justice (Justice Department) funded the American Bar Association’s [Commission on Law and Aging](#) (the ABA Commission) to provide seed funding for a variety of initiatives. One such initiative was coordination of the development of Elder Abuse Fatality Review Teams (EAFRT). EAFRTs examine deaths of individuals that may be caused by or related to elder abuse for the purpose of identifying system gaps and improving victim services. Lessons learned from fatality review teams for child abuse and domestic violence victims have shown a positive impact in improving responses to victims. The Justice Department has further supported technical assistance to coordinate the development of EAFRTs and to publish an instruction manual for replication and implementation. With funding from the U.S. Administration on Aging, the ABA Commission subsequently funded additional EAFRTs through the National Center on Elder Abuse.

In 2017, the Justice Department awarded funding to the ABA Commission and several other organizations for numerous programs and research dedicated to the fight against elder abuse and financial exploitation. The funding has enabled the ABA Commission to build upon the foundational EAFRT model by expanding its initial capacity and evaluating the impact of EAFRTs on victim services. The ABA Commission is currently collaborating with the University of Texas Health Science Center to lead program evaluation activities, establish an expert panel, facilitate information sharing, develop conference presentations and webinars and disseminate products and findings and publish.

By illustration, the ABA Commission’s accomplishments in guardianship issues just for the 2019 calendar year included online training for guardians, developing of an annual state guardianship legislative update, collaborating on numerous webinars on guardianship, and working on projects with state stakeholders in Oregon, Florida, and New York to drive changes in guardianship reform. In addition, the ABA Commission on Law and Aging supports a resource and research library providing comprehensive coverage of standards and guidelines for guardianship matters.

The “Elder Justice Act”

Enacted as part of the Patient Protection and Affordable Care Act, the [Elder Justice Act](#) (EJA) establishes national leadership in the Office of the Secretary of Health and Human Services in the form of an Elder Justice Coordinating Council and Advisory Board. This was the first piece of federal legislation passed to authorize a specific source of federal funds to address elder abuse, neglect and exploitation. The EJA authorizes grants to support improvements in Adult Protective Services, Long-Term Care Ombudsman programs, state survey agencies for Medicare and Medicaid, and grants for the establishment of forensic centers. The EJA also provides funding for programs to promote elder justice through the enhancement of long-term care, and evaluation of elder justice programs.

AMA POLICY

AMA has an extensive body of policy addressing elder mistreatment, the health care costs of violence and abuse, and preventing, identifying and treating abuse. AMA Code of Ethics Opinion 8.10, “Preventing, Identifying and Treating Violence and Abuse,” was issued in 2008 and most recently modified in 2017. The opinion informs of the physician’s

ethical obligation to take appropriate action to avert harm caused by violence and abuse. Physicians are charged with numerous responsibilities regarding diagnosing abuse, knowledge of community and health resources, prevention measures, familiarity with reporting obligations, advocating for training in medical education, providing leadership in raising awareness, and supporting research efforts in this area.

House of Delegates Policy H-515.961, “Elder Mistreatment,” was last modified in 2018 and recognizes elder mistreatment as a pervasive public health issue that requires an organized effort from the medical community to improve recognition and treatment. The policy further advocates for collaboration between the medical team, social services, law enforcement, and the legal system to develop appropriate interventions and evaluation of those interventions. House of Delegates Policy D-515.984, “Health Care Costs of Violence and Abuse Across the Lifespan,” also last modified in 2018, encourages various national agencies to continue to study, conduct research on the cost savings resulting from interventions and to increase funding for research on the impact and costs of elder mistreatment.

CONCLUSION

Your Board recognizes the concerns expressed by those who promulgated Resolution 17-A-19. However, we note that AMA has an established and comprehensive body of policy on the matter. Moreover, several federal initiatives address the resolution’s core concerns. The Affordable Care Act, specifically, the Elder Justice Act, created federal leadership and established programs to promote elder justice. The Uniform Law Commission has enacted model guardianship legislation that has been adopted by 49 states. The American Bar Association Commission on Law and Aging has championed the cause for elder justice for forty years. The Department of Justice and other federal agencies provide funding, and numerous agencies, professional associations, academic medical centers and social service organizations continue to develop initiatives, and research outcomes and effectiveness.

RECOMMENDATIONS

Your Board of Trustees recommends that the following be adopted in lieu of Resolution 17-A-19, and the remainder of this report be filed:

1. That Opinion 8.10, “Preventing, Identifying and Treating Violence and Abuse;” and Policies H-515.961, “Elder Mistreatment;” and H-515-984, “Health Care Costs of Violence and Abuse Across the Lifespan,” be reaffirmed.
2. That our AMA support initiatives by the American Bar Association Commission on Law and Aging and other associations and agencies of the federal government to address elder abuse and to ensure consistent protection of elders’ rights in all states.

APPENDIX - AMA POLICY

E-8.10 Preventing, Identifying and Treating Violence and Abuse. All patients may be at risk for interpersonal violence and abuse, which may adversely affect their health or ability to adhere to medical recommendations. In light of their obligation to promote the well-being of patients, physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse. To protect patients’ well-being, physicians individually should:

- (a) Become familiar with: (i) how to detect violence or abuse, including cultural variations in response to abuse; (ii) community and health resources available to abused or vulnerable persons; (iii) public health measures that are effective in preventing violence and abuse;
- (iv) legal requirements for reporting violence or abuse.
- (b) Consider abuse as a possible factor in the presentation of medical complaints. (c) Routinely inquire about physical, sexual, and psychological abuse as part of the medical history. (d) Not allow diagnosis or treatment to be influenced by misconceptions about abuse, including beliefs that abuse is rare, does not occur in “normal” families, is a private matter best resolved without outside interference, or is caused by victims’ own actions. (e) Treat the immediate symptoms and sequelae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise from being exposed to violence and abuse. (f) Discuss any suspicion of abuse sensitively with the patient, whether or not reporting is legally mandated, and direct the patient to appropriate community resources. (g) Report suspected violence and abuse in keeping with applicable requirements. Before doing so, physicians should: (i) inform patients about requirements to report; (ii) obtain the patient’s informed consent when reporting is not required by law. Exceptions can be made if a physician reasonably believes that a patient’s refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision. (h) Protect patient privacy when reporting by disclosing only the minimum necessary information. Collectively, physicians should:
- (i) Advocate for comprehensive training in matters pertaining to violence and abuse across the continuum of professional education.
- (j) Provide leadership in raising awareness about the need to assess and identify signs of abuse, including advocating for guidelines and policies to reduce the volume of unidentified cases and help ensure that all patients are appropriately assessed. (k) Advocate

for mechanisms to direct physicians to community or private resources that might be available to aid their patients. (l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse. (m) Advocate for change in mandatory reporting laws if evidence indicates that such reporting is not in the best interests of patients.

H-515.961 Elder Mistreatment

Our AMA recognizes: (1) elder mistreatment as a serious and pervasive public health problem that requires an organized effort from physicians and all medical professionals to improve the timely recognition and provision of clinical care in vulnerable elders who experience mistreatment; and (2) the importance of an interdisciplinary and collaborative approach to this issue, and encourage states to bring together teams with representatives from medicine, nursing, social work, adult protective services (APS), criminal and civil law, and law enforcement to develop appropriate interventions and evaluate their effectiveness.

D-515.984 Health Care Costs of Violence and Abuse Across the Lifespan.

1. Our AMA urges the National Academies of Sciences, Engineering, and Medicine to continue to study the impact and health care costs of violence and abuse across the lifespan. 2. Our AMA encourages the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Centers for Disease Control and Prevention to conduct research on the cost savings resulting from health interventions on violence and abuse. 3. Our AMA encourages the appropriate federal agencies to increase funding for research on the impact and health care costs of elder mistreatment.

12. DIRECT-TO-CONSUMER GENETIC TESTS (Resolution 207-A-19)

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 207-A-19 REMAINDER OF REPORT FILED

*See Policies H-65.969, H-185.972, H-315.983, H-460.916, H-460.980, H-480.941,
D-315.970 and D-480.987*

INTRODUCTION

Resolution 207-A-19, “Direct-to-Consumer Genetic Tests,” which was introduced by the Illinois Delegation and referred by the House of Delegates, asked that:

Our American Medical Association regard research using consumer genome data derived from saliva or cheek swab samples as research on human subjects requiring consents in compliance with the Health and Human Services (HHS) Office for Human Research Protection (OHRP), and recommend an “opt in” option to allow more consumer choice in the consent process;

Our AMA amend Policy H-315.983, “Patient Privacy and Confidentiality,” by addition to align with current research and privacy infringement findings, as follows:

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, while working with the Department of Health and Human Services (HHS) to stop the transfer of birthdates and state of residence by genetic testing companies and their affiliates, unless there is explicit user approval, to prevent re-identification of the test user by way of surname inference methods.

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 deidentified 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. Our AMA regards studies using consumer genome data derived from saliva, cheek swab, or other human tissue samples as research on human subjects requiring consents in compliance with the HHS Office for Human Research Protections (OHRP). An "opt in" option is recommended to allow more consumer choice in the consent process.
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 43 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. The AMA will work with Congress and HHS to modify the Genetic Information Nondiscrimination Act of 2008 (GINA), which bans genome-based policy and hiring decisions by health insurance companies and employers, by adding Long-Term Care, Life Insurance, and Disability Insurance to the Act to prevent applicant rejection based on their genetic make up.

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. a. Our AMA supports privacy standards that would prohibit pharmaceutical companies, biotechnology companies, universities, and all other entities with financial ties to the genetic testing company from sharing identified information with other parties without the consent of the user. An exception would be made when requested by law enforcement authorities or when keeping the information would seriously threaten their health or that of others. If a data security breach occurs with the Direct-To-Consumer genetic company or its collaborators, then the company has the responsibility to inform all users of the breach and the impact of the unprotected private data on those individuals;

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;

Our AMA work with the Department of Health and Human Services or other relevant parties to modify the rules to prevent genetic testing entities from transferring information about the user's date of birth and state of residence to third parties which may result in the re-identification of the user based on surname inference;

Our AMA work with Congress and the Department of Health and Human Services to extend the consumer protections of the Genetic Information Non-Discrimination Act (GINA) of 2008 by adding long-term care, disability insurance, and life insurance to the Act, modeled after the laws of other states, such as California.

CURRENT AMA POLICY

Existing AMA policy addresses direct-to-consumer (DTC) genetic testing and privacy (see Appendix for full text). AMA Policy D-480.987, “Direct-to-Consumer Marketing and Availability of Genetic Testing,” recommends that genetic testing be carried out under the personal supervision of a qualified health professional and that advertisements disclose test limitations. AMA Policy H-480.941, “Direct-to-Consumer Laboratory Testing,” advocates for vigilant oversight of DTC laboratory testing and encourages physicians to educate their patients about the risks of DTC tests. AMA Policy H-65.969, “Genetic Discrimination and the Genetic Information Nondiscrimination Act,” supports education as well as legislation intended to provide more comprehensive protections. AMA Policies H-460.916, “Protection of Human Subjects in Research,” and H-460.980, “Ethical and Societal Considerations in Research,” encourage additional education on ethical principles for investigators in human subject research. AMA Policy H-315.983, “Patient Privacy and Confidentiality,” affirms that genetic information should be kept confidential and should not be disclosed to third parties without explicit informed consent.

BACKGROUND

DTC genetic testing landscape

Genetic tests have traditionally been ordered by a physician for specific conditions with clear diagnostic and other medical purposes. This report focuses on DTC genetic testing which may not require a physician order. Beginning with saliva or a cheek swab, DTC genetic tests can reveal DNA segments shared with other individuals, offering insights into familial relationships and ancestry. DTC genetic tests can also report specific variants associated with diverse traits and health conditions.

DTC genetic testing has grown exponentially over the past decade. About 30 million consumers, largely from the United States, have already participated in DTC genetic testing. At this rate, an estimated 100 million individuals will undergo DTC genetic testing by 2021.¹

While the FDA currently does not review all DTC genetic tests before they are offered to the public, those that disclose moderate to high risk health information, such as cancer screening results, are reviewed for evidence that the tests work as advertised.² In 2013, 23andMe stopped providing consumers with genetic health risk information after the FDA sent the company a letter. This action led other DTC companies to stop disclosing genetic health risks to consumers. In 2015, 23andMe was cleared by the FDA to market tests that release results for health conditions including increased risk of cancer, and in 2018 was cleared for pharmacogenomic reports.^{3,4} To date, 23andMe remains the only company that has received FDA clearance for a DTC genetic test.²

Another approach has emerged called a “hybrid” or “DTC 2.0” model of consumer genetic testing that begins with a physician order for screening of healthy individuals.⁵⁻⁷ Different models include those of AncestryDNA, Color Genomics, and Invitae, which may not be required to seek regulatory clearance from the FDA to return genetic health information, based on the inclusion of a physician order. These tests may also be offered through partnerships with employers and health systems, and include cancer risk and pharmacogenomic results.^{8,9} In some cases, College of American Pathologists (CAP) accredited and Clinical Laboratory Improvement Amendments (CLIA) certified laboratories may provide what is considered clinical grade data that may be included in health records and used to support medical decisions.

Genetic databases for clinical research

Genetic databases and biobanks have been designed to support biomedical research by offering various forms of access to participant data. This research has contributed to uncovering the molecular basis for thousands of human diseases and has helped to advance drug discovery.¹⁰ Database sizes are growing which may be necessary to power polygenic risk scores and other findings beyond single gene associations. Such database sizes may not be feasible to build for a single study, so groups instead may work with common datasets.

Shortcomings of the traditional biobank approach have included a lack of participant diversity, and a need to more frequently return results back to participants.^{11,12} When biobanks seek to form external partnerships, particularly with industry, there may be public concern about data security and privacy.¹³ Initiatives such as the 100,000 Genomes Project in the United Kingdom have begun leveraging their participant results to help advance clinical care.¹⁴ However,

a distinction between research and clinical grade genetic results may mean that some research findings should be considered only initial screening information that should undergo clinical confirmation prior to any changes in patient care.¹⁵

The All of Us Research Program

The National Institutes of Health (NIH)'s *All of Us* Research Program was launched in 2018 as part of President Obama's Precision Medicine Initiative, as "an ambitious effort to gather data over time from 1 million or more people living in the United States." The program does not focus on any subset of diseases or conditions. Instead, a key focus is recruiting participation from populations traditionally underrepresented in biomedical research, which has long been a challenge for the genetics field. By late-2019, more than 230,000 total participants were enrolled in *All of Us*, with most participants from underrepresented populations.¹⁶

Genetic data has been highlighted as a key component of the program and in 2018, *All of Us* announced the first awards to three genome centers.¹⁷ In 2019, the program announced a five-year award to Color Genomics to offer genetic counselling services and assist with participant education.¹⁸ Genomic results may be returned to some *All of Us* participants by 2020.¹⁹

Participant data for the *All of Us* program are stored in a cloud environment where identifying information is removed. This platform will allow computation and interactive testing of hypotheses without access to any individual participant data, thus safeguarding against some potential forms of security breaches. Researchers apply for data access and make their names and descriptions of their projects publicly available. Participants will also have access to their own data including their physical measurements, survey data, and genomic results, and they can choose whether to share results with their physician.¹⁶

Research using consumer genomic data

Genetic testing companies such as 23andMe also can engage in peer-reviewed genetic research, leveraging their own genetic databases including in many cases partnerships with academics.²⁰ In addition, genetic testing companies have engaged in their own drug discovery and have partnered with industry via data sharing agreements. In 2018, 23andMe announced a \$300 million drug development partnership with GlaxoSmithKline.²¹ In 2020, 23andMe sold the rights to license the first drug that the company had internally developed as a potential treatment for inflammation.²² While users have been informed that they can opt out of having their data used for research at any time, around 80 percent of users have elected to participate.²³ Currently, users are assigned no rights or compensation for the company's research or commercial products.²⁴

Other models are being explored to directly compensate participants for their research contributions. A recently launched platform named LunaDNA provides users the capability to sell their genomic and other health data for medical research, where data is exchanged for shares of stock. In 2019, LunaDNA merged with the Genetic Alliance's Platform for Engaging Everyone Responsibly (PEER).²⁵ One stated aim is to help individuals become partners and active participants in research, in addition to the possibility of receiving a small share of royalties resulting from future drug discoveries.

Third-party and forensic applications

DTC companies such as 23andMe and AncestryDNA allow users to download their own raw genomic data. These raw data files can then be uploaded to various third-party interpretation platforms which provide services such as mining the biomedical literature or genealogy tools. Use of third-party interpretation platforms has been identified as having the potential to increase a user's risks including validity of results and privacy.²⁶⁻²⁸

In terms of privacy, increasingly it has been recognized that genetic data cannot be deidentified. A DNA profile alone may now be adequate to identify most individuals even in the absence of other identifying information, including individuals that have not previously participated in genetic testing.²⁹ This may increasingly be the case as DNA databases continue to grow with participation from biological relatives that may help uncover identities through DNA matches. It may also be difficult to place safeguards against additional potential uses of genetic data other than those originally intended. For example, an individual's DNA profile designed for a specific purpose such as forensics may be linked to additional genetic data that could reveal health and other sensitive information.³⁰

Awareness around forensic applications of DTC genetic data increased in 2018, when a suspect for the Golden State Killer was identified after the upload of crime scene DNA to GEDmatch.³¹ This platform offered genealogical services by aggregating user data from other services into a large genetic database. Investigators were able to track down a single individual that fit their profile based on a DNA match to distant family members. Many users left the database when its use by law enforcement in criminal investigations became apparent, and GEDmatch changed its terms of service to require “opt-in” for matching to police-uploaded DNA.³² In 2019, GEDmatch was acquired by the forensic genomics firm Verogen.

Terms of service from DTC companies have been shown to have tremendous variability around the use and sharing of genetic data.³³ Such terms may also be subject to change with little notice. In 2019, Family Tree DNA surprised many users by announcing that it had been collaborating with the FBI and supporting queries via access to user genetic information, allegedly without informed consent from their users.³⁴ These revelations led to the Future of Privacy forum, which had released best practices in 2018 that prohibited the sharing of genetic data without consent or as required by law, to remove Family Tree DNA as a supporter.³⁵

The U.S. Department of Defense warned in 2019 that use of DTC genetic testing could place military service members at risk, allowing the enemy to target them via “mass surveillance and the ability to track individuals without their authorization or awareness,” with unintended security consequences.³⁶ Accordingly, service members have been advised to refrain from using DTC genetic tests. Information about some genetic variants can also affect a service member’s career, which may be particularly problematic when the validity of some DTC genetic tests has been questioned.

DTC genetic testing demand appears to have experienced a decline in 2019.³⁷ It is unclear whether this may be due to privacy or other consumer concerns. This development may signal saturation or a shift to more comprehensive models of genetic testing such as those offered by health systems.

Genetic Nondiscrimination and Privacy Legislation

Federal legislation that covers genetic privacy in the U.S. includes the Health Insurance Portability and Accountability Act (HIPAA) and the Genetic Information Nondiscrimination Act (GINA). The HIPAA Privacy Rule applies to health plans, health care providers, and health information clearinghouses but not to third parties outside of health care.³⁸ GINA applies to health insurers and employers but not to other contexts such as life, disability, or long-term care insurance.³⁹

Various states including California also have additional laws enacted that extend genetic discrimination protections to other areas such as life insurance and educational settings.³⁹ The California Consumer Privacy Act (CCPA) may also offer additional privacy protections for some consumers. However, extending GINA’s protections to other contexts in all states would require an act of Congress.

Human Subjects Research Legislation

Unlike earlier genetic research studies using a traditional model, researchers using DTC genetic data from 23andMe have argued that their work is not human subjects research as defined under the U.S. Department of Health and Human Services, which would require fully informed consent and institutional review board (IRB) approval of the research protocols.⁴⁰ Journal editors who published the study agreed that the researchers did not violate the Common Rule because they only used deidentified data. Extending additional protections, as implemented through IRBs, to data used for research by consumer genetics companies will likely require new legislation.

Physician guidance and related AMA efforts

The American College of Medical Genetics and Genomics has released a position statement on DTC genetic testing.⁴¹ Additional guidance on this topic is available from the Association for Molecular Pathology⁴² and the American Society of Human Genetics.^{43,44} The *AMA Journal of Ethics* has published an issue on precision health including DTC genetic testing.⁴⁵ *JAMA* has also published a number of articles covering topics related to consumer genetic testing.⁴⁶

The AMA has several initiatives to help physicians navigate precision medicine including education, research, and advocacy.⁴⁷ The AMA has collaborated with The Jackson Laboratories and Scripps Research Translational Institute

on a continuing medical education series called “Precision Medicine For Your Practice,” which includes a module called “Genomic Testing for the Healthy Individual.”⁴⁸ The AMA hosted a “Driving the Future of Precision Medicine Roundtable” in 2019 that examined the current landscape and innovative practices for precision medicine implementation. The AMA is also represented on the National Academies of Sciences, Engineering, and Medicine (NASEM) Roundtable on Genomics and Precision Health and participated in a 2019 workshop on consumer genomics.⁴⁹

Previous Council on Science and Public Health reports have addressed DTC genetic tests and related issues including genetic discrimination, the Precision Medicine Initiative, and payment and coverage for precision medicine.^{50–52} In 2019, the AMA sent a letter to the Department of Justice to oppose a proposal for the use of DNA testing for detained immigrants.⁵³ The AMA has also worked with states, including Delaware, to extend GINA protections.⁵⁴

CONCLUSION

The AMA has extensive policy on human subject research, consent, and genetic discrimination. The current federal GINA protections are limited to health insurance and employment, leaving consumers in most states without protections for areas such as life, disability, or long-term care insurance. It is important that users of consumer genetic testing are aware of the potential risks of their participation, particularly as the numbers of participants and the various use cases continue to grow. Participants in consumer genetic testing should receive notice and provide consent whenever their genetic information is used or shared.

RECOMMENDATIONS

For purposes of clarity, the Board of Trustees recommends that the following statements be adopted in lieu of Resolution 207-A-19, and that the remainder of this report be filed.

1. That our AMA adopt the following new policy:

“Consumer Genetic Testing and Privacy”

Our AMA:

- (1) will work with relevant stakeholders to advance laws and regulations that prevent genetic testing entities without explicit, informed, and non-coerced user consent from transferring information about a user such as birthdates and state of residence to third parties which may result in the re-identification of the user based on surname inference.
 - (2) supports privacy standards that would prohibit pharmaceutical companies, biotechnology companies, universities, and all other entities with financial ties to the genetic testing company from sharing identifiable information, including DNA, with other parties without informed consent of the user. An exception would be made when requested for a duly executed court order or when compelled for public health or safety reasons as outlined in existing AMA policy including H-315.983, “Privacy and Confidentiality,” and Medical Code of Ethics 4.1.4, “Forensic Genetics.” If a data security or privacy breach occurs with a direct-to-consumer (DTC) genetic company or its collaborators, then the company has the responsibility to inform all users and relevant regulatory bodies of the breach and the impact of the unprotected private data on those individuals.
 - (3) will advocate that research using consumer genomic data derived from saliva or cheek swabs or other human samples should be treated as research on human subjects requiring informed consent consistent with or similar to those required by the Health and Human Services (HHS) Office for Human Research Protection (OHRP), and recommend an “opt in” option to allow more consumer choice in the consent process.
 - (4) will advocate for extending the consumer protections of the Genetic Information Non-Discrimination Act (GINA) of 2008 by adding long-term care, disability insurance, and life insurance to the Act, modeled after the laws of other states, such as California.
2. That the following policies be reaffirmed: H-65.969, “Genetic Discrimination and the Genetic Information Nondiscrimination Act,” H-185.972, “Genetic Information and Insurance Coverage,” D-480.987, “Direct-to-Consumer Marketing and Availability of Genetic Testing,” H-480.941, “Direct-to-Consumer Laboratory

Testing,” H-460.916, “Protection of Human Subjects in Research,” H-460.980, “Ethical and Societal Considerations in Research,” and H-315.983, “Patient Privacy and Confidentiality.”

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APPENDIX – Current AMA Policy

D-480.987, “Direct-to-Consumer Marketing and Availability of Genetic Testing”

Our AMA: (1) recommends that genetic testing be carried out under the personal supervision of a qualified health care professional; (2) encourages individuals interested in obtaining genetic testing to contact a qualified healthcare professional for further information; (3) will work with relevant organizations to develop criteria on what constitutes an acceptable advertisement for a direct-to-consumer genetic test; (4) encourages the U.S. Federal Trade Commission, with input from the U.S. Food and Drug Administration and the Centers for Medicare and Medicaid Services, to require that direct-to-consumer advertisements for genetic testing are truthful and not misleading; such advertisements should include all relevant information regarding capabilities and limitations of the tests, and contain a statement referring patients to physicians to obtain further information; (5) will work to educate and inform physicians regarding the types of genetic tests that are available directly to consumers, including information about the lack of scientific validity associated with some direct-to-consumer genetic tests, so that patients can be appropriately counseled on the potential harms.

H-480.916, “Direct-to-Consumer Laboratory Testing,”

Our AMA will: (1) advocate for vigilant oversight of direct-to-consumer (DTC) laboratory testing by relevant state and federal agencies; and (2) encourage physicians to educate their patients about the risks and benefits of DTC laboratory tests, as well as the risks associated with interpreting DTC test results without input from a physician or other qualified health care professional.

H-65.969, “Genetic Discrimination and the Genetic Information Nondiscrimination Act”

Our AMA: (1) strongly opposes discrimination based on an individual's genetic information; (2) will pursue and support legislation intended to provide robust and comprehensive protections against genetic discrimination and misuse of genetic information; and (3) supports education for health care providers and patients on the protections against genetic discrimination currently afforded by federal and state laws.

H-185.972, “Genetic Information and Insurance Coverage”

AMA believes: (1) Health insurance providers should be prohibited from using genetic information, or an individual's request for genetic services, to deny or limit any health benefit coverage or establish eligibility, continuation, enrollment or contribution requirements. (2) Health insurance providers should be prohibited from establishing differential rates or premium payments based on genetic information or an individual's request for genetic services. (3) Health insurance providers should be prohibited from requesting or requiring collection or disclosure of genetic information. (4) Health insurance providers and other holders of genetic information should be prohibited from releasing genetic information without express prior written authorization of the individual. Written authorization should be required for each disclosure and include to whom the disclosure would be made.

H-460.916, “Protection of Human Subjects in Research”

Our AMA encourages institutions conducting research with human subjects to implement an ongoing credentialing process to assure that all investigators and relevant staff have been appropriately educated in the ethical principles and relevant government regulations related to human subjects research.

H-460.980, “Ethical and Societal Considerations in Research”

(1) Private organizations and academic institutions should jointly develop a means to continue and enhance broadly based study and discussion of ethical and societal issues in biomedical research. (2) The federal government should provide the resources to support new initiatives within the National Institutes of Health for the funding of research studies in bioethics. Existing federal programs that fund bioethical research studies should be preserved. Private foundations should be encouraged to provide resources to support research studies in bioethics. (3) A uniform set of federal regulations governing research with human subjects, based on the core regulations of the Department of Health and Human Services should be adopted by all federal agencies. Uniformity should not preclude additions to Department regulations that do not conflict with the core regulations or that enhance the protection of research subjects. (4) Associations of regional institutional review boards (IRBs) should be formed to enhance IRB performance through the development of educational site visits and local workshops. (5) Each institution should have a system both for monitoring the conduct of biomedical research and for investigating and reporting allegations of research misconduct. (6) All investigators involved in research projects should be responsible for the clear articulation and enforcement of standards that ensure the integrity of scientific data and conclusions. Regardless of whether the research project is a result of individual or collaborative

efforts, investigators should thoroughly understand the data and conclusions in research publications and studies. (7) As part of their formal training in research investigation, graduate, medical and postdoctoral students should be instructed on the importance of adhering to the ethical and scientific requirements in research conduct and in the reporting of research results. (8) Our AMA encourages study of the inclusion of Socioeconomic Status (SES) data in clinical and public health research identify appropriate minimum standards for the inclusion of such data in research studies.

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.

Code of Medical Ethics 4.1.4, "Forensic Genetics"

With the exception of genetic information (or material) collected under the jurisdiction of a coroner, medical examiner, or other medical legal officer, the release of genetic information from a physician's records without the patient's informed consent constitutes a breach of confidentiality. However, under limited circumstances with overriding legal and social considerations, all physicians may disclose such information to the criminal justice system.

Physicians from whom genetic information is sought for purposes of criminal justice: (a) May ethically carry out DNA analysis on stored tissue samples or release genetic information without the consent of a living or deceased patient (or the patient's authorized surrogate) in response to a warrant or court order. (b) Should release only the minimum information necessary for the specific purpose. (c) Should not be required to provide genetic information when: (i) a suspect whose location is known refuses to provide a tissue sample for genetic analysis; or (ii) a tissue sample for the suspect can be obtained from other sources (such as the body of a deceased suspect). (d) Should decline to participate in the use of information from a genetic database created exclusively for criminal justice for any purpose other than identification.

Issued: 2016

13. STUDY OF FORCED ORGAN HARVESTING BY CHINA

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

HOUSE ACTION: RECOMMENDATIONS ADOPTED REMAINDER OF REPORT FILED

See Policy D-370.982

At the 2019 Interim Meeting, the American Medical Association House of Delegates adopted Policy D-370.981, "Study of Forced Organ Harvesting by China." The policy directs the AMA to "gather and study all information available and possible on the issue of forced organ harvesting by China and issue a report to our House of Delegates at the 2020 Annual Meeting."

The Board of Trustees assigned this report to the Office of International Relations. This report highlights evidence examined on organ transplantation practices in the People's Republic of China (PRC) and makes recommendations within the context of the AMA's strategy for involvement in international medical issues.

BACKGROUND

The American Medical Association has opined on organ transplantation practices in the PRC for more than a decade, primarily through its membership and active involvement in the World Medical Association (WMA). As early as 2007, a delegation from the WMA visited the Chinese Medical Association (ChMA) to further discuss ethical principles and to seek compliance with WMA ethical principles. The AMA has expressed its consistent support of WMA policy, including [WMA's Resolution on Organ Donation in China](#). The resolution was first adopted in 2006 and reiterated in 2016 and calls upon the ChMA to cease the practice of using prisoners as organ donors. In 2015, the ChMA reported to the WMA that this practice had been prohibited by the PRC. In 2017, existing WMA policy on organ transplantation was modified to include paragraphs recommending collaboration with governments to ensure that appropriate safeguards are in place to enhance transparency and credibility in the organ transplantation process. At the last meeting of the WMA General Assembly in October 2019, the resolution on organ donation in China was once again submitted for review. The ChMA is now in the process of working with the Medical Ethics Committee of the WMA to revise and clarify this resolution and will formally report its progress to the WMA Council in April 2020.

AMA POLICY

AMA has extensive ethics and House policy on issues in organ procurement and transplantation:

- [E-6.1.1, Transplantation of Organs from Living Donors](#)
- [E-6.1.2, Organ Donation after Cardiac Death](#)
- [E-6.2.1, Guidelines for Organ Transplantation](#)
- [E-9.7.3, Capital Punishment](#)
- [E-1.2.13, Medical Tourism](#)
- [H-370.967, Ethical Procurement of Organs for Transplantation](#)
- [H-370.990, Transplantable Organs as a National Resource](#)

DISCUSSION

There are credible but conflicting and largely anecdotal reports from different sources regarding current transplant practices in the PRC.^{1 2} In 2013, the National Health and Family Planning Commission of the PRC affirmed the government's commitment to aligning transplant practices with guiding principles from the World Health Organization (WHO)³ and the Transplantation Society and International Society of Nephrology's Declaration of Istanbul.⁴ The PRC signed a resolution specifically agreeing to end the practice of accepting organs from condemned prisoners, prohibiting organ trafficking and transplant tourism and strengthening transplant practice and oversight overall.⁵

It appears the development of ethical transplantation practices is a rapidly evolving process in the PRC. While many surgeons and hospitals may be adhering to new standards, there is likely a complex hybrid approach to transplantation includes those who adhere to ethical practices supported officially by the government, and those who may still be operating outside the parameters of international ethical standards.

Scarcity of knowledgeable, independent sources of information limit the transplant community's ability to assess transplant practices in the PRC. Neither the AMA nor the WMA can independently verify sources of transplanted organs or transplantation data, and persistent yet conflicting reports of ethical infractions make it nearly impossible to determine whether any claim of organ sources is indeed what it purports to be.

There is credible evidence to suggest that the PRC's efforts to reform its transplantation practices have not succeeded to the extent the government claims, and that abuses still occur:

- There is no built-in transparency for organ transplantation statistics in China. A detailed statistical analysis published by Israeli researchers in 2019⁶ showed evidence of data manipulation in the organ transplant data sets that were publicly available. Based on available data, they concluded there is no way to definitively extrapolate either the source of organs used, or the total number of transplants performed per year. The study also found evidence that the authors believed indicates donors are being misclassified as "voluntary" when they are not.
- The PRC has relied heavily on organs from executed prisoners and not voluntary organ donors for source organs, a practice which was internationally condemned. The PRC claims to have stopped this practice. Government statistical information indicated a huge increase in voluntary donors, from 23% of organs procured in 2013 to 80% in 2014. The PRC states that voluntary organs then became the sole official organ source in 2015. However, it is not plausible that the country increased its volunteer donor rate from 23% of all organs procured to 100% in just two years. Gains of this magnitude would likely take many years.⁷
- Evidence has been presented⁸ indicating that waiting times for organs are much shorter in the PRC than in the rest of the world, and often as little as two weeks. If accurate, this evidence supports that prisoners are still being used as organ donors, as there does not seem to be a satisfactory alternate explanation.
- China's history of human rights violations against its religious minorities is well-documented by multiple independent sources.^{9 10 11} These violations make accusations of organ harvesting from among these minorities more credible.

While progress has likely been made in developing more humane and ethically acceptable transplantation practices in the PRC, the continued lack of transparency and availability of transplantation data hurts its standing in the international community and leads other countries to question claims that harvesting organs from prisoners has conclusively ceased.

CONCLUSIONS

The AMA has consistently supported ethical organ transplantation policy at the WMA, and specifically, in its interactions with the Chinese Medical Association. The AMA has strong policies to support our position.

Neither the WMA nor the AMA can independently verify either the sources of transplanted organs or transplantation data in the PRC.

Due in part to lack of transparent and readily available organ transplant data, doubts remain as to the success of the PRC's organ transplantation reforms, and there is credible evidence to suggest that abuses may still be taking place.

RECOMMENDATIONS

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

1. That our American Medical Association continue to engage the Chinese Medical Association and the transplant community in the People's Republic of China (PRC) through promotion and support of relevant activities and policies of the World Medical Association that relate to organ transplantation.
2. That our AMA, through its membership in the World Medical Association, continue to call for the PRC's compliance with internationally recognized organ transplantation standards, such as those of the World Health Organization, and for the PRC to make available externally verifiable data on organ transplantation.
3. That our AMA condemn the retrieval of organs for transplantation without the informed consent of the donor.
4. That Policy D-370.981, "Study of Forced Organ Harvesting by China," be rescinded, having been accomplished by this report.

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Additional references are available from the AMA Office of International Relations.

14. NET NEUTRALITY AND PUBLIC HEALTH (Resolutions 208-I-19 and 211-I-19)

Reference committee hearing: see report of Reference Committee B.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTIONS 208-I-19 AND 211-I-19
REMAINDER OF REPORT FILED
*See Policy H-478.978***

INTRODUCTION

At the 2019 Interim Meeting, the House of Delegates (HOD) heard mixed testimony regarding Resolution 208, "Net Neutrality and Public Health," which was introduced by the Medical Student Section and Resolution 211, "Effects of Net Neutrality on Public Health," introduced by the Michigan Delegation.

Resolution 208, "Net Neutrality and Public Health" reads as follows:

RESOLVED, That our American Medical Association advocate for policies that ensure internet service providers transmit essential healthcare data no slower than any other data on that network; and be it further

RESOLVED, That our AMA collaborate with the appropriate governing bodies to develop guidelines for the classification of essential healthcare data requiring preserved transmission speeds; and be it further

RESOLVED, That our AMA oppose internet data transmission practices that reduce market competition in the health ecosystem.

Resolution 211, "Effects of Net Neutrality on Public Health" reads as follows:

RESOLVED, That our American Medical Association amend current policy H-478.980, "Increasing Access to Broadband Internet to Reduce Health Disparities," by addition and deletion as follows:

Increasing Access to Broadband Internet Access to Reduce Health Disparities

Our AMA: (1) will advocate for net neutrality; and (2) will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the U.S. while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.

During the House of Delegates Interim Meeting the reference committee heard testimony on both Resolution 208 and 211, which were heard together. Testimony was heard that favored maintaining the rules of net neutrality, as repeal could lead companies to place limits on how, where, and when patients and providers are able to access health care data. Other concerns regarding repeal of net neutrality focused on the potential for companies to pursue policies that could lessen both innovation and competition in health care technology, or increase the cost of health care delivery, thus negatively impacting both physicians and patients. Testimony concerning the use of the term "net neutrality" and its impact on potential AMA advocacy activities was provided as well. Additionally, testimony was given regarding existing AMA policy which already supports the expansion of broadband and wireless connectivity to all rural and underserved areas of the U.S. Finally, testimony was provided that defining essential health data needs to be further evaluated because the transmission of certain health data may need to take precedence over other data. The resolutions were heard during the House of Delegates 2019 Interim Meeting prior to the start of the coronavirus (COVID-19) pandemic.

BACKGROUND

Net neutrality is the principle guiding the strict regulations placed on internet service providers (ISPs) that prohibit or limit content-controlling behavior in order to ensure an equal and open internet for all.¹ In practice, this means that ISPs should not be able to move some data (for example, certain applications or streaming services) into “fast lanes” while blocking, slowing, or limiting in some fashion other data. In other words, ISPs (such as AT&T Internet Services, Cox Communications, Comcast and Verizon) should not be able to block a user from accessing a service such as Skype, Zoom, or slow down Netflix or Roku, in order to encourage the user to keep a cable package or buy a different video-streaming service.

A core issue to net neutrality is how ISPs should be classified under the Communications Act of 1934, if they should be Title I “information services” or Title II “telecommunications or common carrier services.” The classification affects the Federal Communications Commission’s (FCC) authority over ISPs. As Title II common carriers, the FCC would have significant ability to regulate ISPs, but not if they are classified as Title I. Title I information services are regulated by the Federal Trade Commission (FTC or Commission). In layman’s terms, “common carrier services” move data from one place of the customer’s choosing to another, and “information services” provide processing or storage services for that data. The debate over Title I vs. Title II classification continues even today.

The FCC regulates interstate and international communications by radio, television, wire, satellite, and cable in all 50 states, the District of Columbia and U.S. territories. An independent U.S. government agency overseen by Congress, the FCC is the federal agency responsible for implementing and enforcing America’s communications law and regulations. The makeup of the five-member FCC changes with each U.S. President, and competing interests have ultimately led to the state of net neutrality flipping back and forth over the last several decades. With regard to the FTC, the Commission is headed by five Commissioners, nominated by the President and confirmed by the U.S. Senate, each serving a seven-year term. No more than three Commissioners can be of the same political party. The President chooses one Commissioner to act as Chairman.

DISCUSSION

Federal Regulatory Activity

In the absence of any formal categorization of internet services, the FCC issued several statements regarding broadband regulation.

In 2005, the FCC adopted four principles in order to “encourage broadband deployment and preserve and promote the open and interconnected nature of public Internet.”² The four principles are as follows: (1) consumers are entitled to access the lawful Internet content of their choice; (2) consumers are entitled to run applications and services of their choice, subject to the needs of law enforcement; (3) consumers are entitled to connect their choice of legal devices that do not harm the network; and (4) consumers are entitled to competition among network providers, application and service providers, and content providers.³ At that time, the FCC stated it would consider these principles during “policymaking activities.”

In 2010, the Open Internet Order was passed by the FCC. The goal of the Open Internet Order was to “preserve the Internet as an open platform for innovation, investment, job creation, economic growth, competition, and free expression,” which ultimately revolved around three basic tenets:⁴

- *Transparency.* Fixed and mobile broadband providers must disclose the network management practices, performance characteristics, and terms and conditions of their broadband services;⁵
- *No blocking.* Fixed broadband providers may not block lawful content, applications, services, or non-harmful devices; mobile broadband providers may not block lawful websites, or block applications that compete with their voice or video telephony services; and
- *No unreasonable discrimination.* Fixed broadband providers may not unreasonably discriminate in transmitting lawful network traffic.

According to the FCC, broadband providers invested \$212 billion in the three years following adoption of the rules—from 2011 to 2013—more than in any three-year period since 2002.⁶

Between 2005 and 2012, there were several Congressional attempts to pass legislation containing limitations on net neutrality. These attempts failed, largely due to the argument that the legislation would have benefited industry instead of consumers.

The FCC in its February 26, 2015, open meeting voted 3-2, along party lines, to adopt new open internet rules and released these rules via an Open Internet Report and Order on Remand on March 12, 2015.

One of the most controversial aspects of the rules was the decision to reclassify broadband internet access service (BIAS) as telecommunications service under Title II, thereby subjecting ISPs to a more stringent regulatory framework. The FCC Order reclassifying ISPs as Title II services gave the FCC authority to enforce net neutrality. Specifically, the FCC's 2015 Open Internet Order banned each of the following: Blocking, Throttling, and Paid Prioritization—applying the same rules to both fixed and mobile broadband Internet access service.⁷

- *No Blocking.* The FCC noted at that time that “consumers who subscribe to a retail broadband Internet access service must get what they have paid for—access to all (lawful) destinations on the Internet.”⁸ Thus, the Order adopted a straightforward ban:
 - A person engaged in the provision of broadband Internet access service, insofar as such person is so engaged, shall not block lawful content, applications, services, or nonharmful devices, subject to reasonable network management.
- *No Throttling.* The FCC noted that “the 2010 rule against blocking contained an ancillary prohibition against the degradation of lawful content, applications, services, and devices, on the ground that such degradation would be tantamount to blocking.”⁹ The 2015 Order created a separate rule to guard against degradation targeted at specific uses of a customer’s broadband connection:
 - A person engaged in the provision of broadband Internet access service, insofar as such person is so engaged, shall not impair or degrade lawful Internet traffic on the basis of Internet content, application, or service, or use of a non-harmful device, subject to reasonable network management.
- *No Paid Prioritization.* Paid prioritization occurs when a broadband provider accepts payment (monetary or otherwise) to manage its network in a way that benefits particular content, applications, services, or devices.¹⁰ To protect against “fast lanes,” the 2015 Order adopted a rule that establishes that:
 - A person engaged in the provision of broadband Internet access service, insofar as such person is so engaged, shall not engage in paid prioritization.

In 2017, with a new Administration at the helm, the FCC proposed reclassifying ISPs as Title I services, effectively repealing the previously established neutrality policies and discarding millions of comments submitted by the public to the FCC. On June 11, 2018, the FCC's Restoring Internet Freedom Order took effect, despite attempts by Congress to stay the Order.¹¹ The new Order, among other things, reverses the 2015 classification of BIAS as a telecommunications service under Title II of the Communications Act, shifts much of the oversight from the FCC to the FTC and the U.S. Department of Justice, and provides for a less regulated approach.¹² Specifically, the FCC's framework for protecting Internet freedom under this new Order has three key parts: 1) Consumer Protection; 2) Transparency; and 3) Removes Unnecessary Regulations to Promote Broadband Investment.¹³

- *Consumer Protection.* The Federal Trade Commission will police and take action against Internet service providers for anticompetitive acts or unfair and deceptive practices.
- *Transparency.* Internet service providers must publicly disclose information regarding their network management practices, performance, and commercial terms of service. These disclosures must be made via a publicly available, easily accessible company website or through the FCC's website.
- *Removes Unnecessary Regulations to Promote Broadband Investment.* Removes Title II regulations.

The COVID-19 Pandemic and the Dramatic Surge in Internet Usage

According to a Pew Research Center survey conducted in 2019, approximately two-thirds of rural Americans (63 percent) say they have a broadband internet connection at home, up from about a third (35 percent) in 2007.¹⁴ While encouraging, this is far from ideal—particularly as the nation battles the COVID-19 pandemic. Businesses, K-12 schools, colleges and universities, and health providers across the U.S. have been forced to pivot to a new normal built around telework, eLearning, and telehealth. More than 300 million people were under stay-at-home orders when the national public health emergency was declared, resulting in the use of, and need for, a dramatically increased level of

internet access through their home connections.¹⁵ The pandemic has pushed regulators and politicians at all levels of government to reevaluate current policies related to bandwidth, traffic and network neutrality.

The massive surge in Internet usage during the COVID-19 crisis will play a major role in the debate over what the appropriate regulatory framework should be for broadband access. For those that have high-speed internet connectivity, the internet has withstood the unimaginable increase of online video-calling, telehealth, teleworking, distance learning and leisure television show and movie bingeing. As people in rural areas and underserved urban areas seek to telework, learn remotely, and access telehealth services, the digital divide in the U.S. becomes even more glaring. Broadband availability has been at the heart of the digital divide long before the pandemic hit, with an estimated 21.3 million people lacking a connection of at least 25 Mbps/3 Mbps (the FCC's current benchmark) by the end of 2017, according to the FCC. And although this is a decrease from the prior year of 26.1 million people, the U.S. has much work ahead to close the gap.¹⁶

Current Congressional Activity

In early 2019, federal legislation was introduced that would address the net neutrality debate. However, only one such bill has progressed. The "Save the Internet Act of 2019", H.R. 1644/S. 682 would repeal the Declaratory Ruling, Report and Order, and Order in the matter of restoring internet freedom that was adopted by the Commission on December 14, 2017 (FCC 17–166) and restore the 2015 Order. H.R. 1644 passed (232-190) the House on April 10, 2019 and has been sent to the Senate for consideration.

Republicans in Congress contend that the increased Internet use as a result of shelter-in-place orders is proof positive that the net neutrality rules were unnecessary. Democrats in Congress have turned their focus to the FCC's various Internet connection programs to make sure people at all income levels, in all geographic areas across the U.S. have access to broadband. As a result of the changing Internet landscape due to the pandemic, it is likely that congressional leaders from both parties moving forward will increase their focus on bolstering broadband infrastructure across the country, as this endeavor has bipartisan support, rather than focusing on net neutrality policies specifically.

The Expansion of Telehealth Services as a Result of the COVID-19 Pandemic

Congress appropriated \$200 million to the FCC for the Telehealth Program as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, to help health care providers provide connected care services to patients at their homes or mobile locations in response to the novel Coronavirus 2019 disease (COVID-19) pandemic.¹⁷ The COVID-19 Telehealth Program will provide immediate support to eligible health care providers responding to the COVID-19 pandemic by fully funding their telecommunications services, information services, and devices necessary to provide critical connected care services until the program's funds have been expended or the COVID-19 pandemic has ended. The COVID-19 Telehealth Program is limited to nonprofit and public eligible health care providers.¹⁸

As of May 20, 2020, the FCC's COVID-19 Telehealth Program has approved funding for 132 health care providers in 33 states plus Washington, DC for a total of just over \$50 million in funding.¹⁹ The FCC is continuing to evaluate COVID-19 Telehealth Program applications and distribute additional funding on a rolling basis.

The FCC's Office of Managing Director and Wireline Competition Bureau (WCB) also is waiving the FCC's red light rule²⁰ for COVID-19 Telehealth Program applicants to facilitate prompt review and processing of the maximum number of applications to the Program. The "red light" rule normally prevents the FCC from taking action on applications and other requests by entities with delinquent debts with the agency. While the FCC found good cause existed to waive the "red light" rule, the agency was clear that the waiver solely applied to the COVID-19 Telehealth Program and did not affect the agency's ability to take collection action against delinquent debtors.

In addition, on May 22, 2020, U.S. Senators Brian Schatz (D-Hawaii), Lisa Murkowski (R-Alaska), John Boozman (R-Ark.), Angus King (I-Maine), Gary Peters (D-Mich.), Dan Sullivan (R-Alaska), Kevin Cramer (R-N.D.), and Ed Markey (D-Mass.) introduced the Health Care Broadband Expansion During COVID-19 Act. The bipartisan bill would direct \$2 billion to help health care providers increase their broadband capacity and expand telehealth services during the current public health crisis.²¹

AMA POLICY

Existing AMA policy generally promotes increasing patient access to electronic health data, encouraging innovation and competition amongst technology vendors, and removing barriers to internet-based care. In 2020 the AMA developed and published a guidance document containing privacy principles.²²

Policy H-478.980, “Increasing Access to Broadband Internet to Reduce Health Disparities”

Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the U.S. while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.

Citation: Res. 208, I-18;

Policy D-478.979, “Promoting Internet-Based Electronic Health Records and Personal Health Records” Our American Medical Association will advocate for the Centers for Medicare & Medicaid Services (CMS) to evaluate the barriers and best practices for those physicians who elect to use a patient portal or interface to a personal health record (PHR) and will work with CMS to educate physicians about the barriers to PHR implementation, how to best minimize risks associated with PHR use and implementation, and best practices for physician use of a patient portal or interface to a PHR.

Citation: (BOT Rep. 11, I-11)

CONCLUSION

The essential nature of broadband communication services that has been highlighted by the COVID-19 pandemic makes it clear that without affordable and high-quality broadband services, workforce participation, commerce, education, and telehealth usage, are drastically curtailed. Additionally, access to broadband is a social determinant of health—both in and of itself and in light of its intersection between education and employment opportunities—and therefore an important component of discussions around health equity.²³ The digital divide was already negatively affecting millions of Americans, but the COVID-19 crisis has placed an increased level of stress on an already fragile system especially in rural and underserved areas. Some argue that the surge in internet usage as a result of stay-at-home orders simply confirms that the FCC’s existing policies and programs, combined with low levels of broadband competition, are not meeting the basic needs of Americans. While others contend that the U.S. has fared well during this dramatic surge in internet use as a result of shelter in place orders, much better than some European countries,²⁴ and regulators and Congress should re-focus their efforts on expanding infrastructure. Given the bolstering of the FCC’s COVID-19 Telehealth Program funding and the expansion of telehealth policy through the Centers for Medicare & Medicaid Services^{25,26} as a result of the pandemic, our AMA believes that we too should pivot and re-focus our efforts on advocating for the expansion of broadband infrastructure in rural and underserved urban communities across America. Our AMA believes that as these opportunities to expand broadband access and telehealth are adopted and implemented successfully during this health crisis, both Congress and the Administration will be hard pressed to roll these advances back post-pandemic.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolutions 211-I-19, “Effects of Net Neutrality on Public Health,” and 208-I-19, “Net Neutrality and Public Health,” and that the remainder of the report be filed.

That our American Medical Association support (1) policies ensuring that the transmission speed of essential healthcare data is no slower than other data using the same transmission modality, and (2) data speeds sufficient for high quality, real-time video and audio Telehealth, without paid prioritization.

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3. Id.
4. https://docs.fcc.gov/public/attachments/FCC-10-201A1_Rcd.pdf

5. Note: An ISP provides services that enable its customers to connect through the internet. High-speed internet access is commonly referred to as broadband internet. So, if an ISP is capable of providing high-speed internet access, they are considered broadband internet service providers.
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11. <https://fas.org/sgp/crs/misc/R40616.pdf>
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16. <https://docs.fcc.gov/public/attachments/FCC-19-44A1.pdf>
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18. 42 USC 254(h)(7)(B). “(B)Health care provider --- The term “health care provider” means— (i)post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (ii)community health centers or health centers providing health care to migrants; (iii)local health departments or agencies; (iv)community mental health centers; (v)not-for-profit hospitals; (vi)rural health clinics; (vii)skilled nursing facilities (as defined in section 395i–3(a) of title 42); and (viii)consortia of health care providers consisting of one or more entities described in clauses (i) through (vii).”
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**15. OPPOSING ATTORNEY PRESENCE AT AND/OR RECORDING OF INDEPENDENT
MEDICAL EXAMINATIONS
(Resolution 1-A-19)**

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

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 1-A-19
REMAINDER OF REPORT FILED
*See Policy D-365.996***

At the 2019 Annual Meeting, the House of Delegates (HOD) referred Resolution 1-A-19, “Opposing Attorney Presence at and/or Recording of Independent Medical Examinations” to the Board of Trustees for report. Resolution 1-A-19, introduced by the Illinois Delegation, asked that our American Medical Association (AMA) amend by addition Policy H-365.981, “Workers’ Compensation,” to include language that opposes the ability of courts to compel recording and videotaping of, or allow a court reporter or an attorney to be present during the independent medical examination, as a condition precedent to allowing the physician’s medical opinion in court.

The reference committee heard testimony in opposition to this resolution. Speakers opposing the resolution noted the variability of state laws addressing the recording or videotaping of, or attorney presence at independent medical examinations (IME) for the purpose of resolution of workers’ compensation claims. Furthermore, the state specific nature of workers compensation statutes precludes prescribing a national workers’ compensation guideline. Testimony supportive of adopting the resolution noted that the resolution is consistent with the ethical guidelines of our AMA and of other organizations, and the recording or presence of a third party is intrusive to a private medical exam. Given the diverse testimony regarding the resolution, the HOD referred Resolution 1-A-19.

This report considers the discordancy of existing state laws regarding the physician’s role in IME and presents current AMA policy and *Code of Medical Ethics* opinions. This report analyzes the existing body of AMA policy on the IME in workers’ compensation matters and the physician patient relationship and evaluates the consistency of the proposed resolution with existing policy and concludes with a recommendation for HOD action.

BACKGROUND

An IME is a physical examination conducted at the request of a third party, such as an employer or an insurance company. IMEs arise in the context of workers’ compensation injury claims, although an IME may also be utilized in any personal injury claim or in employer mandated pre-employment or annual physical examinations. Our AMA Policy on workers’ compensation (Policy H -365.981) was initially adopted in 1993 and was most recently modified in 2017 to reflect certain goals that had been met. In addition, a number of states allow for attorney presence during examinations pursuant to a showing of good cause, and/or with the consent of the patient.

DISCUSSION

AMA Code of Ethics Opinion 1.1.1, *Patient-Physician Relationship*, describes the practice of medicine as a moral activity where the relationship between the physician and patient is based on trust. The opinion further addresses circumstances wherein a *limited* patient-physician relationship is created. One example of a limited patient-physician relationship is in the context of an IME. In keeping with ethics guidance, the IME creates a limited patient-physician relationship imposing a duty of care on the physician conducting the IME examination. While this relationship is subject to variable interpretations across the states, our AMA tasks the physician with responsibilities to both the employer or insurer and the patient.

AMA Code of Medical Ethics E-1.2.6, *Work Related & Independent Medical Examinations*, states that physicians who provide medical examinations at the request of employers or insurance companies face a conflict of duties. The physician has responsibilities to *both* the patient and the employer or third party. The core obligations of industry-employed physicians to their patients include disclosure of the nature of the relationship between the physician and the patient and the physician’s departure from the traditional fiduciary role. The physician’s ethical responsibility further obligates the physician to inform the patient about incidental findings discovered during the exam, and when

appropriate, suggest follow-up care. If requested, the physician also provides reasonable assistance in securing follow-up care.

The integrity of the physician-patient relationship is paramount with long-standing and unequivocal policy support by our AMA. Recording equipment, or the presence of an attorney at an IME, interferes with and lends a degree of artificiality to the examination. The need for a confidential and open exchange between the patient and the examining physician is evident. Allowing a third party who has an interest in the outcome of the examination, or recording the examination, could inhibit and intimidate the patient from candid communication during the exam. The intrusion of counsel in the examining room thrusts the adversarial process into the examination room.

The states have an interest in maintaining the integrity of Workers Compensation claims processes. Numerous states have implemented recording requirements for IME and/or allow an attorney's presence during the exam. While one can recognize the state's interest in attempting to interject a method to document proof of the veracity of the IME, AMA policy is unequivocal on patient privacy and the sanctity of the patient-physician relationship. Furthermore, the claims process is not disadvantaged by the lack of a recording or attorney at the IME. The attorneys and the employer or insurer each receive a copy of the examining physician's written report and can request an additional IME. Most importantly, the attorneys have the opportunity to cross examine the physician in a deposition or at trial. Cross examination of an expert is the industry standard and best practice for obtaining evidence.

Your Board recognizes the concerns expressed by those who testified in opposition to adoption of the resolution. There are numerous state law approaches to the issue raised by Resolution 1-A-19. The state-specific nature of the laws precludes the prescribing of workers compensation guidelines. Your Board further acknowledges a state's legitimate reasons for recording or having an attorney present during an IME. However, your Board does not believe these considerations outweigh the sanctity of the patient-physician relationship, even in the more limited context of an IME, particularly given the availability of other documentation methods such as written reports and cross examination.

CONCLUSION

As noted in the preceding paragraph, testimony at the reference committee indicated that state laws may differ widely in how they deal with the issues that Resolution 1-A-19 raises, and testimony did not indicate that physicians in all states opposed the manner in which their state's law addressed those issues. Consequently, your Board does not recommend that our AMA adopt a blanket policy requiring your AMA to always oppose instances where a state law or proposed legislation permits the recording of an independent medical examination. Adopting such a blanket policy would obligate our AMA to oppose state laws and legislative proposals in cases where physicians in the state may not wish our AMA to oppose the law or proposal. Your Board recommends that your AMA oppose attorney presence and the recording of IMEs when asked to do so by a state medical association or national medical specialty society. This approach avoids committing our AMA to opposition where none has been requested by the state medical association, yet empowers your AMA to assist those state medical associations who wish to challenge laws or legislative proposals that the association believes unjustifiably intrude into the limited patient-physician relationship created in the context of an IME.

RECOMMENDATION

Your Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 1-A-19 and that the remainder of the report be filed.

That, upon request of state medical associations and national medical specialty societies, our AMA will provide assistance and consultation in opposing the ability of courts to compel recording and videotaping of, or allow a court reporter or an attorney to be present during the independent medical examination, as a condition precedent to allowing the physician's medical opinion in court.

APPENDIX - AMA POLICY

H-365.981, "Workers' Compensation"

Our AMA: (1) will promote the development of practice parameters, when appropriate, for use in the treatment of injured workers and encourages those experienced in the care of injured workers to participate in such development. (2) will investigate support for appropriate utilization review guidelines for referrals, appropriate procedures and tests, and ancillary services as a method of

containing costs and curbing overutilization and fraud in the workers' compensation system. Any such utilization review should be based on open and consistent review criteria that are acceptable to and have been developed in concert with the medical profession. Physicians with background appropriate to the care under review should have the ultimate responsibility for determining quality and necessity of care. (3) encourages the use of the Guides to the Evaluation of Permanent Impairment. The correct use of the Guides can facilitate prompt dispute resolution by providing a single, scientifically developed, uniform, and objective means of evaluating medical impairment. (4) encourages physicians to participate in the development of workplace health and safety programs. Physician input into healthy lifestyle programs (the risks associated with alcohol and drug use, nutrition information, the benefits of exercise, for example) could be particularly helpful and appropriate. (5) encourages the use of uniform claim forms (CMS 1500, UB04), electronic billing (with appropriate mechanisms to protect the confidentiality of patient information), and familiar diagnostic coding guidelines (ICD-9-CM, CPT; ICD-10-CM, CPT), when appropriate, to facilitate prompt reporting and payment of workers' compensation claims. (6) will evaluate the concept of Independent Medical Examinations (IME) and make recommendations concerning IME's (i) effectiveness; (ii) process for identifying and credentialing independent medical examiners; and (iii) requirements for continuing medical education for examiners. (7) encourages state medical societies to support strong legislative efforts to prevent fraud in workers' compensation. (8) will continue to monitor and evaluate state and federal health system reform proposals which propose some form of 24-hour coverage. (9) will continue to evaluate these and other medical care aspects of workers' compensation and make timely recommendations as appropriate. (10) will continue activities to develop a unified body of policy addressing the medical care issues associated with workers' compensation, disseminate information developed to date to the Federation and provide updates to the Federation as additional relevant information on workers' compensation becomes available.

E-1.1.1.1. Patient-Physician Relationships. 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. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.

A patient-physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate). However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:

- (a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit.
- (b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.
- (c) When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists.

E-1.2.6: Work Related & Independent Medical Examinations. Physicians who are employed by businesses or insurance companies, or who provide medical examinations within their realm of specialty as independent contractors, to assess individuals' health or disability face a conflict of duties. They have responsibilities both to the patient and to the employer or third party. Such industry-employed physicians or independent medical examiners establish limited patient-physician relationships. Their relationships with patients are confined to the isolated examinations; they do not monitor patients' health over time, treat them, or carry out many other duties fulfilled by physicians in the traditional fiduciary role. In keeping with their core obligations as medical professionals, physicians who practice as industry- employed physicians or independent medical examiners should:

- (a) Disclose the nature of the relationship with the employer or third party and that the physician is acting as an agent of the employer or third party before gathering health information from the patient.
- (b) Explain that the physician's role in this context is to assess the patient's health or disability independently and objectively. The physician should further explain the differences between this practice and the traditional fiduciary role of a physician.
- (c) Protect patients' personal health information in keeping with professional standards of confidentiality.
- (d) Inform the patient about important incidental findings the physician discovers during the examination. When appropriate, the physician should suggest the patient seek care from a qualified physician and, if requested, provide reasonable assistance in securing follow-up care.

E-3.2.3 Industry Employed Physicians and Independent Medical Examiners. Physicians may obtain personal information about patients outside an ongoing patient-physician relationship. For example, physicians may assess an individual's health or disability on behalf of an employer, insurer, or other third party. Or they may obtain information in providing care specifically for a work-related illness or injury. In all these situations, physicians have a responsibility to protect the confidentiality of patient information. When conducting third-party assessments or treating work-related medical conditions, physicians may disclose information to a third party:

- (a) With written or documented consent of the individual (or authorized surrogate); or
 - (b) As required by law, including workmen's compensation law where applicable.
- When disclosing information to third parties, physicians should:
- (c) Restrict disclosure to the minimum necessary information for the intended purpose.
 - (d) Ensure that individually identifying information is removed before releasing aggregate data or statistical health information about the pertinent population.

E- 3.2.1 Confidentiality. Patients need to be able to trust that physicians will protect information shared in confidence. They should feel free to fully disclose sensitive personal information to enable their physician to most effectively provide needed services. Physicians in turn have an ethical obligation to preserve the confidentiality of information gathered in association with the care of the patient. In general, patients are entitled to decide whether and to whom their personal health information is disclosed. However, specific consent is not required in all situations. When disclosing patients' personal health information, physicians should:

(a) Restrict disclosure to the minimum necessary information; and

(b) Notify the patient of the disclosure, when feasible.

Physicians may disclose personal health information without the specific consent of the patient (or authorized surrogate when the patient lacks decision-making capacity).

(c) To other health care personnel for purposes of providing care or for health care operations; or

(d) To appropriate authorities when disclosure is required by law.

(e) To other third parties situated to mitigate the threat when in the physician's judgment there is a reasonable probability that: (i) the patient will seriously harm him/herself; or (ii) the patient will inflict serious physical harm on an identifiable individual or individuals.

For any other disclosures, physicians should obtain the consent of the patient (or authorized surrogate) before disclosing personal health information.

16. RESEARCH HANDLING OF DE-IDENTIFIED PATIENT INFORMATION

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

HOUSE ACTION: RECOMMENDATIONS ADOPTED REMAINDER OF REPORT FILED

See Policies H-315.962, H-315.974, H-315.975, H-315.978, H-315.987 and D-315.969

INTRODUCTION

At the 2018 Annual Meeting, Policy D-315.975, "Research Handling of De-Identified Patient Information," was adopted by the House of Delegates (HOD). This policy directs the American Medical Association (AMA) to study the handling of de-identified patient data and report the findings and recommendations to the HOD at the 2019 Annual Meeting. During the 2019 Annual Meeting of the HOD, Board of Trustees (Board) Report 26 and the recommendations included therein were discussed on the House floor. Specifically, mixed testimony was offered on recommendation two in the original report which recommended that our AMA support state-based efforts to protect patient privacy including a patient's right to know whether information is being disclosed or sold and to whom, as well as the right to opt out of the sale of their data. Significant testimony was received concerning the impact of that recommendation on registries, its application across inconsistent state laws, as well as on underserved populations. As a result, the HOD referred the report for further study. In addition, since the 2019 Annual Meeting our AMA has grown increasingly concerned that despite data aggregation and the removal of individually identifying characteristics protected health information, de-identified data can and is being re-identified by entities for a variety of purposes.

BACKGROUND

Health-related information collected during the course of clinical care has always been of great interest for a number of secondary use cases, including scientific research in the academic and commercial settings, public health studies, marketing for pharmaceutical and medical device companies, and a wide variety of other uses. More recently, a new and substantial interest has been raised from technology companies who seek to use patient data to build new clinical tools using machine learning and "big data." Clinical data is the topic of significant ethical guidance and regulation at both the state and federal levels, focused primarily on the appropriate use and handling of identifiable patient information. Little guidance exists, however, on the use of de-identified patient data.

A variety of entities, including provider organizations, clinical laboratories, and commercial entities such as personal genomics companies, may collect patient data intended for clinical use or to deliver genetics information, and then resell de-identified data to other entities for other purposes. Concerns arise in that when the data is de-identified, it is no longer considered PHI and therefore patient authorization or consent for use is not required and therefore not solicited—meaning that patients are not always aware how their data is being used.¹

In addition, there is both a real and perceived lack of transparency and regulation in how patients' data is being sold, distributed, or used outside of their direct health care. Risk of re-identification, which some studies have demonstrated

to be possible through matching data to other publicly available data sources, is another issue related to the use of de-identified data. There are also concerns about access to such information sought for marketing purposes on behalf of commercial entities that have financial interests in physicians' treatment and/or prescribing behavior. In addition, the sale of de-identified data by clinicians and provider organizations may create a real or perceived conflict of interest, which could lead to a loss of patient confidence.

What is Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides extensive protections for patient data that is considered protected health information (PHI).² PHI is information, including demographic information, which relates to an individual's past, present, or future physical or mental health or condition; the provision of health care to the individual; or the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual.³ It should be noted that HIPAA was developed in the era prior to the expansion of machine learning. PHI includes many common identifiers (e.g., name, address, birth date, Social Security Number) when they can be associated with the health information listed above. The HIPAA Privacy Rule sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization.⁴ These safeguards help protect patients from the risk of their data being released or used in manners that could result in discrimination, stigmatization, or embarrassment.^{5,6} Section 164.514(a) of the HIPAA Privacy Rule establishes standards for de-identifying PHI so individuals can no longer be identified by any portion of the data. The use, sale, or distribution of de-identified patient data is not prohibited under HIPAA, since once PHI is de-identified in accordance with the HIPAA Privacy Rule, it is no longer considered PHI and, thus, may be used and disclosed by a covered entity or health information organization (HIO) for any purpose otherwise allowed by law.⁷

In addition to regulation at the federal level, state lawmakers have exhibited a general trend toward establishing stricter guards on the use of patient data and the requirement for patient consent, some of which reflect standards set forth in the European Union's recent General Data Protection Regulation (GDPR).⁸ States are increasingly considering and passing laws to protect consumer privacy as it relates to the use of their personal information. For example, California in June 2018 passed the California Consumer Privacy Act of 2018 (effective January 1, 2020), which protects consumers' rights to: (1) know what personal information a for-profit business has collected about them, where it was sourced from, what it is being used for, whether it is being disclosed or sold, and to whom it is being disclosed or sold; (2) "opt out" of allowing a business to sell their personal information to third parties; (3) have a business delete their personal information, with some exceptions; and (4) receive equal service and pricing from a business, even if they exercise their privacy rights under the Act.⁹ California's law does not apply to information covered by HIPAA, de-identified personal data, or aggregate consumer data, however, as long as the de-identification measures meet the Act's strict standards.¹⁰

What is de-identified patient data?

45 CFR §164.514(a) of HIPAA states that "[h]ealth information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information." Removing identifiers from PHI mitigates privacy risks to individuals and thereby supports the secondary use of data for comparative effectiveness studies, policy assessment, life sciences research, and other endeavors.¹¹ HIPAA requires that covered entities use one of two methods for de-identification: (1) a formal determination by a qualified expert (expert determination); or (2) the removal of specified individual identifiers and an absence of actual knowledge by the covered entity that residual information could be used to identify the individual (safe harbor).

The identifiers that must be removed from PHI in the safe harbor method include:¹²

- Names
- All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP code, and their equivalent geocodes, except for the initial three digits of the ZIP code if, according to the current publicly available data from the Bureau of the Census:
- The geographic unit formed by combining all ZIP codes with the same three initial digits contains more than 20,000 people; and

- The initial three digits of a ZIP code for all such geographic units containing 20,000 or fewer people is changed to 000.
- All elements of dates (except year) for dates that are directly related to an individual, including birth date, admission date, discharge date, death date, and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older
- Telephone numbers
- Vehicle identifiers and serial numbers, including license plate numbers
- Fax numbers
- Device identifiers and serial numbers
- Email addresses
- Web URLs
- Social security numbers
- Internet Protocol addresses
- Medical record numbers
- Biometric identifiers, including finger and voice prints
- Health plan beneficiary numbers
- Full-face photographs and any comparable images
- Account numbers
- Any other unique identifying number, characteristic, or code, except as permitted
- Certificate/license numbers

How is de-identified data used?

De-identified data is used for research to derive information and knowledge about treatment and outcomes, as well as other patient care-related purposes. De-identified data is sourced, collected, and used by a variety of organizations, including health care provider organizations such as hospitals or academic medical centers, and commercial enterprises such as personal genomics and biotechnology companies as well as others that may not be directly related to patient care. Pharmaceutical manufacturers and retail pharmacies may also use de-identified health data to target their advertising. Health care providers use this data typically in research or the direct care of patient populations. Many stakeholders assert that de-identified data can help reduce costs of care, improve treatment options, and support public health initiatives.

Machine learning is a family of methods used by some health care and data solution organizations to help predict certain outcomes and better prepare for and treat patients identified to be at risk. Machine learning models establish predictive rules using vast amounts of computing power. The more data a machine learning model has, the more complex the rules and the more accurate the predictions.¹³ However, machine learning models are vulnerable to biases induced by data that does not adequately represent the patient population, such as data collected from only one institution or one geographic region. In order to develop clinical decision support tools that can be effectively used to treat the diverse patient populations in the United States, large amounts of data are required, and often data from many different providers across the country are required to avoid bias. The data are often sourced from de-identified patient records. Allscripts, for example, used 50 million de-identified patient records, and the application of an advanced machine learning algorithm, to “train” its systems and further improve its clinical decision support tools.¹⁴ Organizations like Orion Health and Precision Driven Health are using datasets like these to generate machine learning aimed at improving health care decisions, and driving operational and cost efficiencies.^{15,16} By combining multiple datasets, such as behavioral data, device use data, patient claim data and socioeconomic and geographic data, these organizations are developing advanced predictive analytics to further improve precision health care.¹⁷ The data used for the purposes of data mining and honing machine learning algorithms are either sourced and used at the organizational level, or de-identified when used for external research, such as the analysis done by Allscripts. Data may be sourced via publicly available de-identified datasets, databases established through collaborative research agreements, or via the purchase of bulk de-identified data, on an exclusive or non-exclusive basis. Since this technology is relatively new in the health care space its implications for patient data are not well-studied. As augmented intelligence and advanced machine learning proliferate in the health care space, the value and number of potential uses of patient health data will inevitably increase. Stakeholders should be prepared for increasing concerns about related patient privacy and data security.

Commercial entities, such as personal genomics companies, are typically not subject to HIPAA's rules around privacy and de-identification. They may collect data from consumers and then subsequently sell the de-identified data to another entity for another purpose. For example, 23andMe, a genomics and biotech service, sells de-identified user data to pharmaceutical companies that use it to conduct research on various diseases. However, patients are not always aware how their data is being used in these types of scenarios.¹⁸ For example, research using de-identified data may result in scientific knowledge that has commercial value. Proper consent for use and/or disclosure of commercial interest in this research is ideal but inconsistent, sometimes resulting in legal action against physicians or researchers.¹⁹

In addition, there is a lack of transparency and regulation in how patients' data is being sold, distributed, or used outside of their direct health care, both by entities subject to HIPAA and commercial actors. Risk of re-identification, which some studies have demonstrated to be possible through matching data to other publicly available data sources, is another issue related to the use of de-identified data. There are also concerns about access to such information that is sought for marketing purposes on behalf of commercial entities that have financial interests in physicians' treatment and/or prescribing behavior.

AMA POLICY

The AMA has multiple policies expressing its recognition of the importance of data privacy and protection of PHI, as well as policies expressing commitment to ensuring safe and appropriate use of de-identified data.

AMA Policy H-315.978, "Privacy and Confidentiality," states that where possible, informed consent should be obtained before personally identifiable health information is used for any purpose. However, in those situations where specific informed consent is not practical or possible, either (1) the information should have identifying information stripped from it or (2) an objective, publicly accountable entity must determine that patient consent is not required after weighing the risks and benefits of the proposed use. Re-identification of personal health information should only occur with patient consent or with the approval of an objective, publicly accountable entity.

AMA Policy H-315.974, "Guiding Principles, Collection and Warehousing of Electronic Medical Record Information," expresses the AMA's commitment to advocating that physicians, as trusted stewards of PHI, should be the owners of all claims data, transactional data and de-identified aggregate data created, established and maintained by a physician practice, regardless of how and where such data is stored but specifically including any such data derived from a physician's medical records, electronic health records, or practice management system.

AMA Policy H-315.983, "Patient Privacy and Confidentiality," states that whenever possible, medical records should be de-identified for purposes of use for utilization review, panel credentialing, quality assurance, and peer review. This policy also states our AMA will 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, and that whenever possible, de-identified data should be used for these purposes. Policy H-315.983, posits that in the event of a sale or discontinuation of a medical practice, 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. This policy includes extensive language emphasizing the AMA's commitment to protecting PHI, and that it will 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 physician 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.

In AMA Policy H-315.975, "Police, Payer, and Government Access to Patient Health Information," the AMA commits to advocating for narrow and clearly defined bounds for the appropriate use of patient information by law enforcement, payers and government entities, for operations that cannot be reasonably undertaken with de-identified data. AMA Policy H-315.987, "Limiting Access to Medical Records," further defines who should and should not have access to this information.

The AMA's *Code of Medical Ethics* includes an opinion on "Access to Medical Records by Data Collection Companies." Opinion E-3.2.4 asserts that 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. The opinion further expresses that physicians who wish to permit third-party access to specific patient information for commercial purposes should: (a) only provide data that has been de-identified, and (b) fully inform each patient whose record would be involved about the purpose(s) for which access would be granted. This opinion, with respect to requests for permission to allow access to or disclose a full medical record, prohibits disclosing identifiable information for commercial purposes without obtaining consent from the patient to do so.

The authors of Resolution 3-A-18, which established Policy D-315.975 and is the subject of this report, expressed particular concern that this *Code of Medical Ethics* Opinion may contradict itself in its emphasis on informing the patient of how their de-identified data will be used and the subsequent emphasis on the importance of obtaining consent. The key difference between the two elements of the opinion lies in the description of the patient information being requested (specific, de-identified patient information vs. full medical record), thus our AMA does not agree that these statements are contradictory.

The resolutions authors also expressed that this Opinion may be in disharmony with the rules set forth in the HIPAA Privacy Rule, specifically stating that authorization, rather than consent, is sometimes mandated for the release of PHI when being requested for purposes not related to treatment, payment, or health care operations (TPO). Ethical Opinion E-3.2.4 was originally issued in 1994 and updated in 1998, prior to the enactment of the HIPAA Privacy Rule, yet provides an even higher standard than the Rule with respect to requirements for consent to disclose patient data, including data that has been de-identified. With respect to authorization requirements, Opinion E-3.2.4 does not include a statement about when authorization, rather than consent, is appropriate and/or required. Guidance provided in the Code of Medical Ethics is provided by standards of conduct that define the essentials of honorable behavior for the physician. They cover broad ethical principles and are not intended to align with law or specific regulations that may be legally enforceable. During a comprehensive eight-year modernization process that ended in 2017, the AMA *Code of Medical Ethics* was reviewed for relevance/timeliness of guidance, clarity, and consistency of guidance. Opinion E-3.2.4 was reorganized in this process, taking the HIPAA provisions into consideration during the process. Care was taken to ensure the Council on Ethical and Judicial Affairs was conservative in suggesting substantive change, doing so only where needed to ensure that guidance remains relevant in the face of changes in biomedical science and conditions of medical practice. No contradictions or points of discord with HIPAA were identified in that review. It is also worth noting that “authorization” and “consent” are frequently (and often incorrectly) conflated in the context of HIPAA.

DISCUSSION

Oversight of patient information

The use of de-identified patient data is not heavily regulated at the federal level. The HIPAA Privacy Rule does not restrict the use or disclosure of de-identified health information, since it is not considered PHI.^{20,21} HIPAA permits secondary uses of de-identified data for purposes such as public health initiatives, research, law enforcement, and other public interest endeavors.^{22, 23} In addition, commercial entities that sell or use de-identified data, such as biotech, “big data” companies such as Google and Amazon, and pharmaceutical companies, are not considered covered entities under HIPAA. Through their interactions with pharmacy benefit managers, pharmacies, payers, physicians and patients, however, they may be indirectly impacted by privacy rules and thus obliged to structure their transactions, projects, and internal data programs such that their partners that are covered entities or business associates thereof meet data privacy requirements under HIPAA and any other applicable standards.

Studies that use de-identified data are exempt from regulations that govern human subject research.^{24,25} Entities that collect and use consumer data, such as pharmaceutical companies or academic institutions conducting research, should employ privacy protections in their practices, such as data security, reasonable collection limits, sound retention and disposal practices, and data accuracy to protect privacy, as guided in recommendations from the Federal Trade Commission (FTC).²⁶ For example, Harvard University, like many academic institutions receiving federal grants, implements strict policy to govern the collection, storage and use of research data, including PHI.²⁷ In addition to the enforcement of strict policy, all human subject research is subject to approval by the institution’s Institutional Review Board (IRB). It is the responsibility of IRBs to specify the security level for research projects they review and approve, obtain confirmation that the relevant security controls are being implemented and decide if the human subject must give consent or in the case of de-identified information, approve the research under an exempt status from obtaining the consent.

Human subject research conducted or supported by certain federal departments or agencies is governed by the Federal Policy for the Protection of Human Subjects (“Common Rule”). Revisions to the Common Rule in 2017 were adopted in response to shifts in science, technology, public engagement, and public expectations that have raised concerns about the limitations of the existing ethical framework in research.²⁸ The rapid pace of change in the availability, utility, and value of patient data, including PHI and de-identified data, will continue to necessitate regular reconsideration of the ethical oversight of patient data and how it is protected by researchers and other entities.

De-identified data and clinical data registries

Clinical data registries sponsored by entities such as national medical societies, or state or local health departments also collect and analyze data (including PHI) on treatment outcomes submitted by physicians, hospitals, and other types of health care providers related to a wide variety of medical procedures, diagnostic tests, and/or clinical conditions. Such registries use the data they collect to produce benchmarks or metrics that their participating health care providers can use to improve the quality of care they provide their patients. Registries also conduct (or work with others to conduct) research on the data they collect to enhance general knowledge about the safety and effectiveness of various medical procedures, diagnostic tests, treatments, and health care products. Other registries, such as public health databases, collect data on various population health events that may or may not involve medical treatment.

In 2018, the AMA reaffirmed Policy H-450.933, “Clinical Data Registries.” This policy states, in part, that “[o]ur AMA encourages multi-stakeholder efforts to develop and fund clinical data registries for the purpose of facilitating quality improvements and research that result in better health care, improved population health, and lower costs;” ... “[o]ur AMA supports flexibility in the development and implementation of clinical data registries;” and “[r]egistries and electronic health records should be interoperable, and should be capable of sharing and integrating information across registries and with other data sources in a HIPAA-compliant and confidential manner.” As evident by the reaffirmation of the Clinical Data Registries policy in 2018, our AMA does not desire to hinder the efforts of these registries to facilitate quality improvements and research that result in better health care, improved population health, and lower costs.

Risks with the re-identification of de-identified data and general ethical concerns

There are significant ethical concerns about the disclosure and use of de-identified health data that are rooted in the risk of re-identification. Studies have shown that certain elements of patient records, although not exclusive or unique to individual patients, increase the risk of re-identification if not removed from individual-level data.^{29,30} Elements such as gender, date of service, date of birth or zip code can potentially be linked back to other sources of data, such as voter registration lists, and could put the data at risk of re-identification.^{31,32} Organizations that collect, store, transfer and distribute de-identified data should take steps to reduce this risk, such as replacing a specific date of birth or date of service with a year.

Additionally, studies assessing the risk of re-identification after attempts to de-identify the data have found that just a few attributes are often enough to render the likelihood of correct re-identification very high. Our AMA policy is clear that the re-identification of personal health information should only occur with patient consent or with the approval of an objective, publicly accountable entity. Furthermore, since our initial Board report was presented during A-19, new studies and legal challenges have emerged that provide additional insight, and by extension raise additional concerns, about the increasing ability of entities (especially those with augmented intelligence (AI) capabilities) to re-identify de-identified patient data.^{33,34,35} Our AMA believes that corporate entities have a responsibility and an obligation to ensure that technical safeguards are being used to prevent the re-identification of de-identified patient data.

In addition to risk of re-identification, there are general ethical concerns with the availability and use of patient health data, even if it is de-identified, without explicit authorization from patients. For example, pharmaceutical companies may use de-identified data to target marketing or advertising efforts to specific physicians, therefore influencing treatment plans for patient populations with specific diseases or conditions. Accountable Care Organizations (ACOs), as business associates of the ACO participants or a covered entity, may use de-identified data to analyze quality measures, population risk scores and patient behaviors.³⁶ Other for-profit entities may use de-identified data for the development of new technology or clinical innovations. These sales of patient records for profit by provider organizations may raise concerns from the public that providers have an ulterior motive for collecting their data during clinical encounters. There are also studies demonstrating that for-profit entities selling de-identified information

gleaned from consumer-facing mobile health applications (apps) frequently are in violation of the apps' stated privacy policies.³⁷ In addition, patient record licensing contracts with exclusive rights may raise questions about the appropriate stewardship of patient data, as such exclusive contracts may be seen to benefit specific licensees at the expense of others, rather than enabling research and product development across the entire marketplace. However, one can imagine limited scenarios where a registry may choose to license de-identified data sets to commercial entities, with or without some degree of exclusivity, and yet maintain proper safeguards that require entities to ensure the data is not re-identified so the data can be used to further medical research.

Consent and authorization

Issues that arise in the potential risks of patient data use can be mitigated by proactively obtaining appropriate authorization or informed consent from patients for the use of their data. In the context of HIPAA, these issues primarily apply to PHI and not de-identified data. The HIPAA Privacy Rule permits, but does not require, a covered entity voluntarily to obtain patient consent for uses and disclosures of PHI for TPO. Covered entities that decide to obtain consent have complete discretion to design a process that best suits their needs. By contrast, an authorization is required by the Privacy Rule for most uses and disclosures of PHI not otherwise allowed by the Rule. Where the Privacy Rule requires patient authorization, voluntary consent is not sufficient to permit a use or disclosure of PHI. An authorization is a detailed document that gives covered entities permission to use PHI for specified purposes (e.g., sale of PHI or use of PHI to conduct marketing activities) or to disclose PHI to a third party specified by the individual. An authorization must include a number of elements, including a description of the PHI to be used and disclosed, the person authorized to make the use or disclosure, the person to whom the covered entity may make the disclosure, an expiration date, and, in some cases, the purpose for which the information may be used or disclosed.³⁸

PHI may be used and disclosed for research without an authorization in limited circumstances: (1) under a waiver of the authorization requirement; (2) as a limited data set with a data use agreement; (3) preparatory to research; and (4) for research on decedents' information. Limited data sets exclude 16 categories of direct identifiers, rather than the 18 identifiers removed in de-identified data. The information in a limited data set is considered PHI and its use or disclosure requires a data use agreement between the covered entity and the entity that will receive or use the data.

Standards and guidance

ONC publishes the "Guide to Privacy and Security of Electronic Health Information" to help physicians, other health care providers and practices work to comply with federal requirements in collecting, storing and using patients' data.³⁹

In addition to the policy set by the AMA and the guidance provided in the *AMA Code of Medical Ethics*, other physician and health care organizations provide guidelines and standards on the use of de-identified patient data. For example, the American Academy of Family Physicians published a "Data Stewardship" policy that facilitates the appropriate collection, storage, transmission, analysis, and reporting of de-identified patient data.⁴⁰ This policy includes guidance on establishing and maintaining a proper patient and physician consent process, as well as the appropriate use of data by third parties and policies that establish requirements for third-party use.

The American College of Physicians (ACP) policy encourages clinical entities and physicians to publish electronically their policies and procedures for sharing patient data and ensuring privacy. ACP's policy also states that in keeping with HIPAA, patients should know what information exists about them, its purpose, who can access and use it, and where it resides. While ACP supports the use of appropriately de-identified patient data for socially important activities, such as population health efforts and retrospective research, it does recommend tighter controls on the risks of re-identification of de-identified data.⁴¹

CONCLUSION

Access to de-identified patient data is important for the future of health care. Its benefits to the field of research have significant implications for our ability to make progress in refining the practice of medicine, reducing health care costs, reducing and preventing chronic disease, identifying cures for deadly conditions, and much more. In practice-level interventions, de-identified data can help practice administrators recognize patterns and gaps in processes and treatment plans across clinicians. Although the use of de-identified patient data can contribute to the continuum of improvement that is much needed across health care, its use comes with significant risks in the area of re-identifying patient data. The use of patient data is rapidly evolving, and our AMA must remain vigilant to ensure patient data is

being used properly, that appropriate safeguards are instituted to ensure risks are mitigated, and that, where patient consent is required or warranted, it is meaningful.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) reaffirm Policies H-315.975, “Police, Payer, and Government Access to Patient Health Information,” H-315.978, “Privacy and Confidentiality,” and H-315.987, “Limiting Access to Medical Records.”
2. That our AMA adopt a technical change to Policy H-315.974, “Guiding Principles, Collection and Warehousing of Electronic Medical Record Information,” by addition as follows:

Policy H-315.974, “Guiding Principles, Collection and Warehousing of Electronic Medical Record Information” Our AMA expressly advocates for physician ownership of all claims data, transactional data and de-identified and/or aggregate data created, established and maintained by a physician practice, regardless of how and where such data is stored but specifically including any such data derived from a physician's medical records, electronic health records, or practice management system, while preserving the principle that physicians act as trusted stewards of Protected Health Information.

3. That our AMA support efforts to promote transparency in the use of de-identified patient data and to protect patient privacy by developing methods of, and technologies for, de-identification of patient information that reduce the risk of re-identification of such information.
4. That our Council on Ethical and Judicial Affairs consider re-examining existing guidance relevant to the confidentiality of patient information, striving to preserve the benefits of widespread use of de-identified patient data for purposes of promoting quality improvement, research, and public health while mitigating the risks of re-identification of such data.
5. That Policy D-315.975, “Research Handling of De-Identified Patient Information,” be rescinded, as having been fulfilled by this report.

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17. DISTRACTED DRIVER EDUCATION AND ADVOCACY

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS REMAINDER OF REPORT FILED

See Policy H-15.952

Board of Trustees Report 12-I-19, “Distracted Driver Education and Advocacy” was amended by the addition of the following recommendation:

That our AMA will escalate the distracted driving campaign to a national level of awareness in coordination with the CDC and the National Education Association to educate elementary up through high school students as well as parents regarding the high-risk behavior of driving while holding cell phones and the opportunity to save lives and avoid injuries, with a review of steps taken and report back to the House at Annual 2020.

BACKGROUND

Distracted driving is any non-driving activity a person engages in while operating a motor vehicle.¹ Non-driving activities have the potential to distract the person from the primary task of driving and increase the risk of crashing.¹ There are three main types of distraction: visual – taking your eyes off the road, manual – taking your hands off the wheel, and cognitive – taking your mind off what you are doing.¹ Data shows that, in 2017, crashes involving a distraction led to 3,166 deaths.¹ However, identifying distracted drivers can be challenging so the actual numbers are likely much higher.

Policy H-15952 asks the AMA to: (a) make it a priority to create a national education and advocacy campaign on distracted driving in collaboration with the Centers for Disease Control and Prevention and other interested stakeholders; and (b) explore developing an advertising campaign on distracted driving with report back to the House of Delegates at the 2019 Interim Meeting.

In working towards implementing the A-19 policy, the AMA had conversations with staff at the Centers for Disease Control and Prevention (CDC). We were informed that their transportation safety work is focused on impaired driving, not distracted driving, since that is where they see the greatest number of injuries and fatalities. While there are evidence-based solutions to address the problem of impaired driving, the evidence is mixed on current strategies to address distracted driving.

Twenty states and the District of Columbia have passed laws to prohibit hand-held cell phone use by drivers to limit distracted driving and save lives.² Legislatures in other states have specifically prohibited texting while driving or cell phone use by younger drivers or school bus drivers.² Research on the effects of driver cellphone and texting bans has found mixed results.^{3,4} While some jurisdictions have seen promising results, overall there is considerable unsettled evidence regarding the effects of these laws on crash risk.^{3,4}

As a result, the CDC directed us to other partners who were working to address this issue. These organizations included the National Highway Traffic Safety Administration (NHTSA), the lead federal agency on the issue of distracted driving, and the Safe States Alliance, a non-profit professional association whose mission is to strengthen the practice of injury and violence prevention. During our own research, we also came across the resources developed by the National Safety Council (NSC), a non-profit public service association that is focused on eliminating preventable deaths at work, in homes and communities, and on the road through leadership, research, education and advocacy.

EXISTING NATIONAL CAMPAIGNS ON DISTRACTED DRIVING

National Highway Traffic Safety Association (NHTSA)

NHTSA’s distracted driver campaign is called “U Drive. U Text. U Pay.”⁵ The campaign is focused on educating Americans about the dangers of distracted driving and partnering with the state and local police to enforce laws against distracted driving that help keep us safe. The campaign involves public service announcements as well as a social

media campaign sharing stories and tips to help save lives. While states determine laws affecting distracted driving, NHTSA provides federal investments that address the states' specific needs.

National Safety Council (NSC)

The NSC also has a national campaign that is focused on National Distracted Driving Awareness Month, which was designated by Congress in 2010 as the month of April, making this year the 10-year anniversary of the campaign's launch.⁶ The slogan for the NSC campaign is "Just Drive." The campaign encourages drivers to keep their attention where it belongs, on the road. As a part of this campaign, the NSC develops free tools, which include a social media tool kit, fact sheets, a pledge, survivor stories, and posters. These tools can be used to learn more about distraction risks and create awareness of them in your community.

AT&T

AT&T also has a national campaign on distracted driving called "It Can Wait."⁷ This campaign, which includes advertising spanning print, radio, TV and online advertising, also began in 2010. The tools developed as part of this campaign include a pledge to always drive distraction free, advocacy tools – talking points, fact sheets, posters, presentations (school and corporate), media talking points, shareable videos, and a virtual reality experience.

AMA ACTIVITIES

On January 7, 2020, the AMA news team published a story titled, "Distracted driving: Most states aren't cracking down on deadly practice," which highlighted the importance of this issue as well as the AMA's model state distracted driving bill.⁸ The AMA has also used its social media platforms (LinkedIn, Twitter, Facebook and the RFS and MSS Facebook pages) to highlight the issue of distracted driving with 5 posts on this issue so far in 2020 (See Images 1 and 2). Engagements (defined as the total amount of likes, shares, retweets, comments and video views) were 171 with the total impressions (defined as the total number of times social media browsers showed the content) being 18,186.

This story led to the AMA receiving an interview request by CBS News on the issue of distracted driving. The AMA referred the reporter to the Medical Association of Georgia, given its success in addressing distracted driving. The interview was held on January 21, 2020. The AMA's position of calling for states to ban the use of handheld cellphones while driving was highlighted in the segment (See Images 3 and 4).⁹

The AMA's Advocacy Resource Center did a survey of state medical societies' legislative priorities for 2020. In looking at the public health priorities, only three states indicated that distracted driving is a priority for them this year, with most states prioritizing public health work on tobacco and e-cigarettes (32 states) and vaccines (30 states). (See Figure 1) The AMA has a model state bill, the "Distracted Driving Reduction Act" and is willing to assist medical societies in addressing this issue.

CONCLUSION

The Board of Trustees recognizes the importance of preventing distracted driving to lower crash rates and improve public safety. As the AMA was working to implement the directive from A-19, which contained a broad resolve to address distracted driving in collaboration with CDC and other stakeholders, the House of Delegates adopted a second directive at I-19 calling for the AMA to focus on educating elementary up through high school students as well as parents regarding the high-risk behavior of driving while holding cell phones.

Through the process of reviewing the literature on effective strategies to reduce distracted driving and discussing efforts underway with relevant stakeholders, the Board of Trustees proposes that AMA policy be updated to reflect the fact that hands-free laws may be a step towards reducing distracted driving in some communities, but overall the evidence of their effectiveness in reducing crash rates is mixed. Therefore, AMA policy should be modified to note the three types of distractions (visual, manual and cognitive) and to call for more research to determine the most effective strategies to reduce distracted driving and related crash risks.

The Board of Trustees further recommends that the directives adopted by House of Delegates be modified and streamlined to delete specific stakeholders that the AMA must work with on a campaign to address distracted driving and to eliminate the focus on "holding cell phones" as it is clear that manual distraction is not the only risky behavior.

Furthermore, the Board believes that the directive should remain broadly focused on preventing distracted driving in order to give the AMA the flexibility to address this important issue as appropriate. While plans are underway with stakeholders to develop a national campaign to address distracted driving, at the time of the writing of this report it was too soon to announce them.

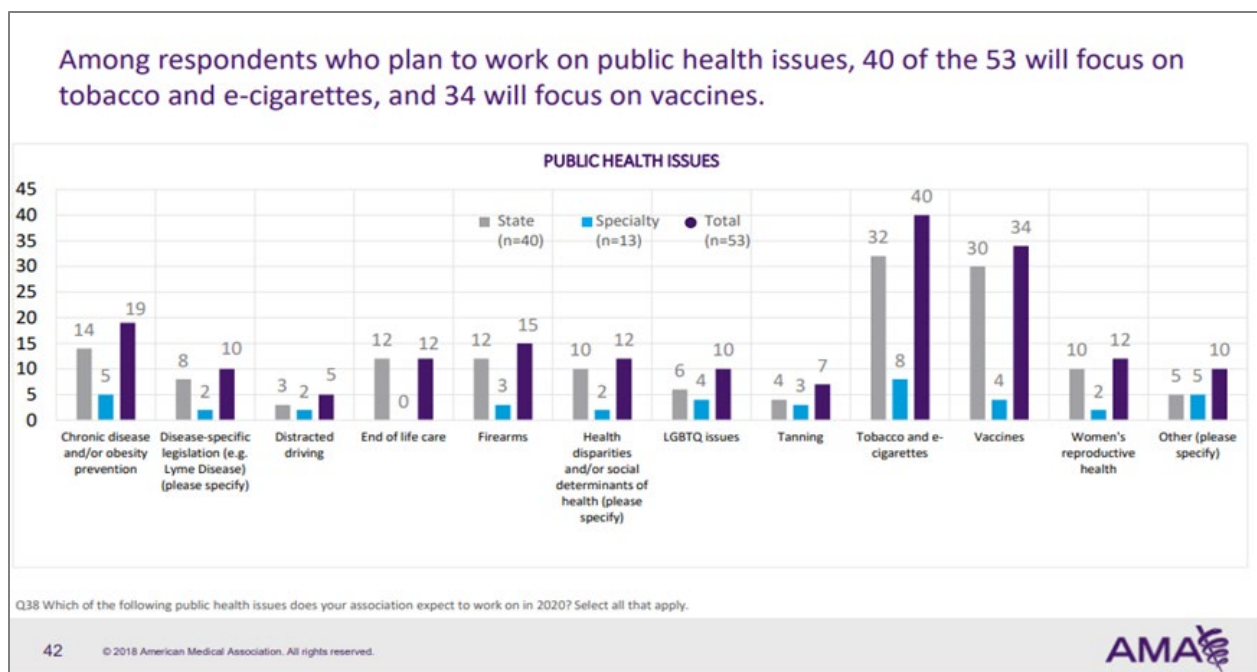
RECOMMENDATION

The Board of Trustees recommends that Policy H-15.952 be amended by addition and deletion to read as follows and the remainder of the report be filed.

H-15.952, “The Dangers of Distraction While Operating Hand-Held Devices”

1. Our AMA encourages physicians to educate their patients regarding the public health risks of ~~text messaging while operating motor vehicles or machinery~~ distracted driving, which includes the risks of visual distraction – taking one’s eyes off the road, manual distraction – taking one’s hands off the wheel, and cognitive distraction – taking one’s mind off what they are doing, and will advocate for state legislation prohibiting the use of handheld communication devices to text message while operating motor vehicles or machinery.
2. Our AMA will: (a) ~~endorse~~ support legislation that would ban the use of hand-held devices while driving, as a step in the right direction towards preventing distracted driving and (b) encourage additional research to identify the most effective strategies to reduce distracted driving-related crash risks.
3. Our AMA: (a) recognizes distracted walking as a preventable hazard and encourages awareness of the hazard by physicians and the public; and (b) encourages research into the severity of distracted walking as a public health hazard as well as ways in which to prevent it.
4. Our AMA supports public education efforts regarding the dangers of distracted driving, particularly activities that take drivers' eyes off the road, and that the use of earbuds or headphones while driving is dangerous and illegal in some states.
5. Our AMA: (a) supports education on the use of earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking; and (b) supports the use of warning labels on the packaging of hand-held devices utilized with earbuds or headphones, indicating the dangers of using earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking.
6. Our AMA will: (a) make it a priority to create a national education and advocacy campaign on distracted driving in collaboration with ~~the Centers for Disease Control and Prevention and other~~ interested stakeholders; and (b) ~~explore developing an advertising campaign on distracted driving with report back to the House of Delegates at the 2019 Interim Meeting.~~
7. ~~Our AMA will escalate the distracted driving campaign to a national level of awareness in coordination with the CDC and the National Education Association to educate elementary up through high school students as well as parents regarding the high risk behavior of driving while holding cell phones and the opportunity to save lives and avoid injuries, with a review of steps taken and report back to the House of Delegates at the 2020 Annual Meeting.~~

Figure 1.



Images 1 and 2

AMA @AmerMedicalAssn

Whether you're texting, calling, or listening through earbuds, distracted driving is hazardous for far too many U.S. citizens. The Distracted Driving Reduction Act prohibits drivers using handheld devices while operating a vehicle.

Distracted driving: Most states aren't cracking down on deadly practice
What's in the news: Eight Americans are killed every day in a car crash involving a distracted driver, and more than 1,000 are injured daily in such ...
ama-assn.org

2:45 PM · Jan 14, 2020 · Sprinklr

View Tweet activity

7 Retweets 4 Likes

American Medical Association (AMA) Published by Sprinklr [?] · January 18 ·

States have the opportunity to save lives by prohibiting drivers from using their phones (entirely) while driving.

Distracted driving: Most states aren't cracking down on deadly practice

8,782 People Reached 78 Engagements

[Boost Post](#)

Image 3



Image 4



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18. FINANCIAL PROTECTIONS FOR DOCTORS IN TRAINING

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: RECOMMENDATIONS ADOPTED REMAINDER OF REPORT FILED

See Policies H-310.903 and H-310.912

At the 2019 Annual Meeting, the House of Delegates referred resolution 608-A-19, “Financial Protections for Doctors in Training,” to the Board of Trustees. Resolution 608, introduced by the Resident and Fellow Section, asked:

That our American Medical Association (AMA) support retirement plans for all residents and fellows, which includes retirement plan matching in order to further secure the financial stability of physicians and increase financial literacy during training; and

That our AMA support that all programs provide financial advising to residents and fellows.

The reference committee heard testimony acknowledging the significance of medical student debt and the need for robust financial counseling. It also heard limited testimony in support of retirement plans and matching, noting concern about the restricted amount of GME funding available to institutions.

BACKGROUND

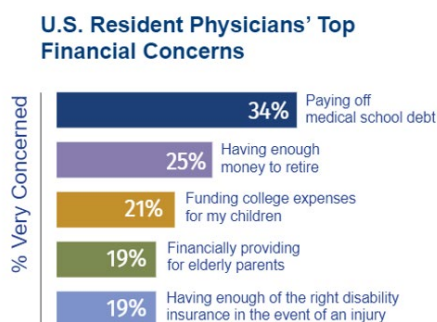
Training institutions generally offer residents and fellows medical, dental, vision and disability benefits that are comparable to those offered to other employees of an institution. Some also offer retirement plan options including matching contributions, but anecdotal reports indicate that this benefit is inconsistent, which results in inequitable and unreliable financial protections for trainees. Similarly, while some training institutions provide education on financial management and planning, anecdotal reports indicate that this benefit is also inconsistent and results in large variation in trainees’ proficiency in and confidence on the subject.

Medicare is the single largest funding source for graduate medical education (GME)¹ with the federal government matching a portion of what state Medicaid programs pay teaching institutions.^{2,3} Funding is limited, and Congress repeatedly considers cuts to GME. As a result, training institutions that do not currently offer retirement-related benefits could be hard-pressed to begin doing so.

DISCUSSION

Retirement savings

The depth and breadth of institutional benefits afforded to physicians in training varies widely and can lead to anxiety over financial stability and preparedness for the future, especially retirement. In fact, resident and fellow respondents to a 2017 study conducted by AMA Insurance (AMAI) reported their two highest concerns as “having enough money to retire” and “paying off medical school debt.”⁴



Source: 2017 Report on U.S. Physicians’ Financial Preparedness – Resident Segment. N=2,502 Multiple answers permitted.

While financial advisors are split on how to prioritize saving money and reducing debt, it is generally agreed upon that taking advantage of retirement plan matching contributions is a must. But, as noted, not all teaching institutions offer this critical benefit to residents and fellows, even where they offer it to other employees. Arguably, as the primary providers of care in a teaching hospital, spending between 50 and 80 hours a week caring for patients, it is not only appropriate that residents and fellows be classified as employees under applicable law but that they be offered retirement plan options, including contribution matching, no less favorable than those offered to other institution employees.

Education and advising

Sound financial education and advising are critical for residents and fellows, who face a unique and challenging financial situation relative to their non-physician peers. Nevertheless, the aforementioned AMAI study indicated that 88% of residents and fellows do not use a financial advisor, with the primary reasons being (1) lack of time, (2) cost, and (3) lack of trustworthiness. These barriers are a strong indication that busy trainees need easy-to-digest, affordable information from credible sources. While our AMA offers some resources, gaps still exist. Therefore, it stands to reason that our AMA should encourage teaching institutions to offer financial education and advising to residents and fellows.

Existing AMA resources

The AMA's Career Planning Resource (<https://www.ama-assn.org/amaone/career-planning-resource>) helps residents and fellows plan and achieve their career goals, and includes basic guidance on topics such as loan repayment options, creating a budget and financial plan, choosing the best insurance policies, and planning for retirement. Additionally, AMAI operates the Physicians Financial Partners program (<https://www.amainsure.com/physicians-financial-partners/about-us.html>), which provides medical students and physicians with a single source to find experienced and fully vetted financial professionals. Finally, the AMA offers member benefits to help medical students and physicians organize personal finances and manage debt, most notably through a partnership with Laurel Road offering discounted rates and other benefits on student loan refinancing, mortgages, and personal loans (<https://www.ama-assn.org/member-benefits/personal-member-benefits-discounts/loans-financial-services>).

Current AMA policy

The AMA has long-standing policy encouraging teaching institutions to offer benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation, as well as supporting quality and affordable comprehensive medical, mental health, dental, and vision care, including professional liability and disability insurance (see for example Policies H-310.912, H-295.942, H-295.873, and H-305.988, which are reproduced in full in the Appendix). Existing AMA policy does not address retirement planning or financial advising for residents and fellows.

CONCLUSION

Residents and fellows often are burdened with significant debt coming out of medical school. As they progress through training, aside from attaining clinical competency, it is of utmost importance that they become financially prepared for the future—whether that entails paying down debt, saving for retirement, or otherwise making sound financial decisions. While some teaching institutions offer benefit packages including retirement plans with matching contributions, many do not, and funds are limited. Similarly, while some institutions provide financial education and advising, many do not, and many trainees are left feeling ill-prepared and unsettled when it comes to their financial security.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 608-A-19 and the remainder of the report be filed:

1. That our American Medical Association (AMA) support the availability of retirement plans for residents and fellows at all teaching institutions that are no less favorable than those offered to other institution employees.

2. That AMA Policy H-310.912, “Residents and Fellows’ Bill of Rights,” be amended by addition and deletion to read as follows:

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. 7 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:

[...]

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

[...]

(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.

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APPENDIX - Relevant AMA Policy

Policy 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 encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation. 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 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 faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents. 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 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. Citation: CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19

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. Citation: 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

Policy H-295.873 “Eliminating Benefits Waiting Periods for Residents and Fellows”

Our AMA: (1) supports the elimination of benefits waiting periods imposed by employers of resident and fellow physicians-in-training; (2) will strongly encourage the Accreditation Council for Graduate Medical Education (ACGME) to require programs to make insurance for health care, dental care, vision care, life, and disability available to their resident and fellow physicians on the trainees' first date of employment and to aggressively enforce this requirement; and (3) will work with the ACGME and with the Liaison Committee on Medical Education (LCME) to develop policies that provide continuous hospital, health, and disability insurance coverage during a traditional transition from medical school into graduate medical education. (4) encourages the Accreditation Council for Graduate Medical Education to request that sponsoring institutions offer to residents and fellows a range of comparable medical insurance plans no less favorable than those offered to other institution employees. Citation: BOT Action in response to referred for decision Res. 318, A-06 Appended: CME Rep. 5, A-10

Policy H-305.988 “Cost and Financing of Medical Education and Availability of First-Year Residency Positions”

Our AMA: 1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education; 2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future; 3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced; 4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained; 5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are; 6. supports continued study of the relationship between medical student indebtedness and career choice; 7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds; 8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs; 9. encourages for-profit hospitals to participate in medical education and training; 10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians; 11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and 12. will advocate that resident and fellow trainees should not be financially responsible for their training. Citation: CME Rep. A, I-83 Reaffirmed: CLRPD Rep. 1, I-93 Res. 313, I-95 Reaffirmed by CME Rep. 13, A-97 Modified: CME Rep. 7, A-05 Modified: CME Rep. 13, A-06

19. ADVOCACY FOR PHYSICIANS AND MEDICAL STUDENTS WITH DISABILITIES

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS

REMAINDER OF REPORT FILED

TITLE CHANGED

See Policies D-90.991 and D-615.977

At the 2019 Annual Meeting, the House of Delegates (HOD) adopted Policy D-90.991, “Advocacy for Physicians with Disabilities.” The policy calls upon our AMA to:

study and report back on eliminating stigmatization and enhancing inclusion of physicians with disabilities including, but not limited to:

1. Enhancing representation of physicians with disabilities within the AMA.
2. Examining support groups, education, legal resources and any other means to increase the inclusion of physicians with disabilities in the AMA...

This report addresses and makes recommendations related to strategies to help reduce stigmatization for physicians with a disability and promote remedies that enhance supportive techniques for these physicians. For the purposes of this report, “disability” is defined as it is under the federal Americans with Disabilities Act (ADA) as “a physical or mental impairment that substantially limits one or more major life activity,” though the report recognizes that this is a legal definition rather than a medical one, and that other valid definitions exist.

DISCUSSION

Eliminating stigmatization

A key component of the stigmatization recognized by Policy D-90.991 is language, including spoken and written words. How physicians refer to each other, patients, and other actors in the healthcare sector can go a long way to lessening unintended emotional or professional burdens. Careful consideration of the proper use of “person first” and “identify first” language when engaging with individuals with disabilities can lead to a greater sense of belonging in the organization and at AMA-sponsored events.

Person-first language can be thought of as language that centers the personhood of someone, while identity-first language centers the community that person feels a sense of belonging to. While person-first language is taught in academic programs and frequently required for publication in scholarly journals, its use in clinical practice can lag. Whether through habit or a return to the jargon acquired during medical training, physicians can find themselves falling back into saying “diabetic” instead of “person with diabetes,” for example.

Adding to the complexity and applicability of its use is the acknowledgement that not all people prefer person-first language, opting for language that centers their identity instead. Prominent examples of this identity-first approach can include members of the deaf community who understand deafness to be a formative factor in a set of cultural beliefs, behaviors, and perspectives central to who they are as people. Likewise, members of the autistic community may prefer “autistic” over “person with autism” because they understand autism as a component of identity.

Additionally, not all disabilities are readily apparent to the outside observer. So-called “invisible disabilities” can be challenging to address because of their less overt nature. An invisible disability can be thought of as any invisible condition that limits a person’s movement or activities and is often misunderstood by others. Examples can include mental health conditions (for example, depression, anxiety, substance use disorders, etc.), learning impairments (dyslexia, attention deficit hyperactivity disorder), or biological medical conditions that aren’t externally apparent, such as diabetes or gastrointestinal diseases. While any disability if serious enough could manifest external signs, the absence of those signs should not be construed to assume a person is free from them.

Cultivating an awareness and sensitivity to how people understand their own abilities, as well as a recognition that not all people feel the same way, is critical to eliminating stigmatization. The AMA should work with its internal resource teams to develop an action plan for properly and effectively addressing language, terms, and vocabulary in use at internal and public AMA events and invest in opportunities to afford a richer understanding of how disability can manifest itself among employees and members.

Enhancing inclusion

Resources for physicians with disabilities are scarce. While professional organizations, such as the Association of Medical Professionals with Hearing Loss, the Society of Healthcare Professionals with Disabilities, exist, their reach tends to be limited and information and resources for physicians may be hard to come by, particularly in times of crisis or emergency. Greater resources exist through organizations designed to help medical students, such as the Association of American Medical Colleges or the Coalition for Disability Access in Health Science and Medical Education, however more work is needed not only to bring together resources for physicians but to create them in the first place.

In 2020, the AMA launched the Access internal employee resource group intended to support and empower individuals with disabilities at the AMA and to expand the relationship of the AMA with people with disabilities. The group seeks to better identify existing access needs within the AMA and support efforts to meet those needs. Going forward, the AMA should support and work with the resource group to promote and foster educational and training opportunities for AMA members and the larger medical community to better understand the role that disabilities can play in the healthcare work environment.

Securing legal protections

Under criteria established by the U.S. Equal Employment Opportunity Commission (EEOC), a healthcare worker must meet one of three criteria to be considered an individual with a disability: the worker has a physical or mental impairment that “substantially limits one or more major life activities;” has a record of impairment that is substantially

limiting; or is treated by an employer as having substantially limited impairment. Examples of “major life activities” include things that can be done with little or no difficulty, such as sitting, walking, seeing, hearing, speaking, learning, concentrating, or any other basic task.

The EEOC also recognizes people with substance use disorders as potentially qualifying for the definition of disability. Physicians with alcohol use disorder are considered to have a qualifying disability under the ADA. Likewise, physicians who have previously had a substance use disorder diagnosis but are not currently engaging in drug use may also be considered to have a disability under the law if that disorder is substantially limiting a major life activity.

In order for physicians with a disability to be protected under the ADA, they must be qualified to perform the essential functions of a job, with or without a reasonable accommodation. This means physicians must be able to meet an employer’s requirements for the job and be able to perform the fundamental job duties on their own or with reasonable assistance. These protections extend only to applicants and employees of a business. Independent contractors of a business, notably, are not covered, meaning that medical staff with a disability, separate from the non-medical employees of a healthcare facility, can find themselves with less protection than the employees. Physicians, particularly medical staff physicians, can thusly benefit from efforts to help them maximize their rights and privileges under the law.

CONCLUSION

According to the U.S. Census Bureau, approximately 85 million people in the United States have a disability, roughly 27 percent of the total population. Studies have shown that many medical treatment facilities may lack the resources necessary to adequately treat patients with disabilities simply for want of accommodations such as a ramp, or adequately sized hallways. It should be understood that if these facilities want for the ability to treat patients, they are likely also inadequate as places of employment for physicians with disabilities. And while federal and state laws have led to improvements for people with disabilities, both as patients and providers who are employees, greater action is required to create a truly equitable work and treatment environment. The reduction of stigma and the promotion of inclusion for physicians with disabilities is a daunting task requiring a variety of approaches and measures in order to achieve success. While the AMA cannot expect to single-handedly make these achievements, it can serve in good faith as a shepherd of them with relatively little disruption or financial cost.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) 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. That our AMA 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. That our AMA 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.
4. That our AMA 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.
5. That part 1 of Policy D-90.991, Advocacy for Physicians with Disabilities, be rescinded as having been accomplished by this report.

20. SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES – FIVE-YEAR REVIEW

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

HOUSE ACTION: RECOMMENDATIONS ADOPTED REMAINDER OF REPORT FILED

See Policy D-600.984

The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) scheduled to submit information and materials for the 2021 American Medical Association (AMA) November Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020, “Summary of Guidelines for Admission to the House of Delegates for Specialty Societies,” and AMA Bylaw 8.5, “Periodic Review Process.”

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

The following organizations were reviewed for the 2021 November Meeting:

- American Academy of Insurance Medicine
- American Academy of Sleep Medicine
- American Society for Gastrointestinal Endoscopy
- American Society for Radiation Oncology
- American Society for Surgery of the Hand
- American Society of Plastic Surgeons
- American Urological Association
- AMSUS The Society of Federal Health Professionals
- North American Spine Society
- Society for Vascular Surgery
- Society of American Gastrointestinal and Endoscopic Surgeons

The American Society of Abdominal Surgeons and the International Academy of Independent Medical Evaluators were also reviewed at this time because they failed to meet the requirements of the review in November 2020.

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

The materials submitted indicate that: American Academy of Insurance Medicine, American Academy of Sleep Medicine, American Society of Gastrointestinal Endoscopy, American Society of Plastic Surgeons, American Urological Association, AMSUS The Society of Federal Health Professionals, and North American Spine Society meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicated that: American Society for Radiation Oncology, American Society for Surgery of the Hand, International Academy of Independent Medical Evaluators, Society for Vascular Surgery, and the Society of American Gastrointestinal and Endoscopic Surgeons did not meet all guidelines and are not in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The American Society of Abdominal Surgeons did not submit materials last year or this year and is therefore not compliant.

RECOMMENDATIONS

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

1. That the American Academy of Insurance Medicine, American Academy of Sleep Medicine, American Society of Gastrointestinal Endoscopy, American Urological Association, American Society of Plastic Surgeons, AMSUS The Society of Federal Health Professionals and North American Spine Society retain representation in the American Medical Association House of Delegates.
2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5, American Society of Radiation Oncology, American Society for Surgery of the Hand, Society for Vascular Surgery, and the Society of American Gastrointestinal and Endoscopic Surgeons be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership.
3. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5 after a year's grace period to increase membership, the American Society of Abdominal Surgeons and the International Association of Independent Medical Evaluators not retain representation in the House of Delegates.

APPENDIX

Exhibit A - Summary Membership Information

| Organization | AMA Membership of Organization's Total Eligible Membership |
|--|---|
| American Academy of Insurance Medicine | 29 of 122 (24%) |
| American Academy of Sleep Medicine | 1,078 of 5,039 (21%) |
| American Society for Gastrointestinal Endoscopy | 1,640 of 7,793 (21%) |
| American Society for Radiation Oncology | 708 of 3,935 (18%) |
| American Society for Surgery of the Hand | 415 of 2,348 (18%) |
| American Society of Abdominal Surgeons | no data to review |
| American Society of Plastic Surgeons | 1,716 of 8,803 (20%) |
| American Urological Association | 1,015 of 6,821 (15%) |
| AMSUS The Society of Federal Health Professionals | 554 of 2,071 (27%) |
| International Academy of Independent Medical Evaluators | 63 of 152 (41%) |
| North American Spine Society | 1,100 of 4,669 (24%) |
| Society for Vascular Surgery | 534 of 2,804 (19%) |
| Society of American Gastrointestinal and Endoscopic Surgeons | 704 of 3,737 (19%) |

Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (Policy G-600.020)

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.
2. The organization must:
 - (a) represent a field of medicine that has recognized scientific validity;
 - (b) not have board certification as its primary focus; and
 - (c) not require membership in the specialty organization as a requisite for board certification.

3. The organization must meet one of the following criteria:
 - (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
 - (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
 - (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.
4. The organization must be established and stable; therefore, it must have been in existence for at least five years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office.
7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

Exhibit C

- 8.2 Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations. Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:
 - 8.2.1 To cooperate with the AMA in increasing its AMA membership.
 - 8.2.2 To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.
 - 8.2.3 To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.
 - 8.2.4 To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.
 - 8.2.5 To provide information and data to the AMA when requested.

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

8 - Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates

- 8.5 Periodic Review Process. Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society, or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.
 - 8.5.1 If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting or may take such other action as it deems appropriate.
 - 8.5.2 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

- 8.5.3 Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.
- 8.5.3.1 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.
- 8.5.3.2 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:
- 8.5.3.2.1 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.
- 8.5.3.2.2 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

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.