

Instruction Sheet

For the Virtual House of Delegates and Reference Committee Hearings

This instruction sheet is provided to assist participants with navigating the virtual House of Delegates and Reference Committee Hearings. Information such as understanding how to use and log into platforms, how to join the speaking queue and what to do if you are having technical problems are included. We advise reading this prior to attendance at the House of Delegates and Reference Committee Hearings. Keep it available during the virtual meeting for reference as well.

Your Two Platforms

You will use two platforms to participate in the House of Delegates and Reference Committees:

1. Lumi Platform	2. Zoom Webinar
<p>Use for:</p> <ul style="list-style-type: none"> • Entering the speaking queue. (A key to the speaking Action Terms you must use will be found in the Lumi platform). • Voting on elections and motions. • Viewing documents. 	<p>Use for:</p> <ul style="list-style-type: none"> • Viewing meeting proceedings. • Raising your hand to speak when asked to do so by the presiding officer. • Enabling your camera • Enabling your microphone, after being called on by the presiding officer.

You will have **both** the Lumi Platform and Zoom Webinar open on your computer in two different windows. You may use two devices. For example, a separate mobile or tablet may be used to log into the Lumi platform to request to speak and vote.

Your Login Instructions

- For the **LUMI** Platform: click on the provided Lumi link (page 2) for the respective session.
 - **Delegate** Credential = 9-character alphanumeric codes mailed and emailed to you.
 - Business Credential: Letter B followed by 8 digits, e.g. B12345678, with password **2021special** (lowercase). This should be used for all hearings and sessions.
 - **Alternates** and members wishing to join the speaking queue during reference committee hearings should login under “Alternate/Guest”
- For **ZOOM**: click on the provided Zoom Webinar link (page 2) for the respective session and **use your first and last name at login**. *If you have previously signed into ZOOM with your account, please double check your login or **display name**. Please ensure you have entered the same first and last name as in LUMI.*
- Reminder to **Alternate Delegates** (only when “seated” in the HOD) you will use your delegate’s Business Credential but must still enter your first and last name in ZOOM.

Your Links

LUMI Links

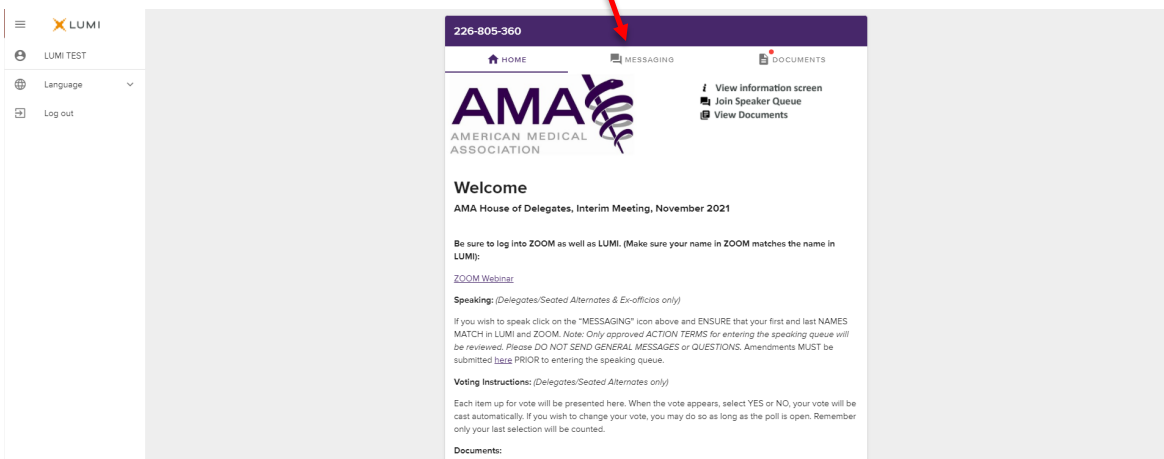
	Lumi Link
HOUSE OF DELEGATES:	https://web.lumiagm.com/226-805-360
Reference Committees:	
Reference Committee on Amends to Constitution & Bylaws	https://web.lumiagm.com/234-902-180
Ref. Comm. A: Medical Service	https://web.lumiagm.com/233-825-983
Ref. Comm. B: Legislation	https://web.lumiagm.com/221-235-355
Ref. Comm. C: Medical Education	https://web.lumiagm.com/269-525-585
Ref. Comm. D: Public Health	https://web.lumiagm.com/230-431-194
Ref. Comm. E: Science and Technology	https://web.lumiagm.com/270-283-390
Ref. Comm. F: Finance	https://web.lumiagm.com/230-465-128
Ref. Comm. G: Medical Practice	https://web.lumiagm.com/237-940-517

ZOOM Links

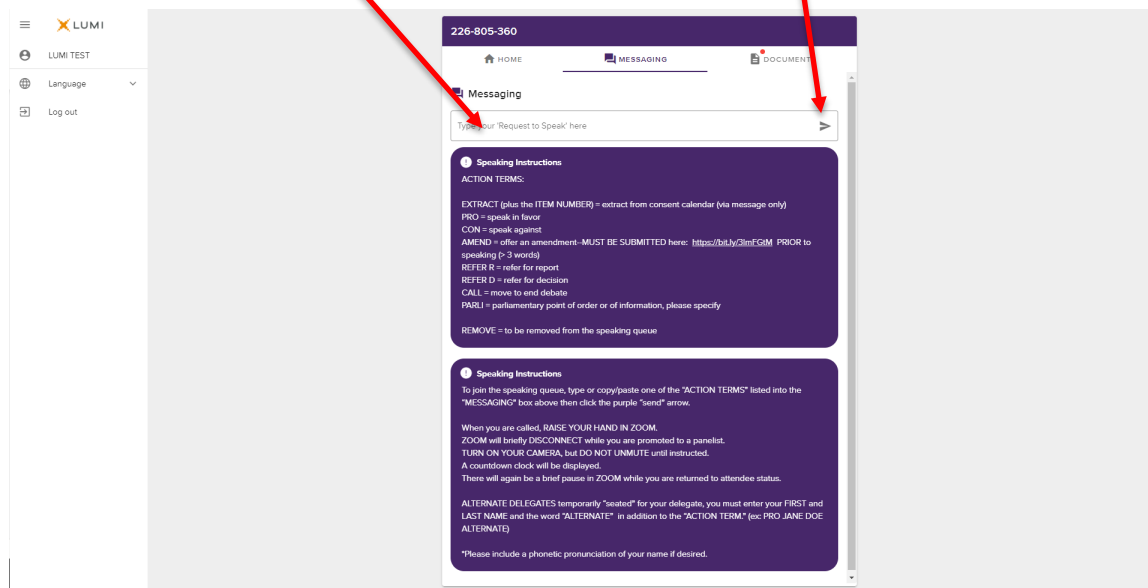
	ZOOM Link
House of Delegates:	https://lumiglobal.zoom.us/j/95914188733?pwd=RnJrWk5CWG5Wb2dDEpHRmprL2plUT09
Reference Committees:	
Reference Committee on Amends to Constitution & Bylaws	https://lumiglobal.zoom.us/j/92680050028?pwd=RGdJNE92dmdISUJKK3dDMkpkcE80Zz09
Ref. Comm. A: Medical Service	https://lumiglobal.zoom.us/j/92680660416?pwd=UnhBazAzZlJ0MlhpM0hSTXlCQTYrdz09
Ref. Comm. B: Legislation	https://lumiglobal.zoom.us/j/95754532235?pwd=bEJ2QzIFR05pTmVHUST0VzBudGZ4UT09
Ref. Comm. C: Medical Education	https://lumiglobal.zoom.us/j/99084129881?pwd=Q0ZHWDFwME9iVHN2VSttZExlVjI6QT09
Ref. Comm. D: Public Health	https://lumiglobal.zoom.us/j/95613263189?pwd=OGE3MWtEV2hmR0FVb3lOS2pEN0ZlZz09
Ref. Comm. E: Science and Technology	https://lumiglobal.zoom.us/j/92884665016?pwd=STNkUWRIMkx5TnBzSHRrTThENVBkUT09
Ref. Comm. F: Finance	https://lumiglobal.zoom.us/j/94151089177?pwd=cjkzdTFxdUdRYjFPbWhCT2RocFZLUT09
Ref. Comm. G: Medical Practice	https://lumiglobal.zoom.us/j/94257023403?pwd=Sy92Y3phL2d4L0NOeHV2a2NjZHErdz09

Speaking during the virtual meeting

- When you log into the LUMI Platform, you will see the HOME Screen.
- To join the Speaking Queue, click the MESSAGING icon in the menu bar.

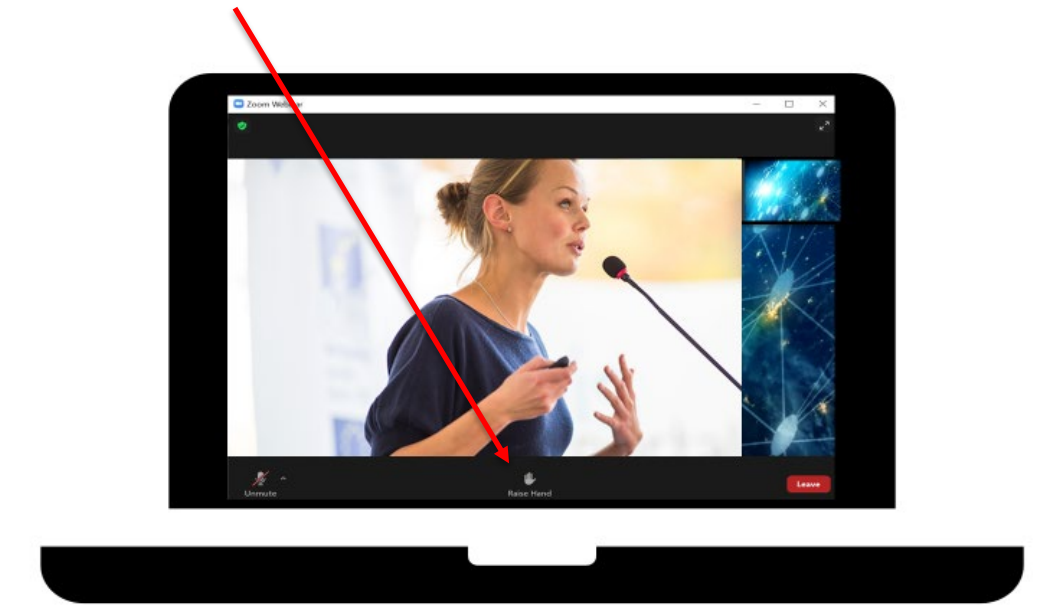


- To join the speaking queue, you MUST enter (copy/paste or type) one of the listed **Action Terms** in the Messaging box at the top and hit the purple arrow icon.

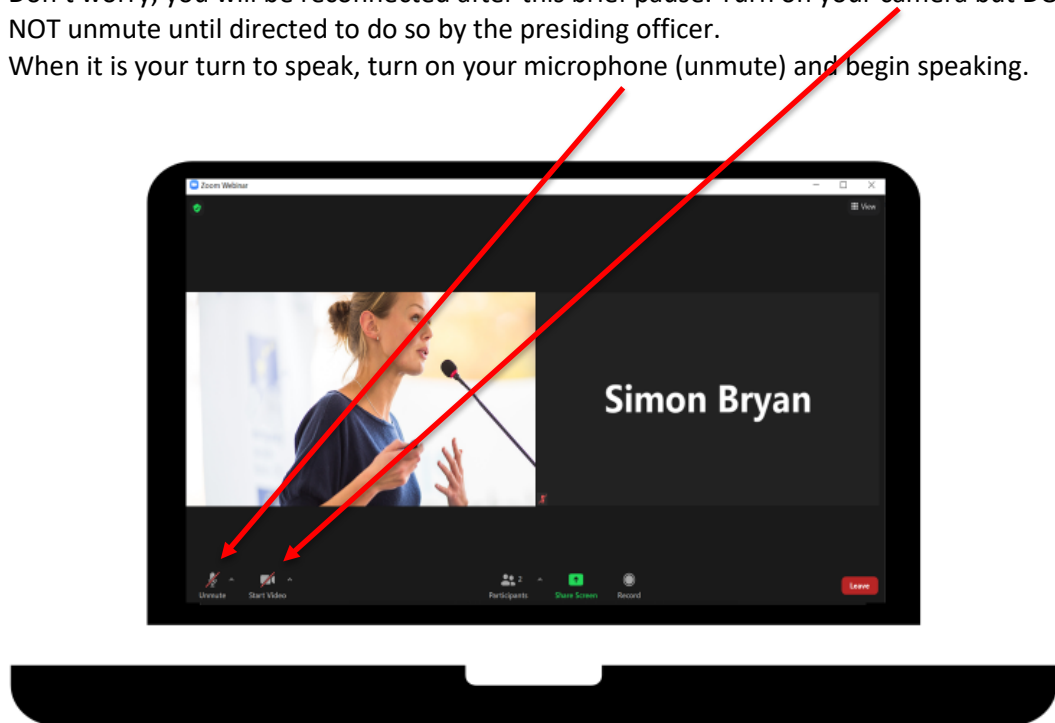


- **ALTERNATE DELGATES FOR THE HOD ONLY**-After your Action Term add your FIRST and LAST NAME and ALTERNATE (ex PRO JANE DOE ALTERNATE)
- If using the Action Term **PARLI**, please also enter your parliamentary inquiry
- **REMINDER:** Use only the appropriate ACTION TERMS as instructed and DO NOT SEND OTHER COMMENTS OR QUESTIONS

- The presiding officer will announce the order of speakers. When your name is announced, **RAISE YOUR HAND IN THE ZOOM PLATFORM.**



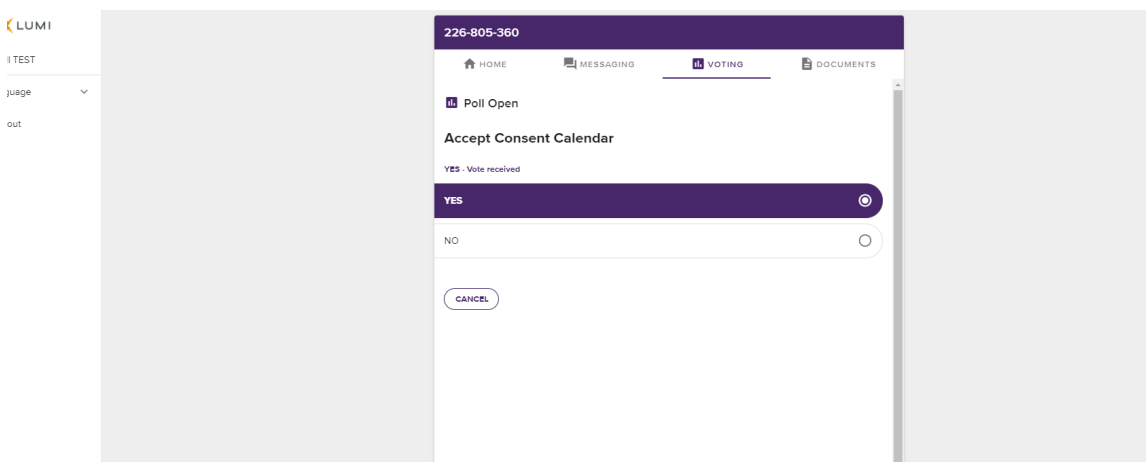
- There will be a brief disconnection from ZOOM as you are promoted to the speaking queue. Don't worry, you will be reconnected after this brief pause. Turn on your camera but DO NOT unmute until directed to do so by the presiding officer.
- When it is your turn to speak, turn on your microphone (unmute) and begin speaking.



- You will see a countdown timer in one of the windows showing your allotted time (90 seconds-unless changed by the presiding officer).
- Once your turn to speak is over, the production team will mute your microphone and disable your camera. There will again be a brief disconnection from ZOOM. Don't panic! You will automatically be reconnected.

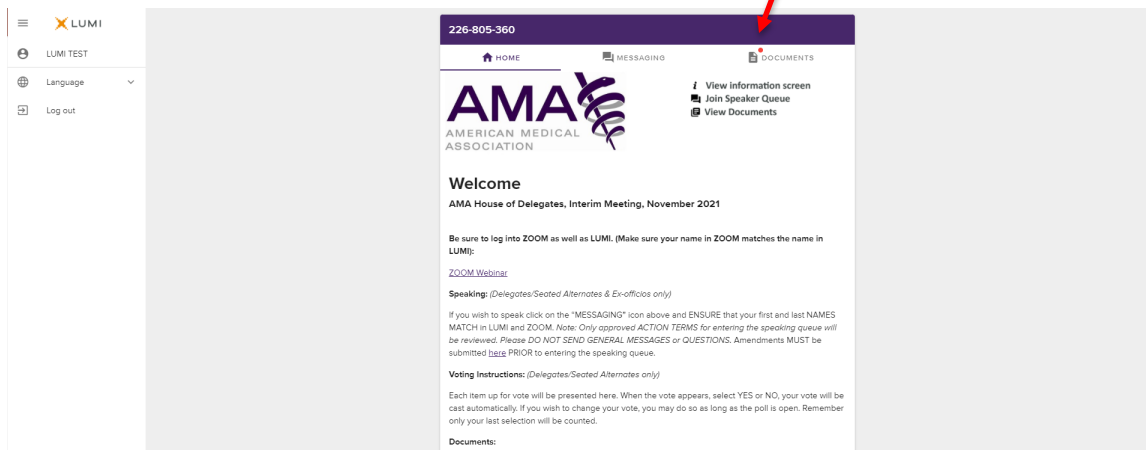
Voting

- Voting items will appear automatically in the Lumi platform.
- When the vote appears, select YES or NO, your vote will be cast automatically. If you wish to change your vote, you may do so as long as the poll is open. Remember only your last selection will be counted.



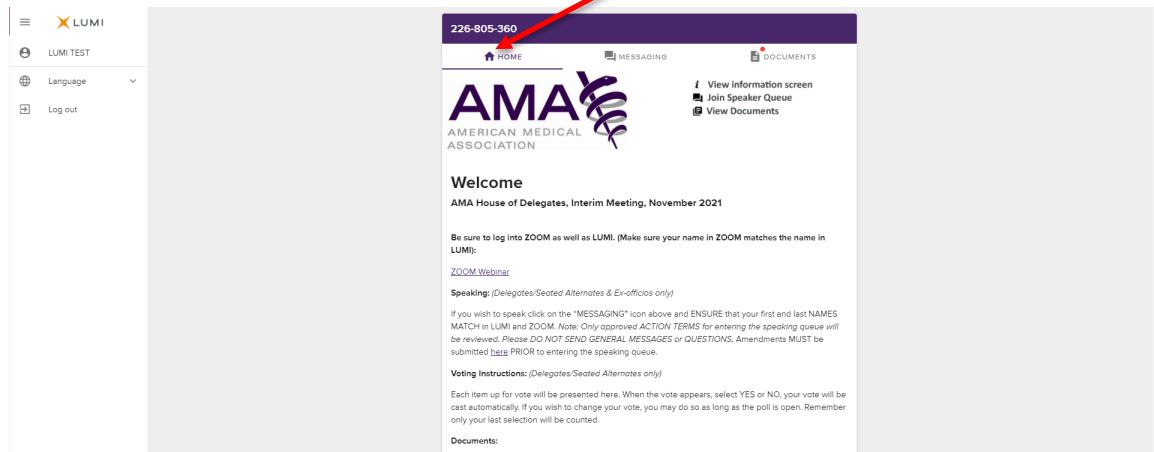
Viewing Documents

- You can view meeting documents by clicking on the DOCUMENTS icon in the menu bar in the Lumi platform. This icon will only be present when there are documents to be viewed.



Home Screen

- You may return to the Home Screen by clicking on the HOME icon on the menu bar in the Lumi platform.



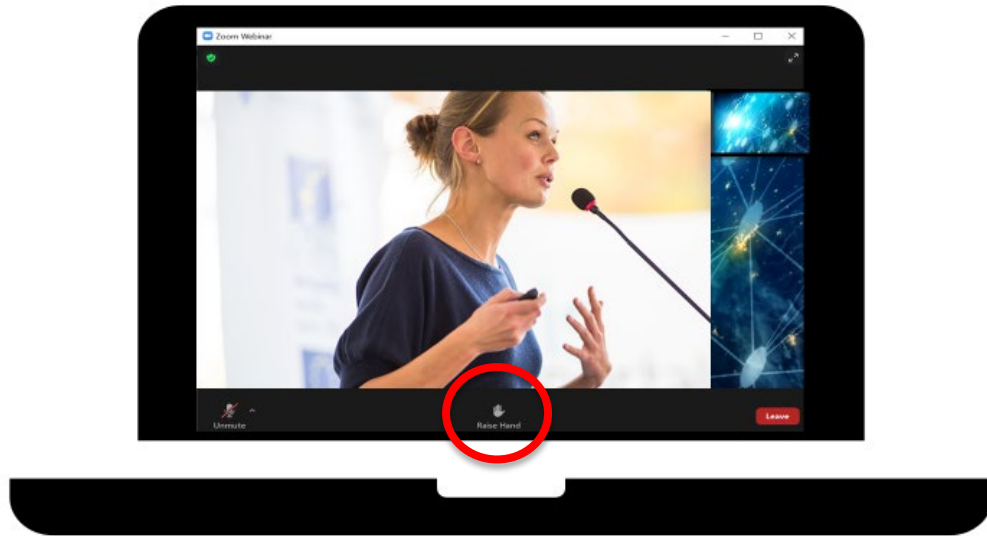
Best Practice Tips

The following are tips to prepare for the best virtual meeting experience:

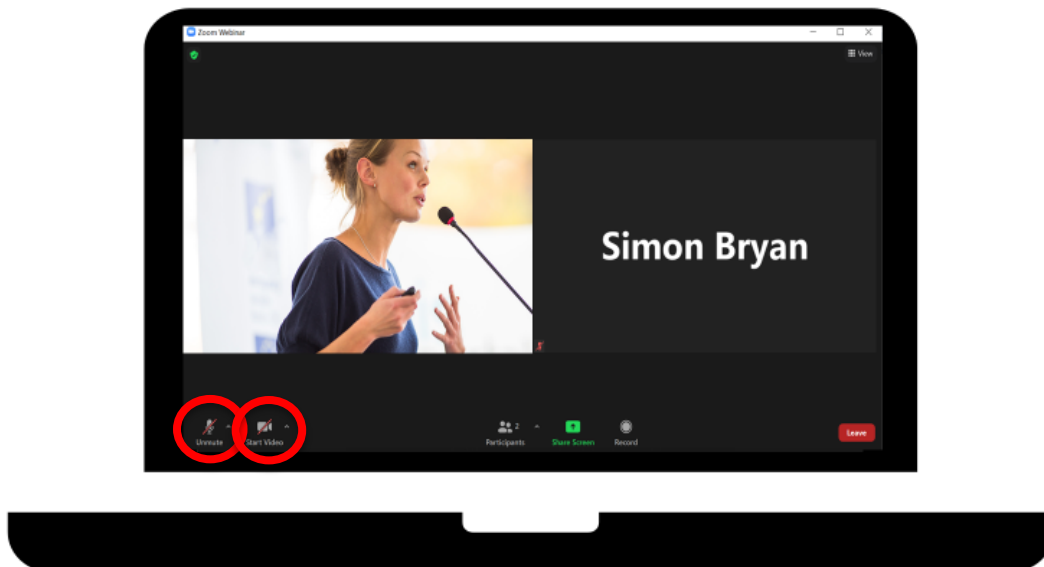
- If possible, connect to the Internet via an Ethernet cable. If using WiFi, ensure that you are close to your wireless router and that your connection is stable.
- Headsets are helpful for hearing audio and speaking more clearly.
- Speakers from the floor will be seen on webcam while speaking. Ensure you have a webcam built into your computer or connect a free-standing one.
- We recommend using Zoom on a computer rather than a mobile device.
 - Please keep your microphone muted in Zoom until prompted.
- You can log into both Zoom Webinar and Lumi **up to 30 minutes** before, and ideally **at least 15 minutes before** each session.

- **Familiarize yourself with Zoom:**

- Make sure you **log into Zoom with your first and last name** so production staff can easily find you in the list.
- Raise your hand icon – use **ONLY** when prompted.



- Turn on your camera in the bottom left corner after the brief pause in Zoom.
- Unmute **ONLY** when called upon to speak using the icon in the bottom left corner.



Practice Session Recording

- The recording of the practice session from the J21 Special Meeting is posted on our website and can be found at <https://youtu.be/V8xU95OI85o>. We will not be having a live practice session for this meeting.

Troubleshooting

- Participants with technical issues should email HODMeetingSupport@ama-assn.org (please include a phone number); we will contact you back as soon as possible to assist. For urgent issues during the meeting, the HOD Hotline: 800-337-1599, will be available for assistance. Please note that unless there is a widespread technical difficulty, proceedings will continue.

FAQs

- **What is my username to log into the Lumi platform?**
Delegates and current and past officers should have an alphanumeric code: a Business Credential beginning with the letter “B” to be used for the reference committees and business sessions. These will be sent by US mail and will be emailed to you as well. Delegates may share their Business Credential with their alternate delegate, but only one person can be logged in with the credential at a time. The password for business sessions and reference committees is **2021special** (lower case). Alternates and others may log into the Lumi platform as “guests” and simply input your first and last name.
- **Does the platform allow for participants to group chat with each other and other voting members during the virtual meeting?**
No, the chat and message functions are not enabled to allow participants to communicate with one another. Participants are responsible for determining a preferred method of communications outside of the provided Lumi platform and Zoom platform. Some options include use of free group chat platforms like Slack, group text or email chains, conference lines, or apps like GroupMe.
- **How do I vote?**
When a motion / resolution is put before the meeting, the voting will automatically pop up within your Lumi platform. Simply click on your selection to cast your vote.
- **Which browsers are supported?**
It is recommended to use the latest versions of Chrome, Firefox, Edge or Safari. Do not use Internet Explorer.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Report of Committee on Rules and Credentials

Presented by: Tripti C. Kataria, MD, Chair

November 12, 2021

1 Mister Speaker, Members of the House of Delegates: Your Committee on Rules and Credentials
2 recommends the following rules for this Special Meeting of the House of Delegates:

3
4 1. Special Meeting of the House of Delegates (HOD)

5 In accordance with the official “Call for the Special Meeting” dated September 13, 2021, the AMA
6 House of Delegates will convene via a virtual platform on November 12-16, 2021 to conduct
7 priority business of the Association.
8

9 2. House of Delegates Security

10 Maximum security shall be maintained at all times to prevent disruptions of the House, and only
11 those individuals who have been properly credentialed shall be permitted to vote or comment.
12

13 3. Credentials

14 The registration record of the Committee on Rules and Credentials shall constitute the official roll
15 call at this Special Meeting of the House. Delegates have been issued a unique Business Credential
16 for use during the virtual meeting and should guard it carefully. If the credential is compromised, it
17 should be reported immediately to HOD@ama-assn.org. Recredentialing can be accomplished by
18 notifying the HOD office electronically, in which case a new credential shall be issued and the
19 previous credential made void. Only delegates or their alternate may vote on business before the
20 House.
21

22 4. Business of the House of Delegates

23 The order of business as published shall be the official order of business for this Special Meeting.
24 This may be varied by the Speaker, subject to any objection sustained by the House. Under the
25 bylaws, business is restricted to that for which this Special Meeting has been called. The House of
26 Delegates will determine which resolutions meet the criteria for consideration at this Special
27 Meeting. No further business shall be entertained.
28

29 5. Privilege of the Floor

30 Delegates may request the privilege of the floor via the virtual platform. An alternate may request
31 the privilege of the floor when “seated” for his/her delegate. The Speaker may grant the privilege of
32 the floor to such persons as may be presented by the President, or Chair of the Board of Trustees, or
33 others who may expedite the business of the House, subject to objections sustained by the House.
34

35 6. Procedures of the House of Delegates

36 As per the official “Call for the Special Meeting” and per the Bylaws governing the Special
37 Meeting, discretion shall be given to the Speaker to conduct the business before the AMA House of
38 Delegates.
39

40 7. Limitation on Debate

41 There will be a 90-second limit on debate per presentation, subject to waiver by the presiding
42 officer for just cause, on any oral presentation.

1 8. No Second Required

2 To expedite consideration of motions before the House, motions shall be assumed to have a second
3 unless an objection to the assumption of a second for a specific motion is expressed.
4

5 9. Conflict of Interest

6 Members of the House of Delegates who have a substantial financial interest in a commercial
7 enterprise, whose interest will be materially affected by a matter before the House of Delegates,
8 must publicly disclose that interest.
9

10 10. Respectful Behavior

11 Courteous and respectful dealings in all interactions with others, including delegates, AMA and
12 Federation staff, and other parties, are expected of all attendees at House of Delegates meetings.
13

14 Mister Speaker, This concludes the Report of the Committee on Rules and Credentials, and we
15 recommend its adoption.

Patricia L. Austin, MD
California

Laurel Ries, MD *
Minnesota

Ariel Carpenter, MD
Kentucky, Sectional Resident

Jayesh Shah, MD
Texas

Dale M. Mandel, MD *
Pennsylvania

Tripti C. Kataria, MD, Chair
American Society of Anesthesiologists

Glen McClain, MD *
Ohio

* Alternate Delegate

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

NOVEMBER 2021 SPECIAL MEETING

ORDER OF BUSINESS - OPENING SESSION

**Friday, November 12, 2021
7:00 pm**

- 1. Call to Order by the Speaker - Bruce A. Scott, MD**
- 2. Invocation**
- 3. National Anthem**
- 4. Address of the President - Gerald E. Harmon, MD**
- 5. Report of the Executive Vice President - James L. Madara, MD**
- 6. AMA Alliance**
- 7. AMPAC**
- 8. AMA Foundation**
- 9. Awards - Gerald E. Harmon, MD**
- 10. Remarks of the Speaker - Bruce A. Scott, MD**
- 11. Report of the Rules and Credentials Committee - Tripti C. Kataria, MD**
- 12. Presentation, Correction and Adoption of Minutes of the June 2021 Special Meeting**
- 13. Acceptance of Business**

Reports of the Board of Trustees - Bobby Mukkamala, MD, Chair

- 01 Racial Essentialism in Medical Education (Info. Report)
- 02 Policing Reform (B)
- 03 Redefining the AMA's Position on ACA and Healthcare Reform (Info. Report)
- 04 2021 AMA Advocacy Efforts (Info. Report)
- 05 Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment (Amendments to C&B)
- 06 Mitigating the Effects of Racism in Health Care: "Best Practices" (Info. Report)
- 07 Improving Clinical Algorithms: Moving Beyond Race and Ethnicity (Info. Report)
- 08 Improved Access and Coverage to Non-opioid Modalities to Address Pain (B)
- 09 Medical Marijuana License Safety (B)
- 10 Physician Access to Their Medical and Billing Records (B)
- 11 National Guidelines for Guardianship (Amendments to C&B)
- 12 Direct-to-Consumer Genetic Tests (B)
- 13 Study of Forced Organ Harvesting by China (Amendments to C&B)
- 14 Net Neutrality and Public Health (B)
- 15 Opposing Attorney Presence at and/or Recording of Independent Medical Examinations (Amendments to C&B)
- 16 Research Handling of De-Identified Patient Information (Amendments to C&B)

- 17 Distracted Driver Education and Advocacy (D)
- 18 Financial Protections for Doctors in Training (F)
- 19 Advocacy for Physicians with Disabilities (F)
- 20# Specialty Society Representation in the House of Delegates - Five-Year Review (Amendments to C&B)

Reports of the Council on Constitution and Bylaws - Pino D. Colone, MD, Chair

- 01 Further Action on Bylaw 7.5.2 (Amendments to C&B)
- 02 Rescission of Bylaws Related to Run-off Elections (Amendments to C&B)
- 03 AMA Women Physicians Section: Clarification of Bylaw Language (Amendments to C&B)

Reports of the Council on Ethical and Judicial Affairs - Alexander M. Rosenau, MD, Chair

- 01 Short-Term Medical Service Trips (Amendments to C&B)
- 02 Amendment to Opinions 1.2.11, "Ethical Innovation in Medical Practice"; 11.1.2, Physician Stewardship of Health Care Resources"; 11.2.1, "Professionalism in Health Care Systems"; and 1.1.6, "Quality" (Amendments to C&B)

Opinion(s) of the Council on Ethical and Judicial Affairs - Alexander M. Rosenau, MD, Chair

- 01 Amendment to Opinion 9.3.2, "Physician Responsibilities to Impaired Colleagues" (Info. Report)

Report of the Council on Long Range Planning and Development - Clarence P. Chou, MD, Chair

- 01 Minority Affairs Section Five-Year Review (F)
- 02 Integrated Physician Practice Section - Five-Year Review (F)

Reports of the Council on Medical Education - Niranjan V. Rao, MD, Chair

- 01 Guiding Principles and Appropriate Criteria for Assessing the Competency of Late Career Physicians (C)
- 02 A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities (C)
- 03 Rural Health Physician Workforce Disparities (C)
- 04 Medical Student Debt and Career Choice (C)
- 05 Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotation (C)

Reports of the Council on Medical Service - Asa C. Lockhart, MD, Chair

- 01 End-of-Life Care (A)
- 02 Access to Health Plan Information Regarding Lower-Cost Prescription Options (G)
- 03 Covering the Remaining Uninsured (A)
- 04 Financing of Home and Community-Based Services (G)
- 05 Integrating Care for Individuals Dually Eligible for Medicare and Medicaid (A)

Reports of the Council on Science and Public Health - Alexander Ding, MD, Chair

- 01 Drug Shortages: 2021 Update (Info. Report)
- 02 Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems (D)
- 03 Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Surgery (D)
- 04 Pharmacovigilance (E)

Report of the HOD Committee on Compensation of the Officers - Steven Tolber, MD, Chair

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

Joint Report(s)

- 01 CMS/CSAPH Joint Report - Reducing Inequities and Improving Access to Insurance for Maternal Health Care (G)

Report of the Speakers - Bruce A. Scott, MD, Speaker; Lisa Bohman Egbert, MD, Vice Speaker

- 01 Report of the Election Task Force (Amendments to C&B)
- 02 Establishing an Election Committee (Amendments to C&B)

-- EXTRACTION OF INFORMATIONAL REPORTS --

Memorial Resolutions

Resolutions (per Report of the Resolutions Committee - Item 14 below)

- 001 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers (Amendments to C&B)
- 002 Disaggregation of Race Data for Individuals of Middle Eastern and North African (MENA) Descent (Amendments to C&B)
- 003 Supporting the Study of Reparations as a Means to Reduce Racial Inequalities (Amendments to C&B)
- 004 Guidelines on Chaperones for Sensitive Exams (Amendments to C&B)
- 005 Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism (Amendments to C&B)
- 006 Evaluating Scientific Journal Articles for Racial and Ethnic Bias (Amendments to C&B)
- 007 Exclusion of Race and Ethnicity in the First Sentence of Case Reports (Amendments to C&B)
- 008 Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954 (Amendments to C&B)
- 009 Banning the Practice of Virginity Testing (Amendments to C&B)
- 010 Improving the Health and Safety of Sex Workers (Amendments to C&B)
- 011 Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions (Amendments to C&B)
- 012 Increased Recognition and Treatment of Eating Disorders in Minority Populations (Amendments to C&B)
- 013 Equal Access to Adoption for the LGBTQ Community (Amendments to C&B)
- 014 Referral change - moved to Ref Comm D - now Resolution 415 (Amendments to C&B)
- 015 Using X-Ray and Dental Records for Assessing Immigrant Age (Amendments to C&B)
- 016 Student-Centered Approaches for Reforming School Disciplinary Policies (Amendments to C&B)
- 017 Gender Equity and Female Physician Work Patterns During the Epidemic (Amendments to C&B)
- 018 Support for Safe and Equitable Access to Voting (Amendments to C&B)
- 019 Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent (Amendments to C&B)
- 020* Recognizing and Remediating "Structural Urbanism" Bias as a Factor in Rural Health Disparities (Amendments to C&B)
- 021* Free Speech and Civil Discourse in the American Medical Association (Amendments to C&B)
- 022* Prohibition of Racist Characterization Based on Personal Attributes (Amendments to C&B)
- 023# AMA Council on Ethical and Judicial Affairs Report on Physician Responsibilities to Impaired Colleagues: CEJA E-9.3.2 (Amendments to C&B)
- 024# Organ Transplant Equity for Persons with Disabilities (Amendments to C&B)
- 025# Opposition to Discriminatory Treatment of Haitian Asylum Seekers (Amendments to C&B)
- 026# Amending AMA Bylaw 2.12.2, Special Meetings of the House of Delegates (Amendments to C&B)
- 101 Standardized Coding for Telehealth Services (A)
- 102 Prevention of Hearing Loss-Associated-Cognitive-Impairment Through Earlier Recognition and Remediation (A)
- 103 Oral Healthcare Is Healthcare (A)
- 104 Improving Access to Vaccinations for Patients (A)
- 105 Fertility Preservation Insurance Coverage for Women in Medicine (A)
- 106 Reimbursement of School-Based Health Centers (A)
- 107 Expanding Medicaid Transportation to Include Healthy Grocery Destinations (A)
- 108 Medicaid and CHIP Coverage of Glucose Monitoring Devices for Patients with Diabetes (A)
- 109 Amending D-440.985, Health Care Payment for Undocumented Persons, to Study Methods to Increase Health Care Access for Undocumented Immigrants (A)
- 110 Caps on Insulin Co-Payments for Patients with Insurance (A)

- 111 Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System (A)
- 112 Expanding Coverage for and Access to Pulmonary Rehabilitation (A)
- 113 Supporting Medicare Drug Price Negotiation (A)
- 114 Medicare and Private Health Insurance for Hearing Aids (A)
- 115 Bundled Payments and Medically Necessary Care (A)
- 116 Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance (A)
- 117 Implant-Associated Anaplastic Large Cell Lymphoma (A)
- 118 Expanding Site-of-Service Neutrality (A)
- 119* Bundling Physician Fees with Hospital Fees (A)
- 120* COBRA for College Students (A)
- 121* Medicaid Tax Benefits (A)
- 122* Increase Funding, Research and Education for Post-Intensive Care Syndrome (A)
- 123# Support for Easy Enrollment Federal Legislation (A)
- 124# Medicare Coverage of Dental, Vision, and Hearing Services (A)
- 125# Medicare Coverage of Dental, Vision and Hearing Services (A)
- 201 Protection of Peer-Review Process (B)
- 202 RESOLUTION WITHDRAWN (B)
- 203 Poverty-Level Wages and Health (B)
- 204 Supporting Collection of Data on Medical Repatriation (B)
- 205 Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits (B)
- 206 Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities to Better Address National Crises (B)
- 207 Authority to Grant Vaccine Exemptions (B)
- 208 Protections for Incarcerated Mothers in the Perinatal Period (B)
- 209 Increasing Access to Hygiene and Menstrual Products (B)
- 210 Advocating for the Amendment of Chronic Nuisance Ordinances (B)
- 211 Support for Mental Health Courts (B)
- 212 Sequestration (B)
- 213 Eliminating Unfunded or Unproven Mandates and Regulations (B)
- 214 Stakeholder Engagement in Medicare Administrative Contractor Policy (B)
- 215 Pharmacy Benefit Manager Reform as a State Legislative Priority (B)
- 216 Preserving Appropriate Physician Supervision of Midlevel Providers and Ensuring Patient Awareness of the Qualifications of Physicians vs. Midlevel Providers (B)
- 217 Studying Physician Supervision of Allied Health Professionals Outside of their Fields of Graduate Medical Education (B)
- 218 Physician Opposition to the Coordinated Effort by Corporations and Midlevel Providers to Undermine the Physician-Patient Relationship and Safe Quality Care (B)
- 219 The Impact of Midlevel Providers on Medical Education (B)
- 220 Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use (B)
- 221 Promoting Sustainability in Medicare Physician Payments (B)
- 222 Opposing Federal Preemption of State Licensing Laws and Scope-of-Practice Expansion Under the Ninth Amendment to Declaration Under the PREP Act (B)
- 223 Paying Physicians for Services According to the Physician Fee Schedule (B)
- 224 Improve Physician Payments (B)
- 225 End Budget Neutrality (B)
- 226 Addressing Adolescent Telehealth Confidentiality Concerns (B)
- 227 Medication for Opioid Use Disorder in Physician Health Programs (B)
- 228 Resentencing for Individuals Convicted of Marijuana-Based Offenses (B)
- 229* CMS Administrative Requirements (B)
- 230* Medicare Advantage Plan Mandates (B)

231* Prohibit Ghost Guns (B)
232* Ban the Gay/Trans (LGBTQ+) Panic Defense (B)
233* Insurers and Vertical Integration (B)
234* Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-dose Medications for Multiple Patients (B)
235# Vital Nature of Board-Certified Physician in Aerospace Medicine (B)
236# Repeal or Modification of the Medicare Appropriate Use Criteria (B)
237# Universal Good Samaritan Statute (B)
238# Increasing Residency Positions for Primary Care (B)
239# Making State Health Care Cost Containment Datasets Free of Cost and Readily Available for Academic Research (B)
240# Ransomware Prevention and Recovery (B)
241# Enforcement of Administrative Simplification Requirements - CMS (B)
301 Equitable Reporting of USMLE Step 1 Scores (C)
302 University Land Grant Status in Medical School Admissions (C)
303 Decreasing Bias in Evaluations of Medical Student Performance (C)
304 Reducing Complexity in the Public Service Loan Forgiveness Program (C)
305 Increase Awareness Among Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status (C)
306 Support for Standardized Interpreter Training (C)
307 Support for Institutional Policies for Personal Days for Undergraduate Medical Students (C)
308 Modifying Eligibility Criteria for Association of American Medical Colleges' Financial Assistance Program (C)
309 Protecting Medical Student Access to Abortion Education and Training (C)
310 Resident and Fellow Access to Fertility Preservation (C)
311 Improving Access to Physician Health Programs for Physician Trainees (C)
312 Accountable Organizations to Resident and Fellow Trainees (C)
313 Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training (C)
314 Updating Current Wellness Policies and Improving Implementation (C)
315 Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc. Equitable for IMGs (C)
316* Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic (C)
317* Creating a More Accurate Accounting of Medical Education Financial Costs (C)
318# The Medical Student Match Mismatch - REVISED (C)
401 Endorsement of Public Health Measures to End the COVID-19 Pandemic and Promotion of Research and Insurance Coverage to Define and Delimit the Emerging Issue of Post-Acute Covid Syndrome (D)
402 Expansion on Comprehensive Sexual Health Education (D)
403 Providing Reduced Parking Fees for Patients (D)
404 Increase Employment Services Funding for People with Disabilities (D)
405 Formal Transitional Care Program for Children and Youth with Special Health Care Needs (D)
406 Addressing Gaps in Patient and Provider Knowledge to Increase HPV Vaccine Uptake and Prevent HPV-Associated Oropharyngeal Cancer (D)
407 Traumatic Brain Injury and Access to Firearms (D)
408* Ensuring Affordability and Equity in COVID-19 Vaccine Boosters (D)
409# Screening for HPV-Related Anal Cancer (D)
410# Affirmatively Protecting the Safety and Dignity of Physicians and Medical Students as Workers (D)
411# Addressing Public Health Disinformation (D)
412# Health Professional Disinformation During a Public Health Crisis (D)
413# Universal Childcare and Preschool (D)

414# Advocacy on the US Department of Education's Spring 2022 Title IX Rules on Sexual Harassment and Assault in Education Programs (D)

415# Reducing Disparities in HIV Incidence Through Pre-Exposure Prophylaxis for HIV (D)

501 Ensuring Continued Access to Equitable Take-Home Methadone Treatment (E)

502 Advocating for Heat Exposure Protections for Outdoor Workers (E)

503 Marketing Guardrails for the "Over-Medicalization" of Cannabis Use (E)

504 Air Pollution and COVID: A Call to Tighten Regulatory Standards (E)

505 Representation of Dermatological Pathologies in Varying Skin Tones (E)

506 Enhancing Harm Reduction for People Who Use Drugs (E)

507# Healthy Air Quality (E)

508# Personal Care Products Safety (E)

509# Wireless Devices and Cell Tower Health and Safety (E)

510# Opposition to Sobriety Requirement for Hepatitis C Treatment (E)

601 "Virtual Water Cooler" for our AMA (F)

602 Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings (F)

603 Abolishment of the Resolution Committee (F)

604 The Critical Role of Physicians in the COVID-19 Pandemic (F)

605 Formalization of the Resolution Committee as a Standing Committee of the American Medical Association House of Delegates (F)

606 Increasing the Effectiveness of Online Reference Committee Testimony (F)

607 AMA Urges Health and Life Insurers to Divest From Investments in Fossil Fuels (F)

608 Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis (F)

609 Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Emergency (F)

610 Creation of Employed Physician Section (F)

611* September 11th as a National Holiday (F)

612* UN International Radionuclide Therapy Day Recognition (F)

613* Due Process at our AMA (F)

614* Insurance Industry Behaviors (F)

615* Employed Physicians (F)

616* Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology System (F)

617* Together We are Stronger Marketing Campaign (F)

618# Dissolution of the Resolution Committee (F)

619# Continuing Equity Education (F)

701 Coverage of Pregnancy-Associated Healthcare for 12 Months Postpartum for Uninsured Patients who are Ineligible for Medicaid (G)

702 System Wide Prior and Post-Authorization Delays and Effects on Patient Care Access (G)

703 Clear Statement Regarding the Use of CPT E/M Outpatient Visit Codes (G)

704 Expanding the AMA's Study on the Economic Impact of COVID-19 (G)

705 Advocating for Program Stability in the Merit-Based Incentive Payment System (G)

706 Support for State Medical Record Retention Laws (G)

707* Fifteen Month Lab Standing Orders (G)

708* Insurance Coverage for Scalp Cooling (Cold Cap) Therapy (G)

709* Prior Authorization - CPT Codes for Fair Compensation (G)

710* Physician Burnout is an OSHA Issue (G)

711# Hospital System Consolidation (G)

712# Advocacy of Private Practice Options for Health Care Operations in Large Corporations (G)

14. Report of the Resolutions Committee

15. Report of the Committee on Rules and Credentials - Tripti C. Kataria, MD, Chair

- Late Resolutions

16. Unfinished Business and Announcements - Bruce A. Scott, MD

* contained in the Handbook Addendum

contained in the Friday Tote

Report of the AMPAC Board of Directors

Presented by: Stephen Imbeau, MD
Chair

It is my privilege to present this report to the AMA House of Delegates on behalf of the AMPAC Board of Directors summarizing our 2021 activities as we prepare for yet another busy election year. Partisan gridlock in Washington, D.C. over infrastructure, tax policy and a host of other controversial issues has made it difficult for medicine's core priorities to break into the forefront. This harsh landscape becomes more treacherous when combined with the impact of a still lingering pandemic, making AMPAC's ability to ensure physicians have a seat at the policy-making table more critical now than ever. We achieve this by supporting federal candidates who will support organized medicine in the halls of Congress as well as political education programs that train physician advocates to work on campaigns for medicine-friendly candidates and to run for office themselves.

As this year marks AMPAC's 60th anniversary, we reflect on our achievements as America's oldest non-union political action committee and leading the way on many political activities like strategic contributions to federal candidates, in-kind contributions, and independent expenditures. At the same time, we recognize that many physicians may not fully understand or appreciate AMPAC's core function, the scope of our work and why we need the support of all physicians. As a result, we've developed a short, educational video that will answer basic questions and aid our existing members in recruiting their colleagues to join the chorus of medicine's most powerful political voice: AMPAC. Click here to view the video: <https://vimeo.com/643850739/bel14a948a>

AMPAC Membership Fundraising

We would like to thank the House of Delegates members who contributed to AMPAC during this special 60th anniversary year, and especially those at the Capitol Club level.

AMPAC revenue through October 31 is \$685,661 and receipts are down by 7 percent compared to this same time last year. One of the most significant impacts on AMPAC's fundraising since the pandemic began has been that the AMA has not held any in-person meetings. This has led to a 75 percent decrease in what AMPAC raises during AMA meetings. Despite pivoting to virtual tactics to counter this, the support of the House of Delegates has diminished considerably in 2020 and 2021.

Currently HOD AMPAC participation is 52 percent, which is noticeably lower than the 76 percent participation achieved in 2019. As a leader, we ask for your support during AMPAC's special anniversary year. For those who have not had a chance to do so yet, we encourage you to visit our website <https://www.ampaonline.org/> and make an investment today to help increase overall AMPAC participation in the HOD. AMPAC is also hosting a virtual booth during this meeting, so visit AMPAC's website for additional details and to view the schedule.

Finally, AMPAC is hosting a virtual Capitol Club event for all current 2021 Capitol Club members on Monday, November 15 from 12:00 - 1:00 p.m. Central Time with special guest Amy Walter. Walter is the Editor and Publisher of *The Cook Political Report* and is one of the best political journalists in Washington, providing analysis of the issues and events that shape the political environment.

All current 2021 Capitol Club members received an invitation to register to attend this event and if you did not receive the invitation, please visit AMPAC's website for more information on how to register for this event.

Political Action

During the current, early giving period AMPAC has prioritized contributions to incumbents who are strong allies of medicine, members of their parties' leadership, on key committees or otherwise in an important position to advance medicine-friendly policies on Capitol Hill. Because 2022 is a redistricting year the AMPAC Board has also taken further steps to avoid early contributions to incumbents whose seats may be significantly impacted by the redrawing of new congressional district boundaries. The overall redistricting picture has gotten clearer as the end of the year approaches and while uncertainty remains for some states/races, the added clarity should allow for contributions to members of Congress who fit the aforementioned criteria and where redistricting complications are no longer a concern.

The overall pace of AMPAC's early giving is expected to pick-up some as the 2022 elections are now a little less than a year away. This will continue to hue closely to the early giving criteria the Board established in June and as always, robust giving expanded to more rank-and-file incumbents as well as first-time candidates, will not happen until the AMPAC Board holds its Congressional Review Committee budgeting meeting in February.

Political Education Programs

Over the course of two weekends in December, physicians, medical students, physician spouses and state medical society staff from across the country will take part in the 2021 Campaign School which will be held virtually due to the ongoing COVID-19 pandemic. During the program, twenty-three participants will be placed into virtual campaign teams and with a hands-on approach our team of political experts will walk them through a simulated campaign, teaching each of them everything they need to know to run a successful race as either a candidate or campaign staff. Senator John Barrasso, MD (WY), a former program graduate, is scheduled to be the keynote speaker. AMPAC is happy to report that previous political education programs held virtually have received high marks from participants, many of whom are seriously considering a run for public office, and we are confident December's program will yield similar results. Dates and format have not been announced for the 2022 Candidate Workshop next spring.

Due to the COVID-19 pandemic, AMPAC announced that the 2021 Candidate Workshop would also be held virtually this year. Building off the success of the virtual Campaign School, AMPAC staff worked with program trainers to convert the one-and-a-half-day in-person programming into a virtual format. Held over the course of two weekends in May, twenty-six physicians, medical students and state society staff participants learned the skills and strategic approach they will need as a candidate out on the campaign trail. During the one-and-a-half-day program, participants learned how and when to make the decision to run, the importance of a disciplined campaign plan and message, the secrets of effective fundraising, the role of spouse and family and much more. Senator Bill Cassidy, MD (LA) and Representative Ami Bera, MD (CA), both former program graduates, provided keynote addresses to the group. AMPAC is proud to report that the virtual program also received high marks from participants.

Conclusion

Once again on behalf of the AMPAC Board of Directors, I am grateful for the opportunity to update our House of Delegates. Please accept our most sincere thanks to those of you who support AMPAC, the work we do and have been doing on behalf of the profession since 1961. Please help us to ensure organized medicine's voice remains strong in our nation's capital.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

William Edmund Bowman, MD

Introduced by North Carolina

Whereas, William E. "Bill" Bowman, MD, an esteemed member of the North Carolina delegation to the American Medical Association, passed away suddenly on March 6, 2021; and

Whereas, Dr. Bowman graduated from Davidson College in 1970 and received his MD degree from the University of North Carolina School of Medicine in 1974, and completed his residency in general surgery in San Francisco; and

Whereas, Dr. Bowman served his country in the US Army in active duty from 1974-1981, and left the Army with the rank of Major; and

Whereas, Dr. Bowman served his community of Greensboro, NC as a highly respected general surgeon from 1981-2008, serving as Chief of Surgery and President of the Medical and Dental Staff at Cone Health; and

Whereas, Dr. Bowman served as Vice President of Medical Affairs at Cone Health from 2008-2017; and

Whereas, Dr. Bowman served the North Carolina Medical Society and its members on numerous committees and on its Board of Directors; and

Whereas, Dr. Bowman served on the North Carolina delegation to the AMA House of Delegates from 2004 until his death, bringing his wisdom and wit to delegation discussions; and

Whereas, Dr. Bowman served on the Board of The Carolinas Center for Medical Excellence from 1996-2008; and

Whereas, Dr. Bowman served on the Board of the North Carolina Professionals Health Program from 2016 until his death in 2021, serving as board chair in 2019-2020; and

Whereas, Dr. Bowman was very supportive of the state and national Alliance activities of his wife, Gay, who served on the AMA Alliance Board from 1998-2005, and as president of the AMA Alliance in 2003-2004; and

Whereas, Dr. Bowman was often happiest working on his farm raising cattle and crops and enjoying the woods and pond; and

Whereas, Dr. Bowman dedicated many hours volunteering with The Healing Gardens at Wesley Long Hospital, Habitat for Humanity and other organizations; and

Whereas, Dr. Bowman leaves a legacy of service and leadership to his community and to the profession of medicine and will be dearly missed by so many; and

Whereas, Dr. Bowman enjoyed long and loving relationships with his wife Gay and their two children and three grandchildren; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize the many contributions made by Dr. Bowman to the medical profession and to the Greater Greensboro community; and be it further

RESOLVED, That our AMA House of Delegates express its sympathy at the passing of our friend and colleague, William E. Bowman, MD, to his wife and family and present them with a copy of this resolution.

REFERRAL CHANGES AND OTHER REVISIONS

November 2021 Special Meeting

REFERRAL CHANGES

WAS	IS NOW
Res. 014 – Reducing Disparities in HIV Incidence Through Pre-Exposure Prophylaxis (PrEP) for HIV	Res. 415 (Ref Comm D)

REVISED RESOLUTIONS

- 318 – The Medical Student MisMatch

WITHDRAWN RESOLUTIONS

- 202 – Interstate Practice of Telemedicine

RESOLUTIONS WITH ADDITIONAL SPONSORS*

- 101 - Standardized Coding for Telehealth Services (Virginia, American Association of Clinical Urologists, District of Columbia, Oklahoma, Tennessee, Alabama, New Jersey, North Carolina, Mississippi, Georgia, Kentucky, Private Practice Physician Section)
- 110 – Caps on Insulin Co-Payments for Patients with Insurance (Medical Student Section, Endocrine Society)
- 214 – Stakeholder Engagement in Medicare Administrative Contractor Policy Processes (American College of Rheumatology, American Academy of Allergy, Asthma & Immunology, American Academy of Dermatology, American Academy of Ophthalmology, American Society of Dermatopathology, Association for Clinical Oncology, Society for Investigative Dermatology, American Gastroenterological Association)
- 224 – Improve Physician Payments (Florida, Mississippi, Oklahoma)
- 225 – End Budget Neutrality (Florida, Mississippi, Oklahoma)
- 609 – Fulfilling Medicine’s Social Contract with Humanity in the Face of the Climate Health Emergency (California, American College of Physicians)
- 610 – Creation of Employed Physician Section (Florida, Mississippi)

* Additional sponsors underlined.

Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

- 05 Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment
- 11 National Guidelines for Guardianship
- 13 Study of Forced Organ Harvesting by China
- 15 Opposing Attorney Presence at and/or Recording of Independent Medical Examinations
- 16 Research Handling of De-Identified Patient Information
- 20# Specialty Society Representation in the House of Delegates - Five-Year Review

CC&B Report(s)

- 01 Further Action on Bylaw 7.5.2
- 02 Rescission of Bylaws Related to Run-off Elections
- 03 AMA Women Physicians Section: Clarification of Bylaw Language

CEJA Report(s)

- 01 Short-Term Medical Service Trips
- 02 Amendment to Opinions 1.2.11, "Ethical Innovation in Medical Practice"; 11.1.2, Physician Stewardship of Health Care Resources"; 11.2.1, "Professionalism in Health Care Systems"; and 1.1.6, "Quality"

Report of the Speakers

- 01 Report of the Election Task Force
- 02 Establishing an Election Committee

Resolution(s)

- 001 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers
- 002 Disaggregation of Race Data for Individuals of Middle Eastern and North African (MENA) Descent
- 003 Supporting the Study of Reparations as a Means to Reduce Racial Inequalities
- 004 Guidelines on Chaperones for Sensitive Exams
- 005 Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism
- 006 Evaluating Scientific Journal Articles for Racial and Ethnic Bias
- 007 Exclusion of Race and Ethnicity in the First Sentence of Case Reports
- 008 Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954
- 009 Banning the Practice of Virginity Testing
- 010 Improving the Health and Safety of Sex Workers
- 011 Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions
- 012 Increased Recognition and Treatment of Eating Disorders in Minority Populations
- 013 Equal Access to Adoption for the LGBTQ Community
- 014 Referral change - moved to Ref Comm D - now Resolution 415
- 015 Using X-Ray and Dental Records for Assessing Immigrant Age
- 016 Student-Centered Approaches for Reforming School Disciplinary Policies
- 017 Gender Equity and Female Physician Work Patterns During the Epidemic
- 018 Support for Safe and Equitable Access to Voting
- 019 Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent
- 020* Recognizing and Remediating "Structural Urbanism" Bias as a Factor in Rural Health Disparities
- 021* Free Speech and Civil Discourse in the American Medical Association
- 022* Prohibition of Racist Characterization Based on Personal Attributes

* Contained in the Handbook Addendum

Contained in the Friday Tote

Reference Committee on Amendments to Constitution and Bylaws

Resolution(s)

- 023# AMA Council on Ethical and Judicial Affairs Report on Physician Responsibilities to Impaired Colleagues: CEJA E-9.3.2
- 024# Organ Transplant Equity for Persons with Disabilities
- 025# Opposition to Discriminatory Treatment of Haitian Asylum Seekers
- 026# Amending AMA Bylaw 2.12.2, Special Meetings of the House of Delegates

* Contained in the Handbook Addendum

Contained in the Friday Tote

REPORT OF THE BOARD OF TRUSTEES

B of T Report 20-N-21

Subject: Specialty Society Representation in the House of Delegates -
Five-Year Review

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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. (Directive to Take Action)
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. (Directive to Take Action)
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. (Directive to Take Action)

Fiscal Note: Less than \$500

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)

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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 023
(N-21)

Introduced by: Pennsylvania, New York, Michigan

Subject: AMA Council on Ethical and Judicial Affairs (CEJA) report on Physician Responsibilities to Impaired Colleagues: CEJA E-9.3.2

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Health systems, corporate, and academic organizations increasingly have their own
2 in-house physician assessment teams that may have inherent conflicts of interest and bias their
3 reports to the preferences of the administration and/or department; and
4

5 Whereas, It is important for physicians to be provided with a fair, objective, external, and
6 independent review when a request is made to assess a physician's potential impairment; and
7

8 Whereas, While CEJA Opinion E-9.4.1, "Due Process & Peer Review," notes the importance of
9 a "fair and objective hearing" and the need to "disclose relevant conflicts of interest," and
10 E-9.4.4, "Physicians with Disruptive Behavior" mentions potential "unintended effects of
11 institutional structures, policies, and practices," neither opinion states that physicians should be
12 provided the opportunity for an independent, external evaluation when a review is requested to
13 assess a potential impairment; and
14

15 Whereas, Fair, objective, external, and independent evaluators may include physician health
16 programs that were specifically mentioned in the earlier version of CEJA Opinion E-9.3.2,
17 "Physician Responsibilities to Colleagues with Illness, Disability or Impairment," but are not
18 clearly identified as resources in the current recently adopted amended E-9.3.2; and
19

20 Whereas, Fair, objective, external, and independent assessments can and sometimes should
21 come from sources other than physician health programs; and
22

23 Whereas, While the recently amended E-9.3.2 improved several provisions of this CEJA
24 Opinion, the revision omitted the need for a fair, objective, external, and independent review;
25 and
26

27 Whereas, CEJA Opinion E-9.3.2 could be clarified to better address physicians' experiences in
28 dealing with programs that are not fair, objective, external, or independent; and
29

30 Whereas, It should be incumbent on the health system, corporate, or academic organization to
31 provide a fair, objective, external and independent review for a physician whom they request be
32 assessed for a potential impairment; therefore be it
33

34 RESOLVED, That our American Medical Association support a fair, objective, external and
35 independent review for physicians who are requested to be assessed for a potential impairment,
36 and support the availability of physician health programs to enable physicians who require
37 assistance to provide safe and effective care (New HOD Policy); and be it further

1 RESOLVED, That our AMA advocate that health system, corporate, and academic
 2 organizations provide a fair, objective, external and independent review for physicians who are
 3 requested to be assessed for a potential impairment (Directive to Take Action); and be it further
 4

5 RESOLVED, That the Council on Ethical and Judicial Affairs consider the following amendment
 6 to Opinion E-9.3.2, "Physician Responsibilities to Colleagues with Illness, Disability or
 7 Impairment":
 8

9 (i) Advocating for supportive services including physician health programs and
 10 accommodations to enable physicians who require assistance to provide safe,
 11 effective care.

12 ...

13 (k) Advocating for fair, objective, external, and independent review for physicians when
 14 a review is requested to assess a potential impairment and its duration. (Modify
 15 Current HOD Policy)

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

Received: 11/03/21

AUTHORS STATEMENT OF PRIORITY

This resolution is viewed by Pennsylvania as a high priority or level 2. In Pennsylvania we are benefitted by a robust PHP program to assist physicians when there are concerns about impairment including but not limited to cognitive, physical, drug or alcohol. Unfortunately, as noted in this resolution, health care systems, corporations and academic institutions feel comfortable using only their own internal system rather than feeling any ethical obligation to provide independent evaluation of the physician's circumstances. We believe that CEJA's inclusion of the ability for the physician to have independent assessment as part of any ethical guideline. As more and more concerns develop with an aging physician population this increases the number of potential physician who will face questions of competency and/or impairment beyond the number who have to be addressed for drug or alcohol. There is a significant potential negative impact if independent review is not part of the ethical expectation. CEJA's guideline are important to be inclusive of this for physicians. It is most appropriate for the AMA House be the one requesting that CEJA consider amending by inclusion to E-9.3.2.

References: 2021: Amendment to Opinion E.9.3.2 "Physician Responsibilities to Impaired Colleagues" CEJA Report 3, 2021
<https://www.ama-assn.org/councils/council-ethical-judicial-affairs/council-ethical-judicial-affairs-cejareports-year>

RELEVANT AMA POLICY

Amendment to Opinion 9.3.2, Physician Responsibilities to Impaired ColleaguesH-140.827

CEJA Opinion 9.3.2, "Physician Responsibilities to Impaired Colleagues," will be retitled as "Physician Responsibilities to Colleagues with Illness, Disability or Impairment" and amended to read as follows:

E-9.3.2 Physician Responsibilities to Colleagues with Illness, Disability or Impairment

Providing safe, high quality care is fundamental to physicians' fiduciary obligation to promote patient welfare. Yet a variety of physical and mental health conditions—including physical disability, medical illness, and substance use—can undermine physicians' ability to fulfill that

obligation. These conditions in turn can put patients at risk, compromise physicians' relationships with patients, as well as colleagues, and undermine public trust in the profession.

While some conditions may render it impossible for a physician to provide care safely, with appropriate accommodations or treatment many can responsibly continue to practice, or resume practice once those needs have been met. In carrying out their responsibilities to colleagues, patients, and the public, physicians should strive to employ a process that distinguishes conditions that are permanently incompatible with the safe practice of medicine from those that are not and respond accordingly.

As individuals, physicians should:

- (a) Maintain their own physical and mental health, strive for self-awareness, and promote recognition of and resources to address conditions that may cause impairment.
- (b) Seek assistance as needed when continuing to practice is unsafe for patients, in keeping with ethics guidance on physician health and competence.
- (c) Intervene with respect and compassion when a colleague is not able to practice safely. Such intervention should strive to ensure that the colleague is no longer endangering patients and that the individual receive appropriate evaluation and care to treat any impairing conditions.
- (d) Protect the interests of patients by promoting appropriate interventions when a colleague continues to provide unsafe care despite efforts to dissuade them from practice.
- (e) Seek assistance when intervening, in keeping with institutional policies, regulatory requirements, or applicable law.

Collectively, physicians should nurture a respectful, supportive professional culture by:

- (f) Encouraging the development of practice environments that promote collegial mutual support in the interest of patient safety.
- (g) Encouraging development of inclusive training standards that enable individuals with disabilities to enter the profession and have safe, successful careers.
- (h) Eliminating stigma within the profession regarding illness and disability.
- (i) Advocating for supportive services and accommodations to enable physicians who require assistance to provide safe, effective care.
- (j) Advocating for respectful and supportive, evidence-based peer review policies and practices that will ensure patient safety and practice competency.

Citation: CEJA Rep. 3, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 024
(N-21)

Introduced by: Pennsylvania

Subject: Organ Transplant Equity for Persons with Disabilities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, People with intellectual and developmental disabilities (IDD) still face discrimination in
2 access of care, specifically regarding barriers of access to transplant surgery, despite federal
3 and local guidelines which protect against discrimination on the basis of disability; and
4

5 Whereas, Transplant centers and medical professionals are unaware or noncompliant with
6 clauses of the Americans with Disabilities Act, Rehabilitation Act, and Affordable Care Act
7 prohibiting discrimination against people with disabilities as is applied to the organ transplant
8 process; and
9

10 Whereas, A 2004 survey found that only 52 percent of people with disabilities who requested a
11 referral to a specialist regarding an organ transplant evaluation actually received a referral,
12 while 35 percent of those “for whom a transplant had been suggested” never even received an
13 evaluation; and
14

15 Whereas, A 2008 survey of pediatric transplant centers found that 43 percent always or usually
16 consider intellectual disabilities an absolute or relative contraindication to transplant due to
17 assumptions and that in some cases, organ transplant centers may categorically refuse to
18 evaluate a patient with a disability as a candidate for transplant; and
19

20 Whereas, Throughout their medical education, health, oral health, and vision health providers
21 receive limited training on the special needs of people with IDD related to common problems
22 and delivery of services, and patients report feeling that physicians generally have little
23 understanding of living with a disability; and
24

25 Whereas, If a person has a disability that is unrelated to the reason a person needs an organ
26 transplant, the disability will generally have little or no impact on the likelihood of the transplant
27 being successful and making assumptions regarding post-transplant quality of life for people
28 with IDD violates AMA ethics; and
29

30 Whereas, Congress established the need for an organization, the Organ Procurement and
31 Transplant Network (OPTN), to facilitate the organ transplantation system across the many
32 transplant centers and sources of organ donors in an efficient manner. The effective guidelines
33 for organ allocation do not include disability status in non-discrimination section 5.4.A; and
34

35 Whereas, Titles II and III of the Americans with Disabilities Act (ADA) prohibit discrimination
36 against people with disabilities in all programs, activities and services of public entities and
37 prohibit private places of public accommodation from discriminating against people with
38 disabilities; and

Whereas, Section 504 of the Rehabilitation Act of 1973 prohibits federally funded programs including hospitals from denying qualified individuals the opportunity to participate in or benefit from federally funded programs, services, or other benefits, denying access to programs, services, benefits or opportunities to participate as a result of physical barriers, and denying employment opportunities they are otherwise entitled or qualified; and

Whereas, Section 1557 of the Affordable Care Act prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities and ensures physical access for individuals with disabilities to healthcare facilities and appropriate communication technology to assist persons who are visually or hearing impaired; therefore be it

RESOLVED, That our American Medical Association support equitable inclusion of people with intellectual and developmental disabilities (IDD) in eligibility for transplant surgery (New HOD Policy); and be it further

RESOLVED, That our AMA support individuals with IDD having equal access to organ transplant services and protection from discrimination in rendering these services (New HOD Policy); and be it further

RESOLVED, That our AMA support the goal of the Organ Procurement and Transplantation Network (OPTN) in adding disability status to their Nondiscrimination policy under the National Organ Transplant Act of 1984 (New HOD Policy); and be it further

RESOLVED, That our AMA work with relevant stakeholders to distribute antidiscrimination education materials for healthcare providers related to equitable inclusion of people with IDD in eligibility for transplant surgery. (Directive to Take Action)

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

Received: 11/03/21

AUTHORS STATEMENT OF PRIORITY

This resolution recognizes that, although there are existing laws prohibiting discrimination on basis of disability, there is evidence to suggest that people with disabilities remain statistically less likely to receive consultation regarding -- and access to -- organ transplantation. Furthermore, although there is evidence to suggest that those with intellectual disabilities have similar outcomes after transplantation, there may be misperceptions to the contrary within the healthcare system. This resolution aims to have our AMA highlight this discrepancy between law and practice. We feel this is timely because this not only provides an avenue for our organization to advocate for those with disability, but to once again bring to the forefront the challenge of sufficient organ procurement in our nation.

References:

Statter MB, Noritz G, Committee on Bioethics C on C with D. Children With Intellectual and Developmental Disabilities as Organ Transplantation Recipients. *Pediatrics*. 2020; 145(5). doi:10.1542/peds.2020-0625 National Council on Disability. Organ Transplant Discrimination Against People with Disabilities: Part of the Bioethics and Disability Series. Published September 25, 2019. Available at: https://ncd.gov/sites/default/files/NCD_Organ_Transplant_508.pdf . Americans with Disabilities Act of 1990, AS AMENDED with ADA Amendments Act of 2008. Accessed July 12, 2020. <https://www.ada.gov/pubs/adastatute08.htm#12102> Section 508 of the Rehabilitation Act. Federal Communications Commission. Published March 1, 2013. Accessed July 12, 2020. <https://www.fcc.gov/general/section-508-rehabilitation-act> Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations 2004; 46p. [Online]. Accessed: http://www.jointcommission.org/NR/rdonlyres/E4E7DD3F-3FDF-4ACC-B69EAEF3A1743AB0/0/organ_donation_white_paper.pdf [2008 October 16] Richards CT, Crawley LM, Magnus D. Use of neurodevelopmental delay in pediatric solid organ transplant listing decisions: inconsistencies in standards across major pediatric

transplant centers. *Pediatric Transplant*. 2009;13(7):843-850. doi:10.1111/j.1399-3046.2008.01072.x special-olympics-golisano-report2018.pdf. Accessed July 12, 2020. <https://dotorg.brightspotcdn.com/e2/95/3dbfbf134796bdf395d873109cb3/specialolympics-golisano-report-2018.pdf> Wightman A, Diekema D, Goldberg A. Consideration of children with intellectual disability as candidates for solid organ transplantation—A practice in evolution. *Pediatr Transplant*. 2018;22:e13091. <https://doi.org/10.1111/petr.13091> Affairs AC on E and J. AMA Code of Medical Ethics' Opinion on Organ Transplantation. *AMA J Ethics*. 2013;15(11):945-946. doi:10.1001/virtualmentor.2013.15.11.coet2-1311. 2018 Act 90. The official website for the Pennsylvania General Assembly. Accessed July 19, 2020. <https://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2018&sessInd=0&act=90> Organ Procurement and Transplantation Network Policies. (2020). https://optn.transplant.hrsa.gov/media/1200/optn_policies.pdf Section 1557 of the Patient Protection and Affordable Care Act. Relevant RFS & AMA Policy: Medical Care of Persons with Developmental Disabilities H-90.968 6.2.2 Directed Donation of Organs for Transplantation Tissue and Organ Donation H-370.983

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 025
(N-21)

Introduced by: New York

Subject: Opposition to Discriminatory Treatment of Haitian Asylum Seekers

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The United States has sought to provide asylum for individuals being persecuted in
2 other countries and has instituted laws and policies to achieve this goal equitably for all peoples
3 of the world; and
4

5 Whereas, Haitians seeking asylum have often experienced discrimination in seeking asylum
6 because of the inaccurate media narrative of an association of AIDS to Haitians; and
7

8 Whereas, The CDC in 1990 changed its policy on AIDS and Haitians thus removing the false
9 narrative on AIDS and Haitians; and
10

11 Whereas, Haitians seeking asylum in the United States continue to experience adverse
12 outcomes in their applications for asylum based on inaccurate narratives and media bias; and
13

14 Whereas, Recent activities at the US border with Mexico have focused heavily on denying entry
15 to Haitians seeking escape from the violence in their native country and returning them to Haiti;
16 and
17

18 Whereas, Our AMA has many policy statements on health disparities, racial discrimination and
19 equality but no policy specific to the matter adversely affecting Haitian asylum seekers;
20 therefore be it
21

22 RESOLVED, That our American Medical Association oppose discrimination against Haitian
23 asylum seekers which denies them the same opportunity to attain asylum status as individuals
24 from other nations. (New HOD Policy)

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

Received: 11/04/21

AUTHORS STATEMENT OF PRIORITY

Recent events at the US Border with Mexico have brought to light discrimination against Haitians seeking to be allowed in our country. They are not given the opportunity to be considered for asylum, but are immediately returned to Haiti – a country currently undergoing violence that includes kidnapping, murder, rape, etc. The government of Haiti is unable to quell the gang violence and Haitian citizens are seeking escape so they may raise their families in safety and peace. AMA needs to adopt policy supporting non-discrimination against the Haitian people seeking asylum. This is an urgent issue and should be ranked as TOP PRIORITY in light of what is currently taking place at the US border.

RELEVANT AMA POLICY**Support of Human Rights and Freedom H-65.965**

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment G-600.067

Our AMA will: (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; (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.

Citation: Res. 009, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 026
(N-21)

Introduced by: Medical Student Section

Subject: Amending AMA Bylaw 2.12.2, Special Meetings of the House of Delegates

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, During the ongoing COVID-19 pandemic, our AMA has conducted three meetings of
2 the House of Delegates as Special Meetings, and the November 2021 meeting is also a Special
3 Meeting; and
4

5 Whereas, These Special Meetings have played a critical role in allowing for our House to adopt
6 policy on key issues such as health equity, telemedicine, and health system reform even under
7 the extenuating circumstances of the pandemic¹⁻³; and
8

9 Whereas, Each of the four recent Special Meetings has involved the introduction of new
10 procedures or alterations of procedures for that meeting; and
11

12 Whereas, Though tremendous efforts have been made at each Special Meeting to ensure the
13 meetings are useful to our organization, Delegates have concerns about the procedures
14 employed, including but not limited to: (1) procedures used in the Special Meeting were not
15 described fully prior to the meetings, (2) some procedures were kept confidential from
16 Delegates, (3) the House was not made aware of any formally established mechanisms by
17 which concerns could be relayed to leadership, (4) there was no independent oversight of these
18 concerns; and
19

20 Whereas, New procedures regulating consideration of items of business have resulted in an
21 unprecedented backlog of policies awaiting consideration by the House of Delegates; and
22

23 Whereas, Our AMA had never held a virtual House of Delegates prior to June 2020, and our
24 Bylaws on Special Meetings were most recently amended at the Interim Meeting in 2009^{4,5}; and
25

26 Whereas, The uncertain course of the COVID-19 pandemic and other natural disasters and
27 national events raise the likelihood that Special Meetings may be imminently necessary in our
28 AMA's future proceedings; and
29

30 Whereas, Our AMA supports individual member participation (G-625.011) and feedback to
31 leadership by members (G-635.011) and Delegates (G-600.031); and
32

33 Whereas, Our AMA has precedent for the creation and release of as-needed reports (G-
34 635.125, G-605.051); therefore be it

1 RESOLVED, That our American Medical Association update its Special Meeting procedures by
2 updating the Special Meetings Bylaws as follows:

- 3
- 4 1. Specification that the processes used to determine which items of business meet
5 or do not meet the purpose for which the Special Meeting is called shall be
6 published online and electronically sent to all members of the House of Delegates
7 prior to the initiation of the Special Meeting.
- 8 2. Specification concerning the processes for how formal feedback may be submitted
9 and reviewed prior to, during, and after the conclusion of the Special Meeting.
- 10 3. Description of how a Special Meeting report, detailing the processes that were
11 used in the meeting, along with a summary of the concerns and suggestions
12 submitted by the formal feedback mechanism, shall be produced by the Speakers
13 and Board of Trustees following each Special Meeting that occurs.
- 14 4. Description of how, after each Special Meeting, a committee that is representative
15 of House membership shall be formed for the purpose of (a) reviewing the Special
16 Meeting and (b) proposing any improvements to the processes for future Special
17 Meetings. (Modify Current HOD Policy)

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

Received: 11/07/21

AUTHORS STATEMENT OF PRIORITY

The past three meetings of our House of Delegates have been Special Meetings, and the current meeting will be a Special Meeting, as well. Though we fervently hope we may get back to normal meetings in June 2022, we recognize the reality that there is no guarantee when the pandemic will have abated enough to safely return to normal meetings. We are concerned that two years of AMA meetings have been governed by the sparse Special Meeting bylaws described in AMA Bylaw 2.12.2, and we believe that after four meetings held under this bylaw it is time to update it, especially while the lessons of the recent Special Meetings are fresh in our memories.

Knowing that even the next meeting for our AMA could be a Special Meeting, we believe it is timely, urgent, and a high priority to request an update in our Special Meeting bylaws.

References:

1. O'Reilly KB. Highlights from the November 2020 AMA Special Meeting. Published November 18, 2020. Accessed September 14, 2021. Online: <https://www.ama-assn.org/house-delegates/special-meeting/highlights-november-2020-ama-special-meeting>
2. O'Reilly KB. Highlights from the June 2021 AMA Special Meeting. Published June 17, 2021. Accessed September 14, 2021. Online: <https://www.ama-assn.org/house-delegates/special-meeting/highlights-june-2021-ama-special-meeting>
3. O'Reilly KB. AMA: Racism is a threat to public health. Published November 16, 2020. Accessed September 14, 2021. Online: <https://www.ama-assn.org/delivering-care/health-equity/ama-racism-threat-public-health>
4. American Medical Association. June 2020 Special Meeting of the House of Delegates (HOD). Website. Accessed September 14, 2021. Online: <https://www.ama-assn.org/house-delegates/special-meeting/june-2020-special-meeting-house-delegates-hod>
5. American Medical Association. House of Delegates Proceedings, Interim Meeting v.2009 i.0002. Published November 10, 2009. Accessed September 14, 2021. Online: https://ama.nmtvault.com/jsp/PSImageViewer.jsp?doc_id=1ee24daa-2768-4bff-b792-e4859988fe94%2Fama_arch%2FHOD000006%2F00000001&pg_seq=6

RELEVANT AMA POLICY

Membership and Governance G-635.005

The House affirms that the AMA shall remain an association of voluntary, individual medical student and physician members and that the Association shall continue to be individually funded and organizationally governed through representation in the HOD.

Report of the Committee on Organization of Organizations, A-03Reaffirmed: CCB/CLRPD Rep. 3, A-12

Statement of Collaborative Intent G-620.030

(1) The AMA House of Delegates endorses the following preamble of a Statement of Collaborative Intent: The Federation of Medicine is a collaborative partnership in medicine. This partnership is comprised of the independent and autonomous medical associations in the AMA House of Delegates and their component and related societies. As the assemblage of the Federation of Medicine, the AMA House of Delegates is the framework for this partnership. The goals of the Federation of Medicine are to: (a) achieve a unified voice for organized medicine; (b) work for the common good of all patients and physicians; (c) promote trust and cooperation among members of the Federation; and (d) advance the image of the medical profession; and (e) increase overall efficiency of organized medicine for the benefit of our member physicians.

(2) The AMA House of Delegates endorses the following principles of a Statement of Collaborative Intent: (a) Organizations in the Federation will collaborate in the development of joint programs and services that benefit patients and member physicians.

(b) Organizations in the Federation will be supportive of membership at all levels of the Federation.

(c) Organizations in the Federation will seek ways to enhance communications among physicians, between physicians and medical associations, and among organizations in the Federation.

(d) Each organization in the Federation of Medicine will actively participate in the policy development process of the House of Delegates.

(e) Organizations in the Federation have a right to express their policy positions.

(f) Organizations in the Federation will support, whenever possible, the policies, advocacy positions, and strategies established by the Federation of Medicine.

(g) Organizations in the Federation will support an environment of mutual trust and respect.

(h) Organizations in the Federation will inform other organizations in the Federation in a timely manner whenever their major policies, positions, strategies, or public statements may be in conflict.

(i) Organizations in the Federation will support the development and use of a mechanism to resolve disputes among member organizations.

(j) Organizations in the Federation will actively work toward identification of ways in which participation in the Federation could benefit them.

CLRPD/CEJA/C&B Report, A-97 Consolidated: CLRPD Rep. 3, I-01 Modified: BOT Rep. 23, A-02 Modified: CCB/CLRPD Rep. 3, A-12

Function, Role and Procedures of the House of Delegates G-600.011

The function and role of the House of Delegates includes setting policy on health, medical, professional, and governance matters, as well as the broad principles within which AMA's business activities are conducted. The Board of Trustees is vested with the responsibility for the AMA's business strategy and the conduct of AMA affairs. Our AMA adopts the *AMA House of Delegates Reference Manual: Procedures, Policies and Practices* as the official method of procedure in handling and conducting the business before the AMA House of Delegates. CCB/CLRPD Rep. 3, A-12

Participation of Individual Members in our AMA G-635.011

Our AMA supports individual member, two-way electronic communications that promote active grassroots discussion of timely issues; regular feedback for AMA leadership; and a needed voice for diverse ideas and initiatives from throughout the Federation. AMA members are encouraged to participate in the activities of the AMA, particularly in the following ways: (1) Though the AMA website or other communications conduits, provide comments and suggestions to the AMA Board and the AMA Councils on their policy development projects and

on other AMA products and services; (2) Participate in the on-line discussion groups on the items of business included in the Handbook of the House of Delegates; (3) Communicate their views on the items of business in the House's Handbook to their AMA delegates and alternate delegates; (4) Inform the AMA, directly or through their AMA delegates, of situations that may represent opportunities to implement the Association's policy positions; (5) Help the AMA promote its policy positions; (6) When opportunities present themselves, explain the value of the AMA and the importance of belonging to the AMA to physicians; and (7) Work to help the AMA increase its membership level.

CCB/CLRPD Rep. 3, A-12

AMA Goals, Roles, and Obligations G-625.011

Our AMA: (1) reaffirms its goal to be the unified voice of the medical profession speaking for all physicians, and, (2) above all, affirms its role and obligations as a steward of our professional values, as well as the right and obligation of individual physicians to participate in the process. Consolidated: CLRPD Rep. 3, I-01 Reaffirmed: BOT Rep. 35, A-08 Reaffirmed: CCB/CLRPD Rep. 3, A-12

Roles and Responsibilities of AMA Delegates and Alternate Delegates G-600.031

(1) Members of the AMA House of Delegates serve as an important communications, policy, and membership link between the AMA and grassroots physicians. The delegate/alternate delegate is a key source of information on activities, programs, and policies of the AMA. The delegate/alternate delegate is also a direct contact for the individual member to communicate with and contribute to the formulation of AMA policy positions, the identification of situations that might be addressed through policy implementation efforts, and the implementation of AMA policies. Delegates and alternate delegates to the AMA are expected to foster a positive and useful two-way relationship between grassroots physicians and the AMA leadership. To fulfill these roles, AMA delegates and alternate delegates are expected to make themselves readily accessible to individual members by providing the AMA with their addresses, telephone numbers, and email addresses so that the AMA can make the information accessible to individual members through the AMA Web site and through other communication mechanisms. (2) The roles and responsibilities of delegates and alternate delegates are as follows: (a) regularly communicate AMA policy, information, activities, and programs to constituents so he/she will be recognized as the representative of the AMA; (b) relate constituent views and suggestions, particularly those related to implementation of AMA policy positions, to the appropriate AMA leadership, governing body, or executive staff; (c) advocate constituent views within the House of Delegates or other governance unit, including the executive staff; (d) attend and report highlights of House of Delegates meetings to constituents, for example, at hospital medical staff, county, state, and specialty society meetings; (e) serve as an advocate for patients to improve the health of the public and the health care system; (f) cultivate promising leaders for all levels of organized medicine and help them gain leadership positions; and (g) actively recruit new AMA members and help retain current members.

Special Advisory Committee to the Speaker of the House of Delegates, I-99 Consolidated: CLRPD Rep. 3, I-01 Modified: Jt. Rep. of the BOT and CLRPD, A-02 Reaffirmed: CCB/CLRPD Rep. 3, A-12 Modified: Speakers Rep., I-18

Ancillary Meetings and Conferences of the House G-600.090

The Speakers of our AMA House must be notified prior to any planning for ancillary meetings and conferences to be scheduled in conjunction with the Annual or Interim Meetings of the House of Delegates in sufficient time to assess the impact of the timing and purpose on the deliberations of the House of Delegates. Prior approval of the Speaker and Vice Speaker is required before any meeting other than regular meetings of AMA Councils, Committees,

Sections, and other groups that are part of the formal structure of our AMA can be scheduled in conjunction with Meetings of the House of Delegates.

Rep. on Rules and Credentials, A-93Consolidated: CLRPD Rep. 3, I-01Reaffirmed: CC&B Rep. 2, A-11Reaffirmed: Joint CCB/CLRPD Rep. 1, A-21

AMA Membership Demographics G-635.125

1. Stratified demographics of our AMA membership will be reported annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.
2. Our AMA will immediately release to each state medical and specialty society, on request, the names, category and demographics of all AMA members of that state and specialty.
3. Our AMA will develop and implement a plan with input from the Advisory Committee on LGBTQ Issues to expand demographics collected about our members to include both sexual orientation and gender identity information, which may be given voluntarily by members and will be handled in a confidential manner.

BOT Rep. 26, A-10Reaffirmed: CCB/CLRPD Rep. 3, A-12Appended: Res. 603, A-17

Greater Involvement of Medical Students in Federation Organizations G-620.050

Our AMA encourages medical societies to provide mechanisms for more direct involvement of students at the state and local levels, and to implement membership options for their state's medical students who are enrolled in medical school for longer than four years. Our AMA will work with the Association of American Medical Colleges to promote medical student engagement in professional medical societies, including attendance at local, state, and national professional organization meetings, during the pre-clinical and clinical years.

CCB/CLRPD Rep. 3, A-12

Data Used to Apportion Delegates G-600.016

1. Our AMA shall issue an annual, mid-year report on or around June 30 to inform each state medical society and each national medical specialty society that is in the process of its 5-year review of its current AMA membership count.
2. "Pending members" (defined as individuals who at the time they apply for membership are not current in their dues and who pay dues for the following calendar year) will be added to the number of active AMA members in the December 31 count for the purposes of AMA delegate allocations to state medical societies for the following year and this total will be used to determine the number of national medical specialty delegates to maintain parity.
3. Our AMA will track "pending members" from a given year who are counted towards delegate allocation for the following year and these members will not be counted again for delegate allocation unless they renew their membership before the end of the following year.
4. Our AMA Board of Trustees will issue a report to the House of Delegates at the 2022 Annual Meeting on the impact of Policy G-600.016 and recommendations regarding continuation of this policy.

BOT Rep. 01, I-18 Modified: BOT Rep. 12, A-19Modified: CCB Rep. 3, I-19

Situational Reporting Responsibilities of the AMA Board of Trustees G-605.051

The Board of Trustees provides reports to the House when the following situations occur:

- (1) the Board submits a report to the House when the Board takes actions that differ from current AMA policy;
- (2) consistent with AMA Bylaws, the Board submits a report to the House when the Board determines that the expenditures associated with recommendations and resolves that were adopted by the House would be inadvisable;
- (3) consistent with AMA Bylaws, the Board transmits reports of the SSS to the House and informs the House of important developments with regard to Federation organizations; and

(4) consistent with Policy G-630.040, the Board reports to the House when the Board's review of the AMA's Principles on Corporate Relationships results in recommendations for changes in the Principles.

In fulfilling its responsibilities to report to the House when certain specified situations develop, the Board should provide succinct reports to the House and, if additional detail is needed, use the AMA web site to provide the additional information to interested members of the House.

CLRPD Rep. 1, A-03 Modified: CCB/CLRPD Rep. 3, A-12

Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine and Legislative Advocacy G-615.103

Our AMA will: (1) study the participation of academic and teaching physicians, residents, fellows, and medical students in organized medicine and legislative advocacy; (2) study the participation of community-based faculty members of medical schools and graduate medical education programs in organized medicine and legislative advocacy; and (3) identify successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine and legislative advocacy.

Res. 608, A-17

Reference Committee A

CMS Report(s)

- 01 End-of-Life Care
- 03 Covering the Remaining Uninsured
- 05 Integrating Care for Individuals Dually Eligible for Medicare and Medicaid

Resolution(s)

- 101 Standardized Coding for Telehealth Services
- 102 Prevention of Hearing Loss-Associated-Cognitive-Impairment Through Earlier Recognition and Remediation
- 103 Oral Healthcare Is Healthcare
- 104 Improving Access to Vaccinations for Patients
- 105 Fertility Preservation Insurance Coverage for Women in Medicine
- 106 Reimbursement of School-Based Health Centers
- 107 Expanding Medicaid Transportation to Include Healthy Grocery Destinations
- 108 Medicaid and CHIP Coverage of Glucose Monitoring Devices for Patients with Diabetes
- 109 Amending D-440.985, Health Care Payment for Undocumented Persons, to Study Methods to Increase Health Care Access for Undocumented Immigrants
- 110 Caps on Insulin Co-Payments for Patients with Insurance
- 111 Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System
- 112 Expanding Coverage for and Access to Pulmonary Rehabilitation
- 113 Supporting Medicare Drug Price Negotiation
- 114 Medicare and Private Health Insurance for Hearing Aids
- 115 Bundled Payments and Medically Necessary Care
- 116 Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance
- 117 Implant-Associated Anaplastic Large Cell Lymphoma
- 118 Expanding Site-of-Service Neutrality
- 119* Bundling Physician Fees with Hospital Fees
- 120* COBRA for College Students
- 121* Medicaid Tax Benefits
- 122* Increase Funding, Research and Education for Post-Intensive Care Syndrome
- 123# Support for Easy Enrollment Federal Legislation
- 124# Medicare Coverage of Dental, Vision, and Hearing Services
- 125# Medicare Coverage of Dental, Vision and Hearing Services

* Contained in the Handbook Addendum

Contained in the Friday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 123
(N-21)

Introduced by: Maryland

Subject: Support for Easy Enrollment Federal Legislation

Referred to: Reference Committee A

1 Whereas, In 2019, the Maryland General Assembly passed legislation to establish the Maryland
2 Easy Enrollment Health Insurance Program with strong support from MedChi, The Maryland State
3 Medical Society; and
4

5 Whereas, The easy enrollment legislation established a statewide mechanism for uninsured
6 people filing Maryland income tax returns to begin the process of enrolling into health coverage
7 by consenting, on their tax return, to have relevant information shared with the health insurance
8 exchange serving state residents; and
9

10 Whereas, A federalized version of the Maryland legislation, entitled the Easy Enrollment in
11 Health Care Act, has been introduced by Senator Chris Van Hollen (D-Maryland) and
12 Congressman Ami Bera, MD (D-California); and
13

14 Whereas, The Easy Enrollment in Health Care Act is supported by the American Academy of
15 Pediatrics, the American Heart Association, and many other stakeholders in health care; and
16

17 Whereas, The legislation will “establish a program which allows any taxpayer who is not
18 covered under minimum essential coverage at the time their return of tax for the taxable year is
19 filed, as well as any other household member who is not covered under such coverage, to, in
20 conjunction with the filing of their return of tax for any taxable year which begins after
21 December 31, 2022, elect to--

22 (1) have a determination made as to whether the household member who is not covered under
23 such coverage is eligible for an insurance affordability program; and

24 (2) have such household member enrolled into minimum essential coverage;” and
25

26 Whereas, The legislation establishes appropriate limitations, including a prohibition on the
27 collection of information relating to citizenship, immigration status, and health status of any
28 household member; and
29

30 Whereas, The legislation will establish a process for the easy enrollment information to be
31 immediately transferred to relevant health insurance exchange and insurance affordability
32 programs “in order to increase the potential for immediate determinations of eligibility for and
33 enrollment in insurance affordability programs and minimum essential coverage;” and
34

35 Whereas, The legislation aligns with our AMA’s mission to strive for the betterment of public
36 health; therefore be it
37

38 RESOLVED, That our American Medical Association support the Easy Enrollment in Health
39 Care Act. (New HOD Policy)

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

Received: 11/06/21

AUTHORS STATEMENT OF PRIORITY

The Easy Enrollment in Health Care Act has been introduced in Congress and it seeking to establish a program that will begin “not later than January 1, 2024.” The AMA should not forestall joining with several national medical specialty societies and other health care stakeholders in support of this legislation.

Reference:

[https://www.vanhollen.senate.gov/imo/media/doc/Easy%20Enrollment%20in%20Health%20Care%20Act%20\[Final%20Bill%20Text\].pdf](https://www.vanhollen.senate.gov/imo/media/doc/Easy%20Enrollment%20in%20Health%20Care%20Act%20[Final%20Bill%20Text].pdf)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 124
(N-21)

Introduced by: Resident and Fellow Section

Subject: Medicare Coverage of Dental, Vision, and Hearing Services

Referred to: Reference Committee A

1 Whereas, The Social Security Act expressly prohibits coverage for most dental services,
2 specifically “services in connection with the care, treatment, filling, removal, or replacement of
3 teeth or structures directly supporting teeth,” by Original Medicare for its beneficiaries¹; and
4

5 Whereas, Though Medicare covers “medically necessary” dental care, the Centers for Medicare
6 & Medicaid Services presently interprets this to cover a very limited scope of services and
7 coverage determinations are often inconsistent--for example, Medicare Part A will cover an oral
8 examination as part of a comprehensive workup in preparation for a kidney transplant, but not
9 for transplantation of non-kidney organs^{2,3}; and
10

11 Whereas, Almost 24 million Medicare beneficiaries have no dental coverage, comprising nearly
12 half of Medicare beneficiaries⁴; and
13

14 Whereas, In 2021, 16.6 million Medicare Advantage enrollees have some dental benefits
15 through their plans, but 78% of those with coverage are enrolled in plans with annual dollar
16 limits on dental coverage (average annual limit of \$1,300), 10% are required to pay an
17 additional premium for dental coverage, and plans with coverage for extensive dental services
18 often necessitate significant coinsurance cost-sharing (most common cost-sharing of 50%)⁴;
19 and
20

21 Whereas, Lack of dental coverage and dental underinsurance leads to Medicare beneficiaries
22 forgoing recommended care, with 47% of those enrolled in Medicare not visiting the dentist in
23 2018⁴; and
24

25 Whereas, Racial inequities are perpetuated in access to dental services, with Black and
26 Hispanic Medicare enrollees most likely to have not seen a dentist in the past year (68% and
27 61%, respectively)⁴; and
28

29 Whereas, Only 7.27% of Medigap (Medicare Supplement) plans offer additional benefits such
30 as dental, hearing, and vision coverage⁵; and
31

32 Whereas, Poor dental health has myriad negative repercussions for patients’ health, including
33 nutritional deficiencies secondary to tooth loss, exacerbation of diabetes and cardiovascular
34 disease by untreated caries and periodontal disease, infections, and delayed diagnoses
35 resulting in preventable complications and adverse outcomes, including for cancer^{6,7}; and
36

37 Whereas, Original Medicare does not cover routine eye examinations for eyeglasses, nor does
38 it cover eyeglasses themselves other than eyeglasses following cataract surgery^{2,8}; and

1 Whereas, Untreated vision loss is correlated with increased risk of falls, depression, cognitive
2 impairment, hospitalization, and mobility limitations among older adults⁹; and

3
4 Whereas, Thirty-nine percent of Medicare beneficiaries reported having trouble seeing even
5 with their glasses, and low-income beneficiaries were most likely to have vision trouble⁹; and

6
7 Whereas, Among Medicare beneficiaries, forty-three percent who have difficulty seeing have not
8 had an eye exam within the last year¹⁰; and

9
10 Whereas, Medicare beneficiaries with supplemental vision plans spent an average of \$415 for
11 vision care, while those with Medicare Advantage spent an average of \$331, with 61% and 65%
12 of spending being comprised of out-of-pocket costs to the patient, indicating that even those
13 who have some vision care have significant out-of-pocket expenses for vision care⁹; and

14
15 Whereas, Medicare beneficiaries hospitalized for common illnesses were shown to have longer
16 mean lengths of stay, higher readmission rates, and higher costs both during hospitalization and
17 ninety days post-discharge if they had partial or severe vision loss compared to matched
18 hospitalized Medicare beneficiaries with no vision loss, resulting in an estimated \$500 million in
19 excess healthcare costs annually¹¹; and

20
21 Whereas, Among Medicare beneficiaries, low vision is associated with an increased risk of hip
22 fractures, depression, anxiety, and dementia, and more prevalent among Black and Hispanic
23 patients¹²; and

24
25 Whereas, Medicare beneficiaries with vision impairment reported lower well-being, which was
26 found to be mediated by limitations on mobility and household activities/ instrumental activities
27 of daily living relative to Medicare patients without visual impairment¹³; and

28
29 Whereas, A 2018 study published in *JAMA Ophthalmology* found that Hispanic and Black
30 Medicare beneficiaries were significantly less likely to report using low-vision devices than white
31 patients, but there were no similar disparities for low-vision rehabilitation (which is covered by
32 Medicare), leading the study authors to conclude that “policy makers could consider expanding
33 Medicare coverage to include low-vision devices in an effort to address significant disparities in
34 the use of this evidence-based intervention”¹⁴; and

35
36 Whereas, Among adults over the age of 65, the prevalence of falls in the past year for patients
37 with vision impairment was over double that for patients without vision impairment (27.6%
38 versus 13.2%), and the prevalence of activity restriction due to fear of falling was much higher in
39 patients with vision impairment as well (50.8% versus 33.9% for patients without vision
40 impairment)¹⁵; and

41
42 Whereas, A 2017 *JAMA Ophthalmology* study indicated that visual impairment was associated
43 with a 1.9- to 2.8-fold increase in cognitive dysfunction or dementia among adults 60 years and
44 older¹⁶; and

45
46 Whereas, Nearly 25% of people aged 65-74 and 50% persons of people over 75 suffer from
47 disabling hearing loss, which is associated with decreased quality of life, increased risk of
48 cognitive decline and hospitalization, and higher healthcare costs by thousands of dollars,
49 outweighing the relative cost of providing hearing services¹⁷⁻²¹; and

1 Whereas, Fewer than 30% of those aged 70 and older who could benefit from hearing aids have
2 ever used them, with many reporting cost as prohibitive, with an average cost of \$2,500 for a
3 pair of digital hearing aids and some ranging up to \$6,000²²⁻²³; and
4

5 Whereas, Original Medicare does not cover hearing exams, hearing aids, or aural rehabilitative
6 services, while Medicare Advantage charges additional premiums for hearing coverage, with
7 out-of-pocket costs and annual limits varying significantly across Advantage plans²⁶⁻²⁵; and
8

9 Whereas, The *Lancet* Commission has recognized hearing impairment as one of the most
10 important modifiable risk factors for dementia, and observed that “hearing aid use was the
11 largest factor protecting from decline” and “the long follow-up times in these prospective studies
12 suggest hearing aid use is protective, rather than the possibility that those developing dementia
13 are less likely to use hearing aids”²⁶; and
14

15 Whereas, Medicare beneficiaries with functional hearing difficulty (which reflects perceived
16 hearing under daily circumstances and takes the use of hearing aids into account for patients
17 that have them) experience more unmet healthcare needs, such that study investigators
18 concluded that “rethinking service delivery models to provide better access to hearing care
19 could lead to increased hearing aid use and improved interactions between providers and
20 patients with hearing loss”²⁷; and
21

22 Whereas, AMA Policy H-185.929, “Hearing Aid Coverage,” supports Medicare covering hearing
23 tests, but does not indicate support for hearing aids or aural rehabilitative services (which
24 includes fittings and adjustments); and
25

26 Whereas, Numerous recent proposals from the legislative and executive branches have
27 proposed the creation of new dental benefits for preventive and restorative services and
28 additional vision and hearing benefits for routine exams and aids under Medicare Part B,
29 including President Biden’s 2022 budget request, legislation (H.R. 3) passed by the House of
30 Representatives in 2019, and most recently, the Senate Democrats’ budget resolution^{5,28,29};
31 therefore be it
32

33 RESOLVED, That our American Medical Association support new Medicare funding that is
34 independent of the physician fee schedule for coverage of: (1) preventive dental care, including
35 dental cleanings and x-rays, and restorative services, including fillings, extractions, and
36 dentures; and (2) routine eye examinations and visual aids, including eyeglasses (New HOD
37 Policy); and be it further

1 RESOLVED, That our AMA amend Policy H-185.929, "Hearing Aid Coverage," by addition to
2 read as follows:

- 3
- 4 1. Our AMA supports public and private health insurance coverage that provides all
- 5 hearing-impaired infants and children access to appropriate physician-led teams
- 6 and hearing services and devices, including digital hearing aids.
- 7 2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes
- 8 the need for replacement of hearing aids due to maturation, change in hearing
- 9 ability and normal wear and tear.
- 10 3. Our AMA encourages private health plans to offer optional riders that allow their
- 11 members to add hearing benefits to existing policies to offset the costs of hearing
- 12 aid purchases, hearing-related exams and related services.
- 13 4. Our AMA supports coverage of hearing tests administered by a physician or
- 14 physician-led team, aural rehabilitative services, and hearing aids as part of
- 15 Medicare's Benefit.
- 16 5. Our AMA supports policies that increase access to hearing aids and other
- 17 technologies and services that alleviate hearing loss and its consequences for the
- 18 elderly.
- 19 6. Our AMA encourages increased transparency and access for hearing aid
- 20 technologies through itemization of audiologic service costs for hearing aids.
- 21 7. Our AMA supports the availability of over-the-counter hearing aids for the
- 22 treatment of mild-to-moderate hearing loss. (Modify Current HOD Policy)

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

Received: 11/06/21

AUTHORS STATEMENT OF PRIORITY

The subject matter in this resolution is the subject of current governmental legislation and regulation. It is important for the AMA HOD to debate and state its intention on these contentious issues. Medicare beneficiaries currently have limited dental, vision and hearing coverage, it is limited in scope and supplemental care is cost-prohibitive. Furthermore, poor dental health, untreated vision loss, and hearing impairment have myriad negative repercussions for patients' health and significant racial inequities in access to care exist. Hundreds of millions of excess dollars are also spent on healthcare costs annually to treat this population when hospitalized for preventable illnesses. Numerous recent proposals from the legislative and executive branches have proposed the creation of new dental benefits and additional vision and hearing benefits. Discussion of this resolution is extremely timely so our AMA can support this critical coverage expansion and maximize its advocacy impact.

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RELEVANT AMA POLICY

Eye Exams for the Elderly H-25.990

Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients; and (2) encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings. [Res. 813, I-05; Reaffirmed: CSAPH Rep. 1, A-15]

Hearing Aid Coverage H-185.929

1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.

2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.
5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.
6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.
7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss.

Citation: CMS Rep. 6, I-15; Appended: Res. 124, A-19

Medicare Coverage for Dental Services H-330.872

Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization. [CMS Rep. 03, A-19]

Importance of Oral Health in Patient Care D-160.925

Our AMA: (1) recognizes the importance of (a) managing oral health and (b) access to dental care as a part of optimal patient care; and (2) will explore opportunities for collaboration with the American Dental Association on a comprehensive strategy for improving oral health care and education for clinicians.

[Res. 911, I-16; Reaffirmed: CMS Rep. 03, A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 125
(N-21)

Introduced by: Medical Student Section

Subject: Medicare Coverage of Dental, Vision, and Hearing Services

Referred to: Reference Committee A

1 Whereas, The Social Security Act expressly prohibits coverage for most dental services,
2 specifically “services in connection with the care, treatment, filling, removal, or replacement of
3 teeth or structures directly supporting teeth,” by Original Medicare for its beneficiaries¹; and
4

5 Whereas, Though Medicare covers “medically necessary” dental care, the Centers for Medicare
6 & Medicaid Services presently interprets this to cover a very limited scope of services and
7 coverage determinations are often inconsistent--for example, Medicare Part A will cover an oral
8 examination as part of a comprehensive workup in preparation for a kidney transplant, but not
9 for transplantation of non-kidney organs^{2,3}; and
10

11 Whereas, Almost 24 million Medicare beneficiaries have no dental coverage, comprising nearly
12 half of Medicare beneficiaries⁴; and
13

14 Whereas, In 2021, 16.6 million Medicare Advantage enrollees have some dental benefits
15 through their plans, but 78% of those with coverage are enrolled in plans with annual dollar
16 limits on dental coverage (average annual limit of \$1,300), 10% are required to pay an
17 additional premium for dental coverage, and plans with coverage for extensive dental services
18 often necessitate significant coinsurance cost-sharing (most common cost-sharing of 50%)⁴;
19 and
20

21 Whereas, Lack of dental coverage and dental underinsurance leads to Medicare beneficiaries
22 forgoing recommended care, with 47% of those enrolled in Medicare not visiting the dentist in
23 2018⁴; and
24

25 Whereas, Racial inequities are perpetuated in access to dental services, with Black and
26 Hispanic Medicare enrollees most likely to have not seen a dentist in the past year (68% and
27 61%, respectively)⁴; and
28

29 Whereas, Only 7.27% of Medigap (Medicare Supplement) plans offer additional benefits such
30 as dental, hearing, and vision coverage⁵; and
31

32 Whereas, A 2016 analysis of over 1,200 older adult respondents in the Health and Retirement
33 Study found that only 68% used dental services, and two-thirds of those who wanted to use
34 dental services but did not do so reported cost as a reason they did not receive dental care⁶;
35 and
36

37 Whereas, The 2016 analysis of the Health and Retirement Study found that 42% of those using
38 dental services received a filling, bonding, or inlay; 34% received a crown, implant, or prosthetic;
39 26% received a gum treatment, tooth extraction, or surgery; and 10% received dentures⁶; and

1 Whereas, Poor dental health has myriad negative repercussions for patients' health, including
2 nutritional deficiencies secondary to tooth loss, exacerbation of diabetes and cardiovascular
3 disease by untreated caries and periodontal disease, infections, and delayed diagnoses
4 resulting in preventable complications and adverse outcomes, including for cancer^{7,8}; and
5

6 Whereas, Original Medicare does not cover routine eye examinations or refractions for
7 eyeglasses or contact lenses, nor does it cover eyeglasses or contact lenses themselves other
8 than eyeglasses following cataract surgery^{2,9}; and
9

10 Whereas, Untreated vision loss is correlated with increased risk of falls, depression, cognitive
11 impairment, hospitalization, and mobility limitations among older adults¹⁰; and
12

13 Whereas, Thirty-nine percent of Medicare beneficiaries reported having trouble seeing even
14 with their glasses, and low-income beneficiaries were most likely to have vision trouble¹⁰; and
15

16 Whereas, Among Medicare beneficiaries, forty-three percent who have difficulty seeing have not
17 had an eye exam within the last year¹¹; and
18

19 Whereas, Only thirty-seven percent of Medicare beneficiaries over the age of 65 had an eye
20 exam at least once every 15 months in one recent study¹²; and
21

22 Whereas, Medicare beneficiaries with supplemental vision plans spent an average of \$415 for
23 vision care, while those with Medicare Advantage spent an average of \$331, with 61% and 65%
24 of spending being comprised of out-of-pocket costs to the patient, indicating that even those
25 who have some vision care have significant out-of-pocket expenses for vision care¹⁰; and
26

27 Whereas, Medicare beneficiaries hospitalized for common illnesses were shown to have longer
28 mean lengths of stay, higher readmission rates, and higher costs both during hospitalization and
29 ninety days post-discharge if they had partial or severe vision loss compared to matched
30 hospitalized Medicare beneficiaries with no vision loss, resulting in an estimated \$500 million in
31 excess healthcare costs annually¹³; and
32

33 Whereas, Among Medicare beneficiaries, low vision is associated with an increased risk of hip
34 fractures, depression, anxiety, and dementia, and more prevalent among Black and Hispanic
35 patients¹⁴; and
36

37 Whereas, Medicare beneficiaries with vision impairment reported lower well-being, which was
38 found to be mediated by limitations on mobility and household activities/ instrumental activities
39 of daily living relative to Medicare patients without visual impairment¹⁵; and
40

41 Whereas, A 2018 study published in *JAMA Ophthalmology* found that Hispanic and Black
42 Medicare beneficiaries were significantly less likely to report using low-vision devices than white
43 patients, but there were no similar disparities for low-vision rehabilitation (which is covered by
44 Medicare), leading the study authors to conclude that "policy makers could consider expanding
45 Medicare coverage to include low-vision devices in an effort to address significant disparities in
46 the use of this evidence-based intervention"¹⁶; and
47

48 Whereas, Among adults over the age of 65, the prevalence of falls in the past year for patients
49 with vision impairment was over double that for patients without vision impairment (27.6%
50 versus 13.2%), and the prevalence of activity restriction due to fear of falling was much higher in
51 patients with vision impairment as well (50.8% versus 33.9% for patients without vision
52 impairment)¹⁷; and

1 Whereas, A 2017 *JAMA Ophthalmology* study indicated that visual impairment was associated
2 with a 1.9- to 2.8-fold increase in cognitive dysfunction or dementia among adults 60 years and
3 older¹⁸; and
4

5 Whereas, A study of over 22,000 nationwide respondents to the Medicare Current Beneficiary
6 Study found that beneficiaries with vision impairment were significantly more likely to be
7 hospitalized over a three-year period¹⁹; and
8

9 Whereas, Nearly 25% of people aged 65-74 and 50% persons of people over 75 suffer from
10 disabling hearing loss, which is associated with decreased quality of life, increased risk of
11 cognitive decline and hospitalization, and higher healthcare costs by thousands of dollars,
12 outweighing the relative cost of providing hearing services²⁰⁻²⁴; and
13

14 Whereas, Fewer than 30% of those aged 70 and older who could benefit from hearing aids have
15 ever used them, with many reporting cost as prohibitive, with an average cost of \$2,500 for a
16 pair of digital hearing aids and some ranging up to \$6,000²⁵⁻²⁶; and
17

18 Whereas, Original Medicare does not cover hearing exams, hearing aids, or aural rehabilitative
19 services, while Medicare Advantage charges additional premiums for hearing coverage, with
20 out-of-pocket costs and annual limits varying significantly across Advantage plans²⁷⁻²⁸; and
21

22 Whereas, The *Lancet* Commission has recognized hearing impairment as one of the most
23 important modifiable risk factors for dementia, and observed that “hearing aid use was the
24 largest factor protecting from decline” and “the long follow-up times in these prospective studies
25 suggest hearing aid use is protective, rather than the possibility that those developing dementia
26 are less likely to use hearing aids”²⁹; and
27

28 Whereas, Medicare beneficiaries with functional hearing difficulty (which reflects perceived
29 hearing under daily circumstances and takes the use of hearing aids into account for patients
30 that have them) experience more unmet healthcare needs, such that study investigators
31 concluded that “rethinking service delivery models to provide better access to hearing care
32 could lead to increased hearing aid use and improved interactions between providers and
33 patients with hearing loss”³⁰; and
34

35 Whereas, AMA Policy H-185.929, “Hearing Aid Coverage,” supports Medicare covering hearing
36 tests, but does not indicate support for hearing aids or aural rehabilitative services (which
37 includes fittings and adjustments); and
38

39 Whereas, Numerous recent proposals from the legislative and executive branches have
40 proposed the creation of new dental benefits for preventive and restorative services and
41 additional vision and hearing benefits for routine exams and aids under Medicare Part B,
42 including President Biden’s 2022 budget request, legislation (H.R. 3) passed by the House of
43 Representatives in 2019, and most recently, the Senate Democrats’ budget resolution^{5,31,32};
44 therefore be it
45

46 RESOLVED, That our American Medical Association support Medicare coverage of preventive
47 dental care, including dental cleanings and x-rays, and restorative services, including fillings,
48 extractions, and dentures (New HOD Policy); and be it further
49

50 RESOLVED, That our AMA support Medicare coverage of routine eye examinations and visual
51 aids, including eyeglasses and contact lenses (New HOD Policy); and be it further

1 RESOLVED, That our American Medical Association amend Policy H-185.929, "Hearing Aid
2 Coverage," by addition to read as follows:

3
4 **Hearing Aid Coverage H-185.929**

5 1. Our AMA supports public and private health insurance coverage that provides all
6 hearing-impaired infants and children access to appropriate physician-led teams
7 and hearing services and devices, including digital hearing aids.

8 2. Our AMA supports hearing aid coverage for children that, at minimum,
9 recognizes the need for replacement of hearing aids due to maturation, change in
10 hearing ability and normal wear and tear.

11 3. Our AMA encourages private health plans to offer optional riders that allow their
12 members to add hearing benefits to existing policies to offset the costs of hearing
13 aid purchases, hearing-related exams and related services.

14 4. Our AMA supports coverage of hearing tests administered by a physician or
15 physician-led team, aural rehabilitative services, and hearing aids as part of
16 Medicare's Benefit.

17 5. Our AMA supports policies that increase access to hearing aids and other
18 technologies and services that alleviate hearing loss and its consequences for the
19 elderly.

20 6. Our AMA encourages increased transparency and access for hearing aid
21 technologies through itemization of audiologic service costs for hearing aids.

22 7. Our AMA supports the availability of over-the-counter hearing aids for the
23 treatment of mild-to-moderate hearing loss. (Modify Current HOD Policy)

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

Received: 11/07/21

AUTHORS STATEMENT OF PRIORITY

This resolution is incredibly timely as [proposals to expand Medicare to cover dental, hearing, and vision services](#) are [being hotly debated in Congress](#). Conferring AMA support for this expansion would be instrumental in anchoring their inclusion in the reconciliation package at a crucial juncture during its negotiation. [A Viewpoint published in the Journal of the American Medical Association on September 27th](#) astutely observed that "The Window of Opportunity is Open" to expand coverage of dental, hearing, and vision benefits in Medicare.

Much has changed since the AMA last examined the issues of Medicare coverage of hearing aids and dental services. Since the Council on Medical Service's report at I-15 on Medicare hearing aids coverage, the *Lancet* Commission published a 2020 report recognizing hearing impairment as among the most important modifiable risk factors for dementia, stating that "hearing aid use was the largest factor protecting from decline." Since the Council's A-19 report on dental coverage under Medicare, the American Dental Association has put forward a [proposal that would fail to expand comprehensive dental coverage to all Medicare beneficiaries](#). AMA policy is silent on the Medicare coverage of vision services. Development of clear new policy around these issues is imperative to inform the AMA's positioning around the active legislation in this arena.

The time is now for the AMA to stand with the [National Dental Association](#) to right a historical wrong in the exclusion of basic oral, eye, and ear care from Medicare coverage to improve the health of all Medicare beneficiaries.

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RELEVANT AMA POLICY

Eye Exams for the Elderly H-25.990

Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients; and (2) encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings.

Res. 813, I-05; Reaffirmed: CSAPH Rep. 1, A-15

Hearing Aid Coverage H-185.929

1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.
5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.
6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.
7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss.

CMS Rep. 6, I-15; Appended: Res. 124, A-19

Medicare Coverage for Dental Services H-330.872

Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization.

CMS Rep. 03, A-19

Importance of Oral Health in Patient Care D-160.925

Our AMA: (1) recognizes the importance of (a) managing oral health and (b) access to dental care as a part of optimal patient care; and (2) will explore opportunities for collaboration with the American Dental Association on a comprehensive strategy for improving oral health care and education for clinicians.

Res. 911, I-16; Reaffirmed: CMS Rep. 03, A-19

Reference Committee B

BOT Report(s)

- 02 Policing Reform
- 08 Improved Access and Coverage to Non-opioid Modalities to Address Pain
- 09 Medical Marijuana License Safety
- 10 Physician Access to Their Medical and Billing Records
- 12 Direct-to-Consumer Genetic Tests
- 14 Net Neutrality and Public Health

Resolution(s)

- 201 Protection of Peer-Review Process
- 202 RESOLUTION WITHDRAWN
- 203 Poverty-Level Wages and Health
- 204 Supporting Collection of Data on Medical Repatriation
- 205 Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits
- 206 Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities to Better Address National Crises
- 207 Authority to Grant Vaccine Exemptions
- 208 Protections for Incarcerated Mothers in the Perinatal Period
- 209 Increasing Access to Hygiene and Menstrual Products
- 210 Advocating for the Amendment of Chronic Nuisance Ordinances
- 211 Support for Mental Health Courts
- 212 Sequestration
- 213 Eliminating Unfunded or Unproven Mandates and Regulations
- 214 Stakeholder Engagement in Medicare Administrative Contractor Policy
- 215 Pharmacy Benefit Manager Reform as a State Legislative Priority
- 216 Preserving Appropriate Physician Supervision of Midlevel Providers and Ensuring Patient Awareness of the Qualifications of Physicians vs. Midlevel Providers
- 217 Studying Physician Supervision of Allied Health Professionals Outside of their Fields of Graduate Medical Education
- 218 Physician Opposition to the Coordinated Effort by Corporations and Midlevel Providers to Undermine the Physician-Patient Relationship and Safe Quality Care
- 219 The Impact of Midlevel Providers on Medical Education
- 220 Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use
- 221 Promoting Sustainability in Medicare Physician Payments
- 222 Opposing Federal Preemption of State Licensing Laws and Scope-of-Practice Expansion Under the Ninth Amendment to Declaration Under the PREP Act
- 223 Paying Physicians for Services According to the Physician Fee Schedule
- 224 Improve Physician Payments
- 225 End Budget Neutrality
- 226 Addressing Adolescent Telehealth Confidentiality Concerns
- 227 Medication for Opioid Use Disorder in Physician Health Programs
- 228 Resentencing for Individuals Convicted of Marijuana-Based Offenses
- 229* CMS Administrative Requirements

* Contained in the Handbook Addendum

Contained in the Friday Tote

Reference Committee B

Resolution(s)

- 230* Medicare Advantage Plan Mandates
- 231* Prohibit Ghost Guns
- 232* Ban the Gay/Trans (LGBTQ+) Panic Defense
- 233* Insurers and Vertical Integration
- 234* Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-dose Medications for Multiple Patients
- 235# Vital Nature of Board-Certified Physician in Aerospace Medicine
- 236# Repeal or Modification of the Medicare Appropriate Use Criteria
- 237# Universal Good Samaritan Statute
- 238# Increasing Residency Positions for Primary Care
- 239# Making State Health Care Cost Containment Datasets Free of Cost and Readily Available for Academic Research
- 240# Ransomware Prevention and Recovery
- 241# Enforcement of Administrative Simplification Requirements - CMS

* Contained in the Handbook Addendum

Contained in the Friday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 235
(N-21)

Introduced by: Aerospace Medical Association

Subject: Vital Nature of Board-Certified Physicians in Aerospace Medicine

Referred to: Reference Committee B

Whereas, Aerospace medicine is an internationally recognized, unique specialty of medicine with advanced education requirements supporting all domains of aviation and space flight; and

Whereas, In over a century of support, the Aerospace Medicine Team, led by aerospace medicine physicians, has advanced the art and science of every human flight endeavor, resulting in improved safety, reduced mishaps, and enhanced mission accomplishment; and

Whereas, Aerospace medicine physicians are required to maintain their professional knowledge and standing with state medical licensure, current specialty board certifications, continuing medical education activities, and ongoing privileging; and have extensive knowledge, skills, and professional self-regulation in the full and total range of the practice of aerospace medicine; and

Whereas, In an effort to reduce costs and pass-on legal liability, there has been a trend in managed medical care, US commercial airlines/space activities and in the US governmental departments to replace aerospace medicine physicians with non-aerospace medicine and mid-level providers, resulting in significantly increased risk and reduced safety margins; and

Whereas, 193 countries are signatories to the Convention on International Civil Aviation ("Chicago Convention"), which obliges the governments to reciprocally implement certain international regulatory standards, including physician responsibility pertaining to medical fitness of license holders, prevention of ill health and management of public health events in aviation; therefore be it

RESOLVED, That our American Medical Association recognize the unique contributions and advanced qualifications of aerospace medicine professionals, and specifically oppose any and all efforts to remove, reduce or replace aerospace medicine physician leadership in civilian, corporate or government aerospace medicine programs and aircrew healthcare support teams; (Directive to Take Action) and be it further

RESOLVED, That our AMA advocate for compliance with international agreements, to include advocating against other mid-level provider scope of practice expansions that threaten the safety, health, and well-being of aircrew, patients, support personnel and the flying public. (Directive to Take Action)

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

Received: 10/26/21

AUTHORS STATEMENT OF PRIORITY

This resolution addresses concerning trends in government / industry that are removing medical departments and specific aviation / space expertise in the military, aviation and commercial space sectors.

Despite AMA's strong policy on scope of practice, companies / government organizations have moved to marginalize physician specialists. Most major airlines have outsourced medical support. The US Air Force has minimized participation of specialists in the Air Force Medical Service, which also supports US Space Force. Even the house of medicine is beginning to lose sight of "physician-led" teams (H-160.912, .906 & .908) in advising / supporting these industries. A trained Aerospace Medicine specialist has been proven over the last century to have the unique knowledge, skills and experience to manage medical risk in the aviation and space environments.

Continuing growth of commercial aerospace industry & the establishment of US Space Force has put workforce pressures on the nation's aerospace medicine specialists. AM residencies are struggling to keep pace with demand (H-45.993).

This requests AMA to adopt language addressing an urgent problem facing this developing situation, and is consistent with existing policy D-35.985 and scope of practice policies. While this situation does not affect most physicians, no specific policy exists on this topic. The specialty society (AsMA) and AOA have enacted similar policy. The AMA's voice could have positive impact. It clearly only affects a sub-group/specialty of US physicians. While it is likely not a "top priority", this resolution could be considered a "medium priority" but due to the timeliness and gap in policy, more likely should be considered a "high priority" resolution.

RELEVANT AMA POLICY**The Structure and Function of Interprofessional Health Care Teams H-160.912**

1. Our AMA defines 'team-based health care' as the provision of health care services by a physician-led team of at least two health care professionals who work collaboratively with each other and the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care.
2. Our AMA will advocate that the physician leader of a physician-led interprofessional health care team be empowered to perform the full range of medical interventions that she or he is trained to perform.
3. Our AMA will advocate that all members of a physician-led interprofessional health care team be enabled to perform medical interventions that they are capable of performing according to their education, training and licensure and the discretion of the physician team leader in order to most effectively provide quality patient care.
4. Our AMA adopts the following principles to guide physician leaders of health care teams:
 - a. Focus the team on patient and family-centered care.
 - b. Make clear the team's mission, vision and values.
 - c. Direct and/or engage in collaboration with team members on patient care.
 - d. Be accountable for clinical care, quality improvement, efficiency of care, and continuing education.
 - e. Foster a respectful team culture and encourage team members to contribute the full extent of their professional insights, information and resources.
 - f. Encourage adherence to best practice protocols that team members are expected to follow.
 - g. Manage care transitions by the team so that they are efficient and effective, and transparent

to the patient and family.

h. Promote clinical collaboration, coordination, and communication within the team to ensure efficient, quality care is provided to the patient and that knowledge and expertise from team members is shared and utilized.

i. Support open communication among and between the patient and family and the team members to enhance quality patient care and to define the roles and responsibilities of the team members that they encounter within the specific team, group or network.

j. Facilitate the work of the team and be responsible for reviewing team members' clinical work and documentation.

k. Review measures of 'population health' periodically when the team is responsible for the care of a defined group.

5. Our AMA encourages independent physician practices and small group practices to consider opportunities to form health care teams such as through independent practice associations, virtual networks or other networks of independent providers.

6. Our AMA will advocate that the structure, governance and compensation of the team should be aligned to optimize the performance of the team leader and team members.

Citation: Joint CME-CMS Rep., I-12; Reaffirmation I-13; Reaffirmed: CMS Rep. 1, I-15;

Reaffirmed: BOT Action in response to referred for decision: Res. 718, A-17

Models / Guidelines for Medical Health Care Teams H-160.906

1. Our AMA defines 'physician-led' in the context of team-based health care as the consistent use by a physician of the leadership knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of these skills.

2. Our AMA supports the following elements that should be considered when planning a team-based care model according to the needs of each physician practice:

Patient-Centered:

a. The patient is an integral member of the team.

b. A relationship is established between the patient and the team at the onset of care, and the role of each team member is explained to the patient.

c. Patient and family-centered care is prioritized by the team and approved by the physician team leader.

d. Team members are expected to adhere to agreed-upon practice protocols.

e. Improving health outcomes is emphasized by focusing on health as well as medical care.

f. Patients' access to the team, or coverage as designated by the physician-led team, is available twenty-four hours a day, seven days a week.

g. Safety protocols are developed and followed by all team members.

Teamwork:

h. Medical teams are led by physicians who have ultimate responsibility and authority to carry out final decisions about the composition of the team.

i. All practitioners commit to working in a team-based care model.

j. The number and variety of practitioners reflects the needs of the practice.

k. Practitioners are trained according to their unique function in the team.

l. Interdependence among team members is expected and relied upon.

m. Communication about patient care between team members is a routine practice.

n. Team members complete tasks according to agreed-upon protocols as directed by the physician leader.

Clinical Roles and Responsibilities:

o. Physician leaders are focused on individualized patient care and the development of treatment plans.

p. Non-physician practitioners are focused on providing treatment within their scope of practice

consistent with their education and training as outlined in the agreed upon treatment plan or as delegated under the supervision of the physician team leader.

q. Care coordination and case management are integral to the team's practice.

r. Population management monitors the cost and use of care, and includes registry development for most medical conditions.

Practice Management:

s. Electronic medical records are used to the fullest capacity.

t. Quality improvement processes are used and continuously evolve according to physician-led team-based practice assessments.

u. Data analytics include statistical and qualitative analysis on cost and utilization, and provide explanatory and predictive modeling.

v. Prior authorization and precertification processes are streamlined through the adoption of electronic transactions.

Citation: CMS Rep. 6, A-14; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed: CMS Rep. 05, A-17

Payment Mechanisms for Physician-Led Team-Based Health Care H-160.908

1. Our AMA advocates that physicians who lead team-based care in their practices receive the payments for health care services provided by the team and establish payment disbursement mechanisms that foster physician-led team-based care.

2. Our AMA advocates that payment models for physician-led team-based care should be determined by physicians working collaboratively with hospital and payer partners to design models best suited for their particular circumstances.

3. Our AMA advocates that physicians make decisions about payment disbursement in consideration of team member contributions, including but not limited to:

- a. Volume of services provided;
- b. Intensity of services provided;
- c. Profession of the team member;
- d. Training and experience of the team member; and
- e. Quality of care provided.

4. Our AMA advocates that an effective payment system for physician-led team-based care should:

- a. Reflect the value provided by the team and that any savings accrued by this value should be shared by the team;
- b. Reflect the time, effort and intellectual capital provided by individual team members;
- c. Be adequate to attract team members with the appropriate skills and training to maximize the success of the team; and
- d. Be sufficient to sustain the team over the time frame that it is needed.

Citation: CMS Rep. 1, I-13; Reaffirmed: CMS Rep. 1, I-15; Reaffirmed: CMS Rep. 08, A-16

Support for Physician Led, Team Based Care D-35.985

Our AMA:

1. Reaffirms, will proactively advance at the federal and state level, and will encourage state and national medical specialty societies to promote policies H-35.970, H-35.973, H-35.974, H-35.988, H-35.989, H-35.992, H-35.993, H-160.919, H-160.929, H-160.947, H-160.949, H-160.950, H-360.987, H 405.969 and D-35.988.

2. Will identify and review available data to analyze the effects on patients? access to care in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services) to determine whether there has been any increased access to care in those states.

3. Will identify and review available data to analyze the type and complexity of care provided by all non-physician providers, including CRNAs in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services),

compared to the type and complexity of care provided by physicians and/or the anesthesia care team.

4. Will advocate to policymakers, insurers and other groups, as appropriate, that they should consider the available data to best determine how non-physicians can serve as a complement to address the nation's primary care workforce needs.

5. Will continue to recognize non-physician providers as valuable components of the physician-led health care team.

6. Will continue to advocate that physicians are best qualified by their education and training to lead the health care team.

7. Will call upon the Robert Wood Johnson Foundation to publicly announce that the report entitled, "Common Ground: An Agreement between Nurse and Physician Leaders on Interprofessional Collaboration for the Future of Patient Care" was premature; was not released officially; was not signed; and was not adopted by the participants.

Citation: BOT Rep. 9, I-11; Reaffirmed: CMS Rep. 1, A-12; Reaffirmed: CMS Rep. 07, A-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 6, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 236
(N-21)

Introduced by: American Academy of Family Physicians, American Academy of Orthopaedic Surgeons, American Academy of Otolaryngology-Head and Neck Surgery, American Academy of Physical Medicine and Rehabilitation, American Association of Neurological Surgeons, American College of Cardiology, American College of Emergency Physicians, American College of Gastroenterology, American College of Surgeons, American Orthopaedic Foot & Ankle Society, American Gastroenterological Association, American Society for Gastrointestinal Endoscopy, American Society for Surgery of the Hand, American Society of Echocardiography, American Society of Nuclear Cardiology, American Urological Association, Congress of Neurological Surgeons, International Society for the Advancement of Spine Surgery, North American Spine Society, Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Computed Tomography, California, American College of Physicians, American Association of Clinical Urologists, American Clinical Neurophysiology Society

Subject: Repeal or Modification of the Medicare Appropriate Use Criteria (AUC) Program

Referred to: Reference Committee B

1 Whereas, In 2014, Congress passed the Protecting Access to Medicare Act (PAMA) [Public
2 Law 113-93], establishing the Medicare Appropriate Use Criteria (AUC) Program for advanced
3 diagnostic imaging; and
4

5 Whereas, Seven years after PAMA's enactment, the Centers for Medicare & Medicaid Services
6 (CMS) continues to face challenges in completing the rulemaking and implementation of the
7 AUC program, fueling existing concerns about the complexity of the law, associated costs, and
8 regulatory burden sustained by physicians and other health care providers to meet the program
9 requirements; and
10

11 Whereas, The AUC program, if ever fully implemented, would impact a substantial number of
12 clinicians, as it would apply to every clinician who orders or furnishes an advanced diagnostic
13 imaging test, unless a statutory or hardship exemption applies; and
14

15 Whereas, Practitioners whose ordering patterns are considered outliers will be subject to prior
16 authorization--at a time when physicians are working to advance policies that reduce the
17 administrative burdens associated with prior authorization; and
18

19 Whereas, The program will be a financial burden for many practices, as it is estimated to cost
20 \$75,000 or more for a practice to implement a Clinical Decision Support Mechanism (CDSM)
21 that complies with the AUC Program rules¹; and

¹ Association for Medical Imaging Management; 2017 <https://ahralink.files.wordpress.com/2017/03/cds-survey-2017.pdf>

1 Whereas, The law is prescriptive, requiring clinicians to use only CDSMs qualified by CMS and
2 only AUC developed by certain qualified entities--preventing the use of other clinical decision
3 support tools and evidenced-based guidelines for advanced diagnostic imaging developed by
4 medical societies and other health care institutions; and
5

6 Whereas, The AUC program creates a complex exchange of information between clinicians that
7 is not yet supported by interoperable electronic health record systems and relies on claims-
8 based reporting at a time when CMS is migrating from claims reporting for quality data; and
9

10 Whereas, Since PAMA's enactment, the AUC program has become obsolete given the
11 subsequent enactment of the Medicare Access and CHIP Reauthorization Act (MACRA) of
12 2015 and the rise of new health care payment and delivery models via the Quality Payment
13 Program (QPP) (alternative payment models and Merit-based Incentive Payment System)
14 designed to hold clinicians responsible for health care resource use; and
15

16 Whereas, Four years after the program's intended start date, technical challenges, including the
17 need for claims processing edits to ensure that only appropriate claims are subject to AUC
18 claims processing edits, have further eroded physician confidence in and support for the
19 program; and
20

21 Whereas, Awareness of the program among physicians and other health care professionals
22 remains low, which is supported by CMS' estimate--based on CY2020 Medicare claims during
23 the program's education and operations testing phase--that between 9-10 percent of all claims
24 subject to the AUC program reported information sufficient to be considered compliant with the
25 program; and
26

27 Whereas, In the CY 2022 Medicare Physician Fee Schedule proposed rule, CMS is yet again
28 proposing to delay the payment penalty phase of the AUC program until the later of
29 January 1, 2023, or the January 1 of the year following the end of the COVID-19 public health
30 emergency; and
31

32 Whereas, Congress and CMS must seriously consider the degree to which the AUC program
33 and QPP requirements overlap and create duplicative reporting burdens for physicians already
34 overwhelmed by the variety of other administrative burdens associated with care delivery; and
35

36 Whereas, There is widespread agreement in the medical community that the program cannot be
37 implemented as originally envisioned without imposing undue burden and cost on physician
38 practices; therefore be it
39

40 RESOLVED, That our American Medical Association Policy H-320.940, "Medicare's Appropriate
41 Use Criteria Program," be amended by addition and deletion to read as follows:
42

43 Our AMA will ~~continue to advocate to Congress for delay the effective date either the~~
44 full repeal of the Medicare Appropriate Use Criteria (AUC) Program or legislative
45 modifications to the program in such a manner that ~~until the Centers for Medicare &~~
46 ~~Medicaid Services (CMS) can adequately addresses~~ technical and workflow
47 challenges, ~~with its implementation and any interaction between~~ maximizes alignment
48 with the Quality Payment Program (QPP), and the use of advanced diagnostic imaging
49 appropriate use criteria. creates provider flexibility for the consultation of AUC or
50 advanced diagnostic imaging guidelines using a mechanism best suited for their
51 practice, specialty and workflow. (Modify Current HOD Policy)

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

Received: 10/28/21

AUTHORS STATEMENT OF PRIORITY

This resolution should be considered at the November 2021 Special Meeting of the AMA HOD to allow the AMA to amend current policy on the AUC Program before the current delays of implementation expire (currently scheduled for January 2022). Many hospital systems and physicians have started trial programs to implement the system based on the 2022 deadline which is expensive and wasteful. In the CY 2022 Medicare Physician Fee Schedule proposed rule, CMS proposed to further delay implementation of the AUC program. Subsequently, the Committee on Appropriations of the U.S. House of Representatives issued a report directing CMS to submit a report to Congress describing the success and challenges associated with the long-delayed implementation of the AUC program. Since legislative action is required to amend the statutory requirements in PAMA, this is the opportune time for the AMA to express physician's concerns with the AUC Program requirements, in order to influence legislation which may be introduced in the next 6 months.

RELEVANT AMA POLICY

Medicare's Appropriate Use Criteria Program H-320.940

Our AMA will continue to advocate to delay the effective date of the Medicare Appropriate Use Criteria (AUC) Program until the Centers for Medicare & Medicaid Services (CMS) can adequately address technical and workflow challenges with its implementation and any interaction between the Quality Payment Program (QPP) and the use of advanced diagnostic imaging appropriate use criteria.

Citation: Res. 229, A-17; Reaffirmed - BOT Action in response to referred for decision: Res. 245, A-19 and Res. 247, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 237
(N-21)

Introduced by: Georgia

Subject: Universal Good Samaritan Statute

Referred to: Reference Committee B

1 Whereas, Good Samaritan statutes exist in all 50 states and the District of Columbia for the
2 purpose of promoting aid to individuals in need of emergency care; and
3

4 Whereas, These statutes widely vary from state to state. This impedes the desired intent of
5 these laws and may prevent physicians from rendering much needed care to patients who are in
6 need of emergency care for a medical condition outside of healthcare settings due to fear of
7 litigation; and
8

9 Whereas, Some states only cover physicians licensed in that state. Physicians without the local
10 state license may be held liable for Good Samaritan acts if physicians are from a different state
11 and may be unfamiliar with the details of the local statutes; and
12

13 Whereas, "Enumeration of Immunity" of Good Samaritan statutes may vary from state to state in
14 such a way that it may not protect every rescuer depending upon the location of the event; and
15

16 Whereas, "Good faith requirement" in the statute may differ from state to state; and
17

18 Whereas, "Specific site of covering" may also vary based on the location of the accident and the
19 rescue; and
20

21 Whereas, "Minimal standard of care" may vary from state to state; and
22

23 Whereas, Federal laws only exist for specific circumstances, such as Aviation Medical
24 Assistance Act and Federal Law Enforcement Officers' Good Samaritan Act of 1998; therefore
25 be it
26

27 RESOLVED, That our American Medical Association help protect patients in need of emergency
28 care and protect physicians and other responders by advocating for a national "universal" Good
29 Samaritan Statute (Directive to Take Action); and be it further
30

31 RESOLVED, That our AMA advocate for the unification of the disparate statutes by creation of a
32 national standard via either federal legislation or through policy directed by the Department of
33 Health and Human Services (HHS) to specify terms that would protect rescuers from legal
34 repercussion as long as the act by the rescuer meets the specified universal minimal standard
35 of conduct and the good faith requirement, regardless of the event location; thus, effectively
36 eliminating variations in the state statutes to facilitate the intent of the Good Samaritan statutes
37 removing barriers that could impede the prompt rendering of emergency care. (Directive to Take
38 Action)

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

Received: 11/01/21

AUTHORS STATEMENT OF PRIORITY

The COVID-19 pandemic has placed additional pressures on the health care system and has led to numerous delays in patients seeking and receiving preventative and other elective care. These delays are likely to lead to unknown emergencies happening outside of emergency rooms and traditional places of care. It is important that physicians are protected when an emergency situation occurs where their expertise and quick clinical judgment is needed. One of the potential barriers to a physician acting as a rescuer in these situations is the unknown due to disparate good Samaritan statutes spanning the country. With the ease of travel in the United States at this time and the ongoing public health crisis, it is imperative that physicians are ready, willing, and able to render emergency care and delaying the implementation of this policy could hamper the ability of physicians to respond to emergencies as travel continues to resume. Good Samaritan laws also serve to protect physicians who respond to emergencies like the COVID-19 crisis and with spikes in cases happening across the country, this would be one way to improve the ability of physicians to appropriately respond to states in which they do not live. Current AMA policy leaves gaps by not addressing the need for continuity across all states.

RELEVANT AMA POLICY

Delivery of Health Care by Good Samaritans H-130.937

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

level of training or experience. (g) Except in extraordinary circumstances or where requested by the EMS providers, the bystander physician should refrain from providing medical oversight of EMS that results in deviation from existing EMS protocols and standing orders.

4. Our AMA urges the International Civil Aviation Organization to make explicit recommendations to its member countries for the enactment of regulations providing "Good Samaritan" relief for those rendering emergency medical assistance aboard air carriers and in the immediate vicinity of air carrier operations.

Citation: (CCB/CLRPD Rep. 3, A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 238
(N-21)

Introduced by: Pennsylvania

Subject: Increasing Residency Positions for Primary Care

Referred to: Reference Committee B

Whereas, We have many physicians (known to be in the thousands within the United States) that have completed the intense and specific education required in medical school whether at allopathic or osteopathic institutions and have successfully passed USMLE part 1, 2 CK and 2 CS or comparable examinations but have not been able to obtain a residency due to the shortage of residency positions in the United States; along with a known shortage of physicians within the United States currently and presumed well into the future due to our aging population; and

Whereas, Even with the known shortage of physicians; and the increasing number of physicians without residencies, expands as more and more candidates go unmatched due to the cap on Medicare support for graduate medical education. Residency positions are not increasing adequately to support the physicians that are available nor correcting the need for more practicing physicians; therefore be it

RESOLVED, That our American Medical Association prioritize the number of accredited residency positions, with the goal to increase the overall number especially in specialties deemed primary care (Directive to Take Action); and be it further

RESOLVED, That our AMA seek to increase the cap of Medicare support for graduate medical education. (Directive to Take Action)

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

Received: 11/03/21

AUTHORS STATEMENT OF PRIORITY

We view this to be a high priority rather than a top priority since it has a significant impact on a subset of physician, yet it has direct implication to physician shortage and thus effects patient care through altering scope of practice issues. Extended care providers champion manpower deficiencies in rural and economically challenged urban areas. This resolution that attempts to match the number of residencies with the number of certified candidates has benefits to patient care as a whole. Clearly as the resolution ask, we are requesting that the AMA continue to advocate for increased GME funding and to direct that funding particularly toward increases in what would be considered primary care residencies.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 239
(N-21)

Introduced by: Pennsylvania

Subject: Making State Health Care Cost Containment Datasets Free of Cost and
Readily Available for Academic Research

Referred to: Reference Committee B

Whereas, All-payer claims databases (APCDs) are centralized databases created to enable healthcare transparency and inform health policies at the state level; and

Whereas, APCDs are critical for emergent statewide research on topics including COVID-19; and

Whereas, APCDs often self-publishes high-level summaries of various aspects of the collected data in a format unsuitable for research; and

Whereas, APCDs deidentified dataset pricing structure is costly, curbing its use in academic research by students and scientists, thereby limiting utilization of this important data to assess novel questions; therefore be it

RESOLVED, That our American Medical Association advocate for affordable and open access to all all-payer claims databases (APCDs) data for academic research purposes. (Directive to Take Action)

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

Received: 11/03/21

AUTHORS STATEMENT OF PRIORITY

All-Payer Claims Databases, such as the PCH4 in Pennsylvania, allow for increased transparency of costs in the American healthcare system. Price transparency is a concept already supported by our AMA, but this resolution provides a specific example of existing raw datasets at the state level that are either inaccessible or too costly for effective utilization in academic research. We feel this is timely because, particularly in a time when health care may be experiencing a shift or even upheaval in the context of the current pandemic, academic researchers must have feasible access to the appropriate data to come to fair and effective conclusions regarding cost containment and proper use of healthcare resources.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 240
(N-21)

Introduced by: Organized Medical Staff Section

Subject: Ransomware Prevention and Recovery

Referred to: Reference Committee B

Whereas, An objective of our American Medical Association is the betterment of healthcare delivery, and the sustainability of physician practices; and

Whereas, Cyberattacks on healthcare systems have spiked during the COVID-19 pandemic, threatening patient care; and

Whereas, According to a survey of IT professionals by HealthITSecurity, more than one in three healthcare organizations globally reported being hit by ransomware in 2020 with a significant 45 percent increase since November 2020¹; and

Whereas, A report commissioned by risk management company Censinet and published in Becker's Hospital Review² found that

1. 67 percent of healthcare organizations have been victims of ransomware attacks, and 33 percent have been hit at least twice;
2. 22 percent of healthcare organizations report increased mortality rates resulting from ransomware attacks;
3. 61 percent of respondents said they lack the confidence to combat ransomware, a slight increase from 55 percent before COVID-19; and

Whereas, Pandemic-related changes only heightened vulnerabilities; Telemedicine and remote work added new ways into systems and economic setbacks led some hospitals to lay off and/or furlough cybersecurity staff³; and

Whereas, If one rural hospital serving several counties with thousands of people in a geographic area were attacked, patients served by that hospital may not have any other healthcare options; and

Whereas, Healthcare organizations tend to defer cybersecurity investment because it can be hard to divert resources to information security if it seems to come at the expense of patient services⁴; and

Whereas, Our AMA-adopted policy D-478.960, Ransomware and Electronic Health Records, suggests advocating to seek inclusion of federal cybersecurity resources allocated to physician

¹ Sophos; (May, 2021); The state of ransomware in healthcare 2021; Accessed 10/13/2021: <https://www.sophos.com/en-us/medialibrary/pdfs/whitepaper/sophos-state-of-ransomware-in-healthcare-2021-wp.pdf>

² Mitchell, H.; (Sept 22, 2021); "Nearly 1 in 4 providers report higher mortality rates after ransomware attacks"; Becker's Health IT; Accessed 10/13/21: <https://www.beckershospitalreview.com/cybersecurity/nearly-1-in-4-providers-report-higher-mortality-rates-after-ransomware-attacks.html>

³ Weiner, S. (July, 2021); "The growing threat of ransomware attacks on hospitals"; AAMC; Accessed 10/13/21: <https://www.aamc.org/news-insights/growing-threat-ransomware-attacks-hospitals>

⁴ *ibid*

practices, hospitals, and healthcare entities sufficient to protect the security of the patients they serve as part of infrastructure legislation; therefore be it

RESOLVED, That our American Medical Association work with other stakeholders to seek legislation or regulation that funds assistance to cover cyberattack prevention and recovery expenses for physician practices, hospitals, and healthcare entities to ensure continuity of optimal patient care (Directive to Take Action); and be it further

RESOLVED, That our AMA, in collaboration with appropriate stakeholders, develop a toolkit for physician practices, hospitals, and healthcare entities to include best practices on preventing cyberattacks and a plan of action for when such an attack happens to their practice or institution; the toolkit should include guides to financial resources. (Directive to Take Action)

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

Received: 11/07/21

AUTHORS STATEMENT OF PRIORITY

Ransomware and malware attacks are a threat to some of the Nation's most sensitive information, and that is the protected health information of the Nation's people. An objective of our AMA is the betterment of health care delivery, and the sustainability of physician practices. Cyberattacks on healthcare systems have spiked during the COVID-19 pandemic, threatening patient care. A report commissioned by a risk management company released in September 2021 found 67 percent of healthcare organizations have been victims of ransomware attacks, and 33 percent have been hit at least twice; 22 percent of healthcare organizations report increased mortality rates resulting from ransomware attacks. Pandemic-related changes only heightened vulnerabilities, such as telemedicine and remote work. Current AMA policy calls upon healthcare facilities and integrated networks to do their part to achieve and maintain robust cybersecurity infrastructure; however, this can be a costly undertaking, especially for independent and rural physician practices and rural healthcare organizations.

Current Congressional deliberation of a comprehensive infrastructure bill presents us with an opportunity to seek funding assistance to cover prevention and recovery expenses for physician practices and hospitals. This top-priority resolution would enhance the work that our AMA has already accomplished on cybersecurity preparedness and education. Physician practices desperately need a readily available toolkit with a comprehensive plan to fall back on when cyberattacks occur and time is critical. Important action is needed now, not only to prevent further harm but to empower physicians to continue to care for their patients in the communities in which they live.

RELEVANT AMA POLICY

Ransomware and Electronic Health Records D-478.960

1. Our AMA acknowledges that healthcare data interruptions are especially harmful due to potential physical harm to patients and calls for prosecution to the fullest extent of the law for perpetrators of ransomware and any other malware on independent physicians and their practices, healthcare organizations, or other medical entities involved in providing direct and indirect care to patients.

2. Our AMA will: (a) advocate for federal legislation which provides for the prosecution of perpetrators of ransomware and any other malware on any and all healthcare entities, involved

in direct and indirect patient care, to the fullest extent of the law; (b) encourage health care facilities and integrated networks that are under threat of ransomware attacks to upgrade their cybersecurity and to back up data in a robust and timely fashion; (c) advocate that the security of protected healthcare information be considered as an integral part of national cybersecurity protection; and (d) seek inclusion of federal cybersecurity resources allocated to physician practices, hospitals, and health care entities sufficient to protect the security of the patients they serve, as part of infrastructure legislation.

Citation: Res. 210, A-21

Indemnity for Breaches in Electronic Health Record Cybersecurity D-315.977

Our AMA will advocate for indemnity or other liability protections for physicians whose electronic health record data and other electronic medical systems become the victim of security compromises.

Citation: Res. 221, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 241
(N-21)

Introduced by: Private Practice Physician Section

Subject: Enforcement of Administrative Simplification Requirements - CMS

Referred to: Reference Committee B

1 Whereas, Our American Medical Association has previously affirmed that administrative
2 simplification, including automation and standardization of electronic transactions, is a high
3 priority in order to provide affordable, timely, and effective care; and
4

5 Whereas, The National Standards Group (NSG) at the Centers for Medicare and Medicaid
6 Services (CMS) Office of Burden Reduction is empowered to enforce administrative
7 simplification requirements to ensure standardization throughout the ecosystem of payers,
8 physicians, and clearinghouses; and
9

10 Whereas, Violations of administrative simplification requirements by health plans and payer
11 business associates, including clearinghouses, are prevalent and have an adverse effect on
12 healthcare practices and patients via higher costs and resulting in limited access to affordable
13 healthcare; and
14

15 Whereas, The NSG at the CMS Office of Burden Reduction has stated that the enforcement
16 mechanism against health plan violations is based on the idea of “voluntary compliance,” the
17 only program of this type in the federal government where compliance is “voluntary;” and
18

19 Whereas, The NSG at the CMS Office of Burden Reduction has failed to impose any financial
20 penalties in the past seven years on health plans for violation of HIPAA administrative
21 simplification requirements while at the same time, CMS imposed numerous penalties on
22 physicians and the healthcare producer industry, including for violations of HIPAA privacy rules
23 which are governed by the same rules as the HIPAA administrative simplification requirements,
24 MACRA MIPS penalties, “Open Payments” Sunshine Act violation penalties, and numerous
25 other financial penalties; therefore be it
26

27 RESOLVED, That our American Medical Association take the position that the failure by the
28 National Standards Group at the Centers for Medicare and Medicaid Services Office of Burden
29 Reduction to effectively enforce the HIPAA administrative simplification requirements as
30 required by the law and its failure to impose financial penalties for non-compliance by health
31 plans is clearly unacceptable (New HOD Policy); and be it further
32

33 RESOLVED, That our AMA take the position that the National Standards Group at the Centers
34 for Medicare and Medicaid Services Office of Burden Reduction practices of closing complaints
35 without further investigation and ignoring overwhelming evidence that contradicts health plan
36 assertions is also unacceptable (New HOD Policy); and be it further
37

38 RESOLVED, That our American Medical Association advocate for enhanced enforcement of the
39 HIPAA Administrative Simplification requirements for health plans. (Directive to Take Action)

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

Received: 11/07/21

AUTHORS STATEMENT OF PRIORITY

Administrative burdens imposed by health insurers take away valuable clinical hours from patient care and increase overhead costs, threatening the viability of independent practices already under financial pressures from the COVID-19 pandemic. As the pace of independent practices closing their doors or becoming acquired by health systems or private equity continually increases, It is imperative to obtain relief from these administrative burdens as soon as possible.

Reference Committee C

CME Report(s)

- 01 Guiding Principles and Appropriate Criteria for Assessing the Competency of Late Career Physicians
- 02 A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities
- 03 Rural Health Physician Workforce Disparities
- 04 Medical Student Debt and Career Choice
- 05 Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotation

Resolution(s)

- 301 Equitable Reporting of USMLE Step 1 Scores
- 302 University Land Grant Status in Medical School Admissions
- 303 Decreasing Bias in Evaluations of Medical Student Performance
- 304 Reducing Complexity in the Public Service Loan Forgiveness Program
- 305 Increase Awareness Among Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status
- 306 Support for Standardized Interpreter Training
- 307 Support for Institutional Policies for Personal Days for Undergraduate Medical Students
- 308 Modifying Eligibility Criteria for Association of American Medical Colleges' Financial Assistance Program
- 309 Protecting Medical Student Access to Abortion Education and Training
- 310 Resident and Fellow Access to Fertility Preservation
- 311 Improving Access to Physician Health Programs for Physician Trainees
- 312 Accountable Organizations to Resident and Fellow Trainees
- 313 Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training
- 314 Updating Current Wellness Policies and Improving Implementation
- 315 Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc. Equitable for IMGs
- 316* Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic
- 317* Creating a More Accurate Accounting of Medical Education Financial Costs
- 318# The Medical Student Match Mismatch - REVISED

* Contained in the Handbook Addendum

Contained in the Friday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 318
(N-21)

Introduced by: North Carolina, District of Columbia, Georgia, Oklahoma, Mississippi,
New Jersey, Tennessee, South Carolina, Kentucky

Subject: The Medical Student Match MisMatch

Referred to: Reference Committee C

Whereas, The National Resident Matching Program (NRMP) has run a computer based, well organized, evolving matching program placing medical student seniors and graduates in available residency slots since 1952; and

Whereas, The number of NRMP applicants has risen significantly since 2017 to include US-MD seniors, US-DO seniors, US-IMGs, IMGs and some repeat or specialty applicants (total 48,502 for 2021) without a matching rise in US Residency slots (only 38,106 potential residency slots for matching); and

Whereas, The US National Resident Matching Program (NRMP) has a consistent mismatch of a significant number of applicants, sometimes a bit less or more, each year now for about 10 years with dramatic increases in the last two years; and

Whereas, The average senior medical student graduates with about \$250,000.00 of debt and about 20% of these graduates with over \$400,000.00 of medical school debt; and

Whereas, Most states require completion of a residency accredited by the Accreditation Council for Graduate Medical Education (ACGME) before full state medical licensure; and

Whereas, A non-matching student may be facing significant debt with no way to repay, since no job prospects as a resident physician will still leave existing educational debt; and

Whereas, A non-matching student has graduated from medical school; and

Whereas, Even without recent data we believe the potential for large debt, but no job, will certainly increase health professional disparity since the potential mismatch and large debt will discourage an ethnically diverse or a racially diverse medical student and thus the profession; and

Whereas, AMA has both robust policy on all the above issues and a powerful FREIDA computer application (see www.ama-assn.org/amgone/freida/); therefore be it

RESOLVED, That our American Medical Association use its existing resources or find new ones to: (1) help educate rising senior US medical students on how to have a successful match; (2) give real time help to US medical students, including international medical graduates, to navigate post matching results; (3) help unmatched US medical students and international medical graduates navigate loan repayment strategies; and (4) guide the unmatched towards alternative professional options in medical or public or commercial sectors (Directive to Take Action); and be it further

- 1 RESOLVED, That the assigned AMA staff engage with AMA legal and AMA advocacy staff to
- 2 redouble AMA efforts legislatively or otherwise, to increase and fund the additional graduate
- 3 medical education slots. (Directive to Take Action)

Fiscal Note: Estimated \$165,000 annually to implement this resolution.

Received: 10/28/21

AUTHORS STATEMENT OF PRIORITY

Obviously, the Resident Match Mismatch effects students and residents, but they now are about half of AMA membership. BUT as the physician shortage grows over time, the Mismatch will begin to effect even more, in fact MOST physicians and practices. THIS is the time to ACT, because the Mismatch has greatly increased over the last two years; AND with a new Administration in DC, THIS IS the time for AMA ACTION for more Residency slots, particularly with President Biden's interest in "Human Infrastructure." To really move along the project, we need NEW POLICY as listed. WE CAN MAKE a difference in a Democrat controlled DC, particularly with our preponderance, now, at AMA, of IN TUNE AMA leadership. The AMA is best positioned to lead in this arena at this time.

AMA Policy and References

THE MATCH HISTORY AND BACKGROUND

AMA Policy

See FREIDA™ AMA Residency & Fellowship Programs Database (ama-assn.org)

Key AMA Match Policy is D-310.977 first written in 2005 and modified and amended many times since.

H-200.949 Primary Care Workforce

H-310.910 Preliminary Year Program Placement

H-200.954 US Physician Shortage

D-310.974 Policy Suggestions to Improve the National Matching Program

References

The Match: Explaining the Application Process and Your Residency Results. St George's University, from the SGU Pulse, the Medical School Blog, March 17, 2021 (adopted from 2018 version), Grenada, West Indies.

Match Day Explained: How Med Students Take the Next Career Step. March 4, 2016, from the University of Michigan, Med U.

Brendan Murphy: AMA News Writer

Medical Students match in record numbers, celebrate virtually, March 20, 2020

[2021 Main Residency Match Results and Data Report Now Available - The Match, National Resident Matching Program \(nrmp.org\)](#)

[Trends in Race/Ethnicity Among Applicants and Matriculants to US Surgical Specialties, 2010-2018 | Health Disparities | JAMA Network Open | JAMA Network](#)

THE MISMATCH

References

Brendan Murphy, AMA staff writer

Why medical students aren't matching -June 7, 2015 (staff writers)

No Match for you? SOAP offers last minute option – March 8, 2021

Ten Years After, Kristi Dyer, August 15, 2009...from MOM supported by Amazon Services, LLC

[Graduate Medical Education \(GME\) Funding News & Info | American Medical Association \(ama-assn.org\)](#)

AMA Policy

H-310.910 Preliminary Year Program Placement

H-305.988 Availability of First-Year Residency Positions

H-200.954 US Physician Shortage

H-200.949 Principles to Address Primary Care Workforce

D-305.967 Full Funding of Graduate Medical Education

MEDICAL STUDENT DEBT

References

Medical Student Debt, AMSA, 2021 from the ASMA web page, some based on AAMC data from the 1994-2003 Questionnaire

What is the Average Medical Student Debt? From NerdWallet 2021. From their web page

How to pay off student debt. From Weatherby Healthcare, 2021 (a CHG Company) their web page

AMA Policy
H-305.925 Medical Education Costs and Medical Student Debt

POTENTIAL JOBS IF NOT MATCHED

References

Ten Years Later...see above

Physician Jobs without ABME Board Certification or Medical Licensure. 2021. From the MDJourney, by the WPFamily web page.
16 Jobs for Physicians without a Residency or Licensure. By Catherine Carroll on the Physician Tycoon web page.

AMA Policy
See above
D-200.980 Physician Practices in Underserved Areas

RELEVANT AMA POLICY

Principles of and Actions to Address Primary Care Workforce H-200.949

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.

9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.

18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.

19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.

20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.

21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.

22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.

23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.

24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.

25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

Citation: CME Rep. 04, I-18

US Physician Shortage H-200.954

Our AMA:

(1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;

(2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;

(3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;

(4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;

(5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;

(6) encourages medical schools to include criteria and processes in admission of medical

students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;

(7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;

(8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;

(9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;

(10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and

(11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.

(12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.

Citation: Res. 807, I-03; Reaffirmation I-06; Reaffirmed: CME Rep. 7, A-08; Appended: CME Rep. 4, A-10; Appended: CME Rep. 16, A-10; Reaffirmation: I-12; Reaffirmation A-13;

Appended: Res. 922, I-13; Modified: CME Rep. 7, A-14; Reaffirmed: CME Rep. 03, A-16;

Appended: Res. 323, A-19; Reaffirmed: CME Rep. 3, A-21

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

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; Appended: Res. 321, A-15; Reaffirmed: CME Rep. 05, A-16; Modified: CME Rep. 04, A-16

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-

traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial

planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new policies and novel approaches to prevent debt from influencing specialty and subspecialty choice.

23. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.

Citation: CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21 Reaffirmed in lieu of: Res. 311, A-21

Preliminary Year Program Placement H-310.910

1. Our AMA encourages the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, and other involved organizations to strongly encourage residency programs that now require a preliminary year to match residents for their specialty and then arrange with another department or another medical center for the preliminary year of training unless the applicant chooses to pursue preliminary year training separately.

2. Our AMA encourages appropriate stakeholders to explore options to decrease the burden upon medical students who must apply to separate preliminary PGY-1 and categorical PGY-2 positions.

3. Our AMA will work with the Accreditation Council for Graduate Medical Education to

encourage programs with PGY-2 positions in the National Resident Matching Program (NRMP) with insufficient availability of local PGY-1 positions to create local PGY-1 positions that will enable coordinated applications and interviews for medical students.

4. Our AMA encourages the NRMP, the San Francisco Match, the American Urological Association, the Electronic Residency Application Service, and other stakeholders to reduce barriers for medical students, residents, and physicians applying to match into training programs, including barriers to “couples matching,” and to ensure that all applicants have access to robust, informative statistics to assist in decision-making.

5. Our AMA encourages the NRMP, San Francisco Match, American Urological Association, Electronic Residency Application Service, and other stakeholders to collect and publish data on a) the impact of separate matches on the personal and professional lives of medical students and b) the impact on medical students who are unable to successfully “couples match” with their significant others due to staggered entry into residency, utilization of unlinked match services, or other causes.

Citation: Res. 306, A-12; Appended: CME Rep. 03, A-19

Policy Suggestions to Improve the National Resident Matching Program D-310.974

Our AMA will: (1) request that the National Resident Matching Program review the basis for the extra charge for including over 15 programs on a primary rank order list and consider modifying the fee structure to minimize such charges; (2) work with the NRMP to increase awareness among applicants of the existing NRMP waiver and violations review policies to assure their most effective implementation; (3) request that the NRMP continue to explore measures to maximize the availability of information for unmatched applicants and unfilled programs including the feasibility of creating a dynamic list of unmatched applicants; (4) ask the National Resident Matching Program (NRMP) to publish data regarding waivers and violations with subsequent consequences for both programs and applicants while maintaining the integrity of the match and protecting the identities of both programs and participants; (5) advocate that the words “residency training” in section 8.2.10 of the NRMP Match agreement be added to the second sentence so that it reads, “The applicant also may be barred from accepting or starting a position in any residency training program sponsored by a match-participating institution that would commence training within one year from the date of issuance of the Final Report” and specifically state that NRMP cannot prevent an applicant from maintaining his or her education through rotating, researching, teaching, or otherwise working in positions other than resident training at NRMP affiliated programs; and (6) work with the Educational Commission for Foreign Medical Graduates, Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, and other graduate medical education stakeholders to encourage the NRMP to make the conditions of the Match agreement more transparent while assuring the confidentiality of the match and to use a thorough process in declaring that a violation has occurred.

Citation: (CME Rep. 15, A-06; Appended: Res. 918, I-11; Appended: CME Rep. 12, A-12)

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).

2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.

16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding

physician education and training while providing appropriate compensation for residents and fellows.

30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

Citation: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep. 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended: CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18; Modified: Res. 233, A-19; Modified: BOT Rep. 25, A-19; Reaffirmed: CME Rep. 3, A-21

Effectiveness of Strategies to Promote Physician Practice in Underserved Areas D-200.980

1. Our AMA, in collaboration with relevant medical specialty societies, will continue to advocate for the following: (a) Continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations. (b) Permanent reauthorization and expansion of the Conrad State 30 J-1 visa waiver program. (c) Adequate funding (up to at

least FY 2005 levels) for programs under Title VII of the Health Professions Education Assistance Act that support educational experiences for medical students and resident physicians in underserved areas.

2. Our AMA encourages medical schools and their associated teaching hospitals, as well as state medical societies and other private sector groups, to develop or enhance loan repayment or scholarship programs for medical students or physicians who agree to practice in underserved areas or with underserved populations.

3. Our AMA will advocate to states in support of the introduction or expansion of tax credits and other practice-related financial incentive programs aimed at encouraging physician practice in underserved areas.

4. Our AMA will advocate for the creation of a national repository of innovations and experiments, both successful and unsuccessful, in improving access to and distribution of physician services to government-insured patients (National Access Toolbox).

5. Our AMA supports elimination of the tax liability when employers provide the funds to repay student loans for physicians who agree to work in an underserved area.

Citation: CME Rep. 1, I-08; Modified: CME Rep. 4, A-10; Reaffirmation I-11; Appended: Res. 110, A-12; Reaffirmation A-13; Reaffirmation A-14; Appended: Res. 312, I-16; Appended: Res 312, I-16

Reference Committee D

BOT Report(s)

17 Distracted Driver Education and Advocacy

CSAPH Report(s)

02 Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems

03 Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Surgery

Resolution(s)

401 Endorsement of Public Health Measures to End the COVID-19 Pandemic and Promotion of Research and Insurance Coverage to Define and Delimit the Emerging Issue of Post-Acute Covid Syndrome

402 Expansion on Comprehensive Sexual Health Education

403 Providing Reduced Parking Fees for Patients

404 Increase Employment Services Funding for People with Disabilities

405 Formal Transitional Care Program for Children and Youth with Special Health Care Needs

406 Addressing Gaps in Patient and Provider Knowledge to Increase HPV Vaccine Uptake and Prevent HPV-Associated Oropharyngeal Cancer

407 Traumatic Brain Injury and Access to Firearms

408* Ensuring Affordability and Equity in COVID-19 Vaccine Boosters

409# Screening for HPV-Related Anal Cancer

410# Affirmatively Protecting the Safety and Dignity of Physicians and Medical Students as Workers

411# Addressing Public Health Disinformation

412# Health Professional Disinformation During a Public Health Crisis

413# Universal Childcare and Preschool

414# Advocacy on the US Department of Education's Spring 2022 Title IX Rules on Sexual Harassment and Assault in Education Programs

415# Reducing Disparities in HIV Incidence Through Pre-Exposure Prophylaxis for HIV

* Contained in the Handbook Addendum

Contained in the Friday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 409
(N-21)

Introduced by: Pennsylvania

Subject: Screening for HPV-Related Anal Cancer

Referred to: Reference Committee D

1 Whereas, 8,300 adults in the US will be diagnosed with anal cancer with an estimated 1,280
2 deaths in 2019¹; and
3

4 Whereas, The human papillomavirus (HPV) causes more than 90% of anal cancers² and HPV
5 testing can be conducted via screening anal Pap test and/or HPV test; and
6

7 Whereas, Studies have identified the value of anal cancer screening for high-risk populations
8 since AMA policy was adopted to support continued research on the diagnosis and treatment of
9 anal cancer and its precursor lesions, including the evaluation of the anal pap smear as a
10 screening tool for anal cancer³; and
11

12 Whereas, The American Society for Colon and Rectal Surgeons (ASCRS) has developed a
13 strong recommendation based on moderate quality evidence, 1B, stating that patients at
14 increased risk for anal squamous neoplasms should be identified by history, physical
15 examination and laboratory testing, noting that the risk is higher in HIV-positive individuals, men
16 who have sex with men (MSM), and women with a history of cervical dysplasia⁴; and
17

18 Whereas, The American Cancer Society reports expert opinion that (1) anal pap smear testing
19 is a reasonable approach for screening patients at increased risk by swabbing the anal lining for
20 microscopic analysis; (2) although there is no widespread agreement on the best screening
21 schedule, some experts recommend the test be done every year in MSM or HIV-positive
22 individuals and every 2-3 years in the HIV-negative population; (3) patients with positive results
23 on an anal pap test should be referred for a biopsy; and (4) if anal intraepithelial neoplasia is
24 found on the biopsy, it might need to be treated especially if it is high grade⁵; and
25

26 Whereas, An expert panel convened by the American Society for Colposcopy and Cervical
27 Pathology and the International Anal Neoplasia Society suggests that HIV-positive women and
28 women with lower genital tract neoplasia may be considered for screening with anal cytology
29 and triage to treatment if anal high-grade squamous intraepithelial lesions (HSIL) is diagnosed⁶;
30 and
31

32 Whereas, Dacron swab cytology provides modest sensitivity and nylon-flocked swab cytology
33 has higher specificity and accuracy for detecting high grade squamous intraepithelial lesion in
34 anal cancer and has been proposed to lower costs of population-based screening⁷; and
35

36 Whereas, Preliminary analyses have shown anal cancer screening to be cost effective for HIV-
37 positive individuals, MSM, and women with a history of cervical dysplasia with quality life
38 adjusted years (QALYs) increases of 4.4 years at a cost of \$34,763 per life year gained overall,
39 and particular cost effectiveness of annual anal pap testing for MSM at a cost of \$16,000 per
40 QALY saved⁸; therefore be it

- 1 RESOLVED, That our American Medical Association support advocacy efforts to implement
2 screening for anal cancer for high-risk populations (New HOD Policy); and be it further
3
4 RESOLVED, That our AMA support national medical specialty organizations and other
5 stakeholders in developing guidelines for interpretation, follow up, and management of anal
6 cancer screening results. (New HOD Policy)

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

Received: 11/03/21

AUTHORS STATEMENT OF PRIORITY

National Cancer Institute. SEER anal cancer stat facts
2021 <https://seer.cancer.gov/statfacts/html/anus.html>.

Estimated New Cases in 2021 9,090

% of All New Cancer Cases 0.5%

Estimated Deaths in 2021 1,430

% of All Cancer Deaths 0.2%

The low prevalence of anal cancer in the general population prevents the use of routine screening. However, screening of selected populations has been shown to be a more promising strategy. Potential screening modalities include digital anorectal exam, anal Papanicolaou testing, human papilloma virus co-testing, and high-resolution anoscopy. Expands current policy to include up to date techniques.

Current AMA Policy

Use of the Anal Pap Smear as a Screening Tool for Anal Dysplasia H-460.913

Our AMA supports continued research on the diagnosis and treatment of anal cancer and its precursor lesions, including the evaluation of the anal pap smear as a screening tool for anal cancer. (Res. 512, A-04; Reaffirmed: CSAPH Rep. 1, A-14)

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2. About HPV / HPV & Cancer. <https://www.analcancerfoundation.org/about-hpv/hpv-cancer/>
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 410
(N-21)

Introduced by: Resident and Fellow Section

Subject: Affirmatively Protecting the Safety and Dignity of Physicians and Medical Students as Workers

Referred to: Reference Committee D

1 Whereas, Physicians across the country have been disciplined, harassed, ignored, or fired as a
2 result of efforts to bring attention to or address unsafe working conditions or inadequate
3 Personal Protective Equipment (PPE)¹⁻⁵; and
4

5 Whereas, Unjust firing, punishment, persistence of unsafe conditions, and fear of retaliation
6 over pandemic safety concerns are unconscionable, should be affirmatively challenged, and
7 should never be allowed to occur; and
8

9 Whereas, Physicians may have several legal options and protections in such adverse situations
10 that they may not be aware of, including state-specific and federal laws and policies⁶⁻⁸; and
11

12 Whereas, In certain instances, inquiry from journalists and the potential for negative publicity
13 may lead to policy reversals on the part of employers that enhance physician safety in the
14 workplace⁴; and
15

16 Whereas, 2020 data from AMA Physician Practice Benchmark Surveys indicate accelerating
17 shifts in physician practice trends toward larger practices, especially among younger physicians,
18 and decreased rates of physician practice ownership⁹; and
19

20 Whereas, Rising rates of physician employment and decreasing private practice affiliation affect
21 physician autonomy and vulnerability to employers and hospital administrators in the labor
22 market^{4, 9}; and
23

24 Whereas, As health care workers, employed physicians including resident physicians, face
25 unique workplace risks and may require unique workplace protections and vigilance on the part
26 of physician advocates¹⁰; and
27

28 Whereas, A 2014 AMA-sponsored RAND investigation of 30 physician practices in six found
29 that autonomy and occupation of practice leadership or managements roles associated with
30 better professional satisfaction, recommending vigilance surrounding physician satisfaction as
31 consolidation of practices into larger health systems continues¹¹; and
32

33 Whereas, AMA Policy H-440.810, "Availability of PPE," states that our AMA will "advocate that it
34 is the responsibility of health care facilities to provide sufficient PPE for all employees and staff
35 in" appropriate situations associated with increased risks, support physicians "being permitted to
36 use their professional judgement and augment institution-provided PPE" with personally-
37 provided PPE, and support "a physician's right to participate in public commentary addressing
38 the adequacy of clinical resources" and safety conditions during pandemic or disaster
39 situations¹²; and

1 Whereas, Though AMA has published guiding principles that outline vulnerability of medical
2 students, residents, and fellows and obligations to protect their safety and well-being,
3 comprehensive information regarding ongoing safety concerns across the nation is unavailable
4 and AMA principles do not provide for enforcement or logistical support¹³⁻¹⁴; and
5

6 Whereas, AMA Policy H-440.810 excludes vulnerable categories of physicians and physicians-
7 in-training and others working or learning in hospitals or medical facilities, such as independent
8 contractors and medical students¹²; and
9

10 Whereas, The British Medical Association provides comprehensive guidance to British
11 physicians about raising PPE concerns anonymously or publicly, requesting additional
12 resources, and offers organizational assistance to physicians navigating the process¹⁵; and
13

14 Whereas, Bipartisan legislation was introduced in the 116th Congress by Rep. Ruiz (D-CA) and
15 Rep. Marshall (R-KS) to expand due process protections to all emergency physicians,
16 regardless of employer (including contract medical groups), in response to, for instance, unfair
17 terminations of attending physicians and vulnerability felt by resident physicians who requested
18 safe and fair working conditions during the COVID-19 pandemic¹⁶⁻¹⁷; and
19

20 Whereas, Many resident physicians lack due process protections and may be disciplined or
21 terminated for issues potentially unrelated to academic or clinical performance¹⁸; and
22

23 Whereas, AMA policies H-225.950 and H-310.912 broadly cover due process protections for
24 employed physician staff and appear non-binding for residents/fellows, respectively; and
25

26 Whereas, Resident physicians, as particularly vulnerable frontline health care workers during
27 and apart from the pandemic, warrant protection related to working conditions, when publicly
28 voicing concerns, and due process when employment is at risk¹⁸⁻¹⁹; and
29

30 Whereas, Health care workers, among others, have already been singled out for disparate
31 treatment and excluded from protection during the pandemic once; and
32

33 Whereas, CDC recommended in the spring of 2020 that Americans who could not work
34 remotely stay at home if they or someone in their household became sick, despite widespread
35 gaps in access to paid sick leave²⁰⁻²²; and
36

37 Whereas, The Families First Coronavirus Response Act and CARES Act passed in 2020, which
38 guaranteed eligible workers paid sick leave through the end of that year to address the
39 aforementioned gaps, allowed for the particular exclusion of health care workers²⁰⁻²¹; and
40

41 Whereas, Emergency paid sick leave legislation in 2020 was found to have helped flatten the
42 curve of COVID-19 cases, and paid sick leave has numerous well-established benefits for
43 families and their health²³⁻²⁴; and
44

45 Whereas, Health care workers should not be singled out for exclusion from policies intended to
46 protect workers and their families; therefore be it
47

48 RESOLVED, That our American Medical Association review reports of unsafe working
49 conditions and unfair retaliation for public expression of safety concerns on the part of
50 physicians and trainees and consider methods to provide logistical and legal support to such
51 aggrieved parties (Directive to Take Action); and be it further

1 RESOLVED, That our AMA develop and distribute specific guidelines on how physicians and
2 trainees may make public comments on working conditions and legal options to promote
3 workplace safety (e.g. filing formal OSHA complaints), as well as other workplace protection
4 issues as appropriate (Directive to Take Action); and be it further
5

6 RESOLVED, That AMA policy H-440.810, "Availability of PPE," be amended by addition to read
7 as follows:

- 8 1. Our AMA affirms that the medical staff of each health care institution should be
9 integrally involved in disaster planning, strategy and tactical management of ongoing
10 crises.
- 11 2. Our AMA supports evidence-based standards and national guidelines for PPE use,
12 reuse, and appropriate cleaning/decontamination during surge conditions.
- 13 3. Our AMA will AMA advocate that it is the responsibility of health care facilities to
14 provide sufficient personal protective equipment (PPE) for all employees and staff, as
15 well as trainees and contractors working in such facilities, in the event of a pandemic,
16 natural disaster, or other surge in patient volume or PPE need.
- 17 4. Our AMA supports physicians and health care professionals and other workers in
18 health care facilities in being permitted to use their professional judgement and augment
19 institution-provided PPE with additional, appropriately decontaminated, personally-
20 provided personal protective equipment (PPE) without penalty.
- 21 5. Our AMA supports a physician's right to participate in public commentary addressing
22 the adequacy of clinical resources and/or health and environmental safety conditions
23 necessary to provide appropriate and safe care of patients and physicians during a
24 pandemic or natural disaster; resident physicians and medical students must have the
25 right to participate in public commentary addressing the adequacy of resources for their
26 own safety in such conditions.
- 27 6. Our AMA will work with the HHS Office of the Assistant Secretary for Preparedness
28 and Response to gain an understanding of the PPE supply chain and ensure the
29 adequacy of the Strategic National Stockpile for public health emergencies.
- 30 7. Our AMA encourages the diversification of personal protective equipment design to
31 better fit all body types, cultural expressions and practices among healthcare personnel
32 (Modify Current HOD Policy); and be it further
33

34 RESOLVED, That our AMA support the inclusion of health care workers in workplace
35 protections and programs generally applicable to employees in other sectors, barring
36 extenuating circumstances and evidence-based reasoning supporting otherwise (New HOD
37 Policy); and be it further
38

39 RESOLVED, That our AMA support legislation and other policies protecting physicians and
40 medical students from violence and unsafe working conditions. (New HOD Policy)

Fiscal Note: Estimated cost to implement this resolution is \$28,000.

Received: 11/06/21

AUTHORS STATEMENT

Resident physicians, as particularly vulnerable frontline health care workers during and before the pandemic, warrant protection related to working conditions. This is particularly true when publicly voicing concerns and for due process when employment is at risk. Though AMA has published guiding principles that outline vulnerability of medical students, residents, and fellows and obligations to protect their safety and well-being, comprehensive information regarding ongoing safety concerns across the nation is unavailable. Additionally, AMA principles do not provide for enforcement or logistical support in this area. COVID-19 has exacerbated the need to address how employers address this issue for the coming years. The AMA needs to take action if we are to adequately protect the safety and dignity of our trainee and physician colleagues.

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RELEVANT AMA POLICY

Availability of Personal Protective Equipment (PPE) H-440.810

1. Our AMA affirms that the medical staff of each health care institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises.
2. Our AMA supports evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions.
3. Our AMA will AMA advocate that it is the responsibility of health care facilities to provide sufficient personal protective equipment (PPE) for all employees and staff in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need.
4. Our AMA supports physicians and health care professionals in being permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided personal protective equipment (PPE) without penalty.
5. Our AMA supports a physician's right to participate in public commentary addressing the adequacy of clinical resources and/or health and environmental safety conditions necessary to provide appropriate and safe care of patients and physicians during a pandemic or natural disaster.
6. Our AMA will work with the HHS Office of the Assistant Secretary for Preparedness and Response to gain an understanding of the PPE supply chain and ensure the adequacy of the Strategic National Stockpile for public health emergencies.
7. Our AMA encourages the diversification of personal protective equipment design to better fit all body types, cultural expressions and practices among healthcare personnel.

9.4.1 Peer Review & Due Process

Physicians have mutual obligations to hold one another to the ethical standards of their profession. Peer review, by the ethics committees of medical societies, hospital credentials and utilization committees, or other bodies, has long been established by organized medicine to scrutinize professional conduct. Peer review is recognized and accepted as a means of promoting professionalism and maintaining trust. The peer review process is intended to balance physicians' right to exercise medical judgment freely with the obligation to do so wisely and temperately.

Fairness is essential in all disciplinary or other hearings where the reputation, professional status, or livelihood of the physician or medical student may be adversely affected.

Individually, physicians and medical students who are involved in reviewing the conduct of fellow professionals, medical students, residents or fellows should:

(a) Always adhere to principles of a fair and objective hearing, including:

- (i) a listing of specific charges,
- (ii) adequate notice of the right of a hearing,
- (iii) the opportunity to be present and to rebut the evidence, and
- (iv) the opportunity to present a defense.

(b) Ensure that the reviewing body includes a significant number of persons at a similar level of training.

(c) Disclose relevant conflicts of interest and, when appropriate, recuse themselves from a hearing.

Collectively, through the medical societies and institutions with which they are affiliated, physicians should ensure that such bodies provide procedural safeguards for due process in their constitutions and bylaws or policies. [Res. 412, I-20; Appended: Res. 414, A-21]

Principles of Due Process for Medical License Complaints D-275.964

1. Our AMA will explore ways to establish principles of due process that must be used by a state licensing board prior to the restriction or revocation of a physician's medical license, including strong protections for physicians' rights.

2. Our AMA takes the position that: A) when a state medical board conducts an investigation or inquiry of a licensee applicant's quality of care, that the standard of care be determined by physician(s) from the same specialty as the licensee applicant, and B) when a state medical board conducts an investigation or inquiry regarding quality of care by a medical licensee or licensee applicant, that the physician be given:

- (i) a minimum of 30 days to respond to inquiries or requests from a state medical board, (ii) prompt board

decisions on all pending matters, (iii) sworn expert review by a physician of the same specialty, (iv) a list of witnesses providing expert review, and (v) exculpatory expert reports, should they exist.

AMA Principles for Physician Employment H-225.950

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.

Our 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. AMA Assistance for Members in Matters Pertaining to Physician-Hospital/Health System Relationships D-215.990

1. As a benefit of membership our AMA will provide assistance, such as information and advice (but not legal opinions or representation), as appropriate to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other similar entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.

2. Our AMA encourages the Federation of Medicine and its members to provide assistance, such as information and advice (but not legal opinions or representation), as appropriate to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other similar entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process. [Res. 238, A-08; Appended: Res. 301, A-11; Reaffirmed: CME Rep. 1, A-21]

Medical Staff Membership H-220.951

Our AMA (1) requests The Joint Commission to require that conditions for hospital medical staff membership be based only on the physician's professional training, experience, qualifications, and adherence to medical staff bylaws; and (2) will work toward protecting the due process rights of physicians when medical staff privileges are terminated without appropriate due process as described by the medical staff bylaws. [Res. 721, I-91; Reaffirmed by Res. 802, I-94; Reaffirmed: CLRPD 1, A-04; Reaffirmation A-05; Modified: CMS Rep. 1, A-15; Reaffirmed: Res. 235, I-18]

Residents and Fellows' Bill of Rights H-310.912

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA adopts the following 'Residents and Fellows' Bill of Rights' as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially

and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

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

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as 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.

8. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.

9. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).

10. The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.

11. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles. [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; Modified: Res. 304, A-21; Modified: Res. 305, A-21]

9.4.4 Physicians with Disruptive Behavior

The importance of respect among all health professionals as a means of ensuring good patient care is foundational to ethics. Physicians have a responsibility to address situations in which individual physicians behave disruptively, that is, speak or act in ways that may negatively affect patient care, including conduct that interferes with the individual's ability to work with other members of the health care team, or for others to work with the physician.

Disruptive behavior is different from criticism offered in good faith with the aim of improving patient care and from collective action on the part of physicians. Physicians must not submit false or malicious reports of disruptive behavior.

Physicians who have leadership roles in a health care institution must be sensitive to the unintended effects institutional structures, policies, and practices may have on patient care and professional staff.

As members of the medical staff, physicians should develop and adopt policies or bylaw provisions that:

(a) Establish a body authorized to receive, review, and act on reports of disruptive behavior, such as a medical staff wellness committee. Members must be required to disclose relevant conflicts of interest and to recuse themselves from a hearing.

(b) Establish procedural safeguards that protect due process.

(c) Clearly state principal objectives in terms that ensure high standards of patient care, and promote a professional practice and work environment.

(d) Clearly describe the behaviors or types of behavior that will prompt intervention.

(e) Provide a channel for reporting and appropriately recording instances of disruptive behavior. A single incident may not warrant action, but individual reports may help identify a pattern that requires intervention.

(f) Establish a process to review or verify reports of disruptive behavior.

(g) Establish a process to notify a physician that his or her behavior has been reported as disruptive, and provide opportunity for the physician to respond to the report.

(h) Provide for monitoring and assessing whether a physician's disruptive conduct improves after intervention.

(i) Provide for evaluative and corrective actions that are commensurate with the behavior, such as self-correction and structured rehabilitation. Suspending the individual's responsibilities or privileges should be a mechanism of final resort.

(j) Identify who will be involved in the various stages of the process, from reviewing reports to notifying physicians and monitoring conduct after intervention.

(k) Provide clear guidelines for protecting confidentiality.

(l) Ensure that individuals who report instances of disruptive behavior are appropriately protected. [[AMA Principles of Medical Ethics: I,II,VIII](#) Issued: 2016]

Principles for Strengthening the Physician-Hospital Relationship H-225.957

The following twelve principles are AMA policy:

PRINCIPLES FOR STRENGTHENING THE PHYSICIAN-HOSPITAL RELATIONSHIP

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes, with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.

2. The organized medical staff, a self-governing organization of professionals, possessing special expertise, knowledge and training, discharges certain inherent professional responsibilities by virtue of its authority to regulate the professional practice and standards of its members, and assumes primary responsibility for many functions, including but not limited to: the determination of organized medical staff membership; performance of credentialing, privileging and other peer review; and timely oversight of clinical quality and patient safety.
3. The leaders of the organized medical staff, with input from the hospital governing body and senior hospital managers, develop goals to address the healthcare needs of the community and are involved in hospital strategic planning as described in the medical staff bylaws.
4. Ongoing, timely and effective communication, by and between the hospital governing body and the organized medical staff, is critical to a constructive working relationship between the organized medical staff and the hospital governing body.
5. The organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The organized medical staff and hospital bylaws, rules and regulations should be aligned, current with all applicable law and accreditation body requirements and not conflict with one another. The hospital bylaws, policies and other governing documents do not conflict with the organized medical staff bylaws, rules, regulations and policies, nor with the organized medical staff's autonomy and authority to self govern, as that authority is set forth in the governing documents of the organized medical staff. The organized medical staff, and the hospital governing body/administration, shall, respectively, comply with the bylaws, rules, regulations, policies and procedures of one another. Neither party is authorized to, nor shall unilaterally amend the bylaws, rules, regulations, policies or procedures of the other.
6. The organized medical staff has inherent rights of self governance, which include but are not limited to:
 - a) Initiating, developing and adopting organized medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing body, which approval shall not be unreasonably withheld. The organized medical staff bylaws shall be adopted or amended only by a vote of the voting membership of the medical staff.
 - b) Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.
 - c) Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter. No summary suspension, termination or reduction of privileges can be imposed without organized medical staff action as authorized in the medical staff bylaws and under the law.
 - d) Identifying a fair hearing and appeals process, including that hearing committees shall be composed of peers, and identifying the composition of an impartial appeals committee. These processes, contained within the organized medical staff bylaws, are adopted by the organized medical staff and approved by the hospital governing board, which approval cannot be unreasonably withheld nor unilaterally amended or altered by the hospital governing board or administration. The voting members of the organized medical staff decide any proposed changes.
 - e) Establishing within the medical staff bylaws: 1) the qualifications for holding office, 2) the procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee, and 3) the qualifications for election and/or appointment to committees, department and other leadership positions.
 - f) Assessing and maintaining sole control over the access and use of organized medical staff dues and assessments, and utilizing organized medical staff funds as appropriate for the purposes of the organized medical staff.
 - g) Retaining and being represented by legal counsel at the option and expense of the organized medical staff.
 - h) Establishing in the organized medical staff bylaws, the structure of the organized medical staff, the duties and prerogatives of organized medical staff categories, and criteria and standards for organized medical staff membership application, reapplication credentialing and criteria and processing for privileging. The standards and criteria for membership, credentialing and privileging shall be based only on quality of care criteria related to clinical qualifications and professional responsibilities, and not on economic credentialing, conflicts of interest or other non-clinical credentialing factors.
 - i) Establishing in the organized medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other organized medical staff activities,

and engaging in all activities necessary and proper to implement those bylaw provisions including, but not limited to, periodic meetings of the organized medical staff and its committees and departments and review and analysis of patient medical records.

j) The right to define and delegate clearly specific authority to an elected Medical Executive Committee to act on behalf of the organized medical staff. In addition, the organized medical staff defines indications and mechanisms for delegation of authority to the Medical Executive Committee and the removal of this authority. These matters are specified in the organized medical staff bylaws.

k) Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.

l) Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff.

m) Enforcing the organized medical staff bylaws, regulations and policies and procedures.

n) Establishing in medical staff bylaws, medical staff involvement in contracting relationships, including exclusive contracting, medical directorships and all hospital-based physician contracts, that affect the functioning of the medical staff.

7. Organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body, as well as between those two entities and the individual members of the organized medical staff.

8. The self-governing organized medical staff determines the resources and financial support it requires to effectively discharge its responsibilities. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.

9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.

10. Individual members of the organized medical staff, if they meet the established criteria that are applicable to hospital governing body members, are eligible for full membership on the hospital governing body. Conflict of interest policies developed for members of the organized medical staff who serve on the hospital's governing body are to apply equally to all individuals serving on the hospital governing body.

11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff.

12. Areas of dispute and concern, arising between the organized medical staff and the hospital governing body, are addressed by well-defined processes in which the organized medical staff and hospital governing body are equally represented. These processes are determined by agreement between the organized medical staff and the hospital governing body. [Res. 828, I-07Reaffirmed in lieu of Res. 730, A-09Modified: Res. 820, I-09Reaffirmed: Res. 725, A-10; Reaffirmation A-12; Reaffirmed: CMS Rep. 6, I-13; Reaffirmed: CMS Rep. 5, A-21]

AMA Statement on Family and Medical Leave H-420.979

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy;

(2) maternity leave for the employee-mother;

(3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and

(4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements

therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. [BOT Rep. A, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: CMS Rep. 03, A-16]

Employed Physicians and the AMA G-615.105

1. Our AMA will strive to become the lead association for physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities.
2. As a benefit of membership our AMA will provide, through the Sections and Special Groups, assistance, such as information and advice, but not legal opinions or representation, as appropriate, to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.
3. Our AMA will work through the Organized Medical Staff Section and other sections and special groups as appropriate to represent and address the unique needs of physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities. [Res. 601, I-11; Reaffirmed: Joint CCB/CLRPD Rep. 1, A-21]

Physician Impairment H-275.940

The AMA adopts the policy that, except in the case of summary suspension necessary to protect patients from imminent harm, no adverse action be taken against the privileges of a physician by a hospital, managed care organization or insurer based on a claim of physician impairment without a suitable due process hearing in accordance with medical staff bylaws to determine the facts related to the allegations of impairment and, where appropriate, a careful clinical evaluation of the physician.

Medical Staff Role in the Development of Substance Abuse Policies and Procedures H-225.966

1. Our AMA establishes the primacy of medical staff authority in substance abuse policy and procedures covering any pre-employment, credentialing, or other phases of physician evaluation.
2. Policy of the AMA states that medical staff must be involved in the development of the institution's substance abuse policy, including: (a) selection of analytical methods to ensure scientific validity of the test results, (b) determination of measures to maintain confidentiality of the test results, (c) in for-cause post-incident/injury testing, definition of standards for determining whether cause exists and which incidents and/or injuries will result in testing, and (d) development of mechanisms to address the physical and mental health of medical staff members.
3. The AMA believes all drug and alcohol testing must be performed only with substantive and procedural due process safeguards in place. [Res. 701, I-97; Reaffirmed: CME Rep. 2, A-07; Reaffirmed: BOT Rep. 22, A-17]

Hospital Decisions to Grant Exclusive Contracts H-230.987

The AMA supports the concept that individual medical staff members who have been granted clinical privileges are entitled to full due process in any attempt to abridge those privileges by granting of exclusive contracts by the hospital governing body. [Res. 119, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CLRPD Rep. 1, A-05; Reaffirmed: CMS Rep. 1, A-15]

Due Process H-295.998

- (1) Our AMA reaffirms its 1974 approval of the policy adopted by the Liaison Committee on Medical Education, which states: "The faculty of a medical school establish criteria for student selection and develop and implement effective policies and procedures regarding, and make decisions about, medical student application, selection, admission, assessment, promotion, graduation, and any disciplinary action. The medical school makes available to all interested parties its criteria, standards, policies, and procedures regarding these matters."
- (2) In addition, to clarify and protect the rights of medical students, the AMA recommends that: (a) Each school develop and publish in its catalog, student handbook or similar publication the institutional policies and procedures both for evaluation of academic performance (promotion, graduation, dismissal, probation, remedial work, and the like) and for nonacademic disciplinary decisions. (b) These policies and procedures should define the responsible bodies and their function and membership, provide for timely progressive verbal and written notification to the student that his/her academic/nonacademic performance

is in question, and provide an opportunity for the student to learn why it has been questioned. (c) These policies and procedures should also ensure that when a student has been notified of recommendations by the responsible committee for nonadvancement or dismissal, he/she has adequate notice and the opportunity to appear before the decision-making body to respond to the data submitted and introduce his/her own data. (d) The student should be allowed to be accompanied by a student or faculty advisor. (e) The policies and procedures should include an appeal mechanism within the medical school. (f) The student should be allowed to continue in the academic program during the proceedings unless extraordinary circumstances exist, such as physical threat to others. [CME Rep. D, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10; Modified: CEJA Rep. 01, A-20]

Inappropriate Federal Prosecution H-65.985

The AMA (1) encourages state and county medical societies to investigate suspected violations of civil rights or denial of due process in federal prosecutions involving physicians; and (2) will respond to any requests for assistance from these societies once they have investigated, if they find that such a violation has taken place. [Sub. Res. 516, I-92; Reaffirmation A-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmed: CEJA Rep. 03, A-19]

Physician and Medical Staff Member Bill of Rights H-225.942

Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:
Preamble

The organized medical staff, hospital governing body, and administration are all integral to the provision of quality care, providing a safe environment for patients, staff, and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.

The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients.

Medical staff self-governance is vital in protecting the ability of physicians to act in their patients' best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:

I. Our AMA recognizes the following fundamental responsibilities of the medical staff:

- a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body.
- b. The responsibility to provide leadership and work collaboratively with the health care organization's administration and governing body to continuously improve patient care and outcomes, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
- c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.
- d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.
- e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.
- f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.

II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities:

- a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent

legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.

b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.

c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.

d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts, close medical staff departments, or to transfer patients into, out of, or within the health care organization.

e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.

f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.

III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:

a. The responsibility to work collaboratively with other members and with the health care organizations administration to improve quality and safety.

b. The responsibility to provide patient care that meets the professional standards established by the medical staff.

c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.

e. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.

f. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.

g. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.

h. The responsibility to utilize and advocate for clinically appropriate resources in a manner that reasonably includes the needs of the health care organization at large.

IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:

a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.

b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.

c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care, medical staff matters, or personal safety, including the right to refuse to work in unsafe situations, without fear of retaliation by the medical staff or the health care organization's administration or governing body, including advocacy both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.

e. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.

f. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.

g. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.

h. The right of access to resources necessary to provide clinically appropriate patient care, including the right to participate in advocacy efforts for the purpose of procuring such resources both in collaboration with and independent of the organization's advocacy efforts, without fear of retaliation by the medical staff or the health care organization's administration or governing body. [BOT Rep. 09, A-17; Modified: BOT Rep. 05, I-17; Appended: Res. 715, A-18; Reaffirmed: BOT Rep. 13, A-19; Modified: BOT Rep. 13, A-21; Modified: CMS Rep. 5, A-21]

Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934

Our AMA adopts the following principles:

- (1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training.
- (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all state-required licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement for completing one year of accredited GME in the U.S.: (a) completion of medical school and residency training outside the U.S.; (b) extensive U.S. medical practice; and (c) evidence of good standing within the local medical community.
- (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA.
- (4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians.
- (5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements.
- (6) There should be no reporting of actions against medical students to state medical licensing boards.
- (7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems, as well as gaps in student knowledge and skills.
- (8) The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants. [CME Rep. 8, A-99; Reaffirmed: CME Rep. 4, I-01; Reaffirmed: CME Rep. 2, A-11; Modified: CME Rep. 2, A-12; Modified: CME Rep. 2, A-21]

Graduate Medical Education and the Corporate Practice of Medicine H-310.904

Our AMA: (1) recognizes and supports that the environment for education of residents and fellows must be free of the conflict of interest created between a training site's fiduciary responsibility to shareholders and the educational mission of residency or fellowship training programs; (2) encourages the Accreditation Council for Graduate Medical Education (ACGME) to update its "Principles to Guide the Relationship between Graduate Medical Education, Industry, and Other Funding Sources for Programs and Sponsoring Institutions Accredited by the ACGME" to include corporate-owned lay entity funding sources; and (3) will continue to monitor issues, including waiver of due process requirements, created by corporate control of graduate medical education sites. [Res. 303, A-19; Modified: CME Rep. 2, I-20]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 411
(N-21)

Introduced by: Young Physicians Section
Subject: Addressing Public Health Disinformation
Referred to: Reference Committee D

Whereas, Our AMA has strong policy in support of physician autonomy, and a broad interpretation of physician scope-of-practice; and

Whereas, The American Board of Medical Specialties issued a statement¹ expressing concern “about the serious public health effects of the persistent spread of misinformation regarding the COVID-19 virus. Misinformation has been directly linked to much of the vaccine hesitancy and disregard for practical safeguards against infection, including masking and distancing, and is a contributing factor hindering national efforts to combat the virus;” and

Whereas, The Federation of State Medical Boards issued a statement¹ that “spreading COVID-19 vaccine misinformation may put your medical license at risk,” noting that: “Physicians who generate and spread COVID-19 vaccine misinformation or disinformation are risking disciplinary action by state medical boards, including the suspension or revocation of their medical license. Due to their specialized knowledge and training, licensed physicians possess a high degree of public trust and therefore have a powerful platform in society, whether they recognize it or not. They also have an ethical and professional responsibility to practice medicine in the best interests of their patients and must share information that is factual, scientifically grounded and consensus-driven for the betterment of public health. Spreading inaccurate COVID-19 vaccine information contradicts that responsibility, threatens to further erode public trust in the medical profession and puts all patients at risk;” and

Whereas, One report³ states that “just 12 people are behind most vaccine hoaxes on social media;” and

Whereas, There is significant erosion of public trust in government and other institutions; and

Whereas, Our AMA and other organizations should be careful not to be perceived as suppressing legitimate points-of-view, while also publicly pushing back against misinformation and disinformation in public health; therefore be it

RESOLVED, That our American Medical Association collaborate with relevant stakeholders on efforts to combat public health disinformation on all forms of media. (Directive to Take Action)

AUTHORS STATEMENT OF PRIORITY

The YPS submits Addressing Public Health Disinformation as a high priority-resolution. Disinformation on social media undermines public health efforts and sows distrust in medicine and towards health care professionals. We hope the AMA (together with stakeholders) can increase efforts towards fighting disinformation via the media. This is urgent, timely, and highly impactful.

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

Received: 11/06/21

References:

1. "ABMS Issues Statement Supporting Role of Medical Professionals in Preventing COVID-19 Misinformation," at <https://www.abms.org/news-events/abms-issues-statement-supporting-role-of-medical-professionals-in-preventing-covid-19-misinformation/>, dated 9/13/21, accessed 10/3/21
2. "FSMB: Spreading COVID-19 Vaccine misinformation may put medical license at risk" at <https://www.fsmb.org/advocacy/news-releases/fsmb-spreading-covid-19-vaccine-misinformation-may-put-medical-license-at-risk/>, dated 7/29/21, accessed 10/3/21
3. "Just 12 people are behind most vaccine hoaxes on social media," on NPR.org at <https://www.npr.org/2021/05/13/996570855/disinformation-dozen-test-facebooks-twitters-ability-to-curb-vaccine-hoaxes> dated 5/14/21, accessed 10/3/21

RELEVANT AMA POLICY

An Urgent Initiative to Support COVID-19 Vaccination and Information Programs D-440.921

Our AMA will institute a program to promote the integrity of a COVID-19 vaccination information program by: (1) educating physicians on speaking with patients about COVID-19 infection and vaccination, bearing in mind the historical context of "experimentation" with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about up-to-date, evidence-based information regarding COVID-19 and associated infections as well as the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations; and (5) educating physicians and other healthcare professionals on means to disseminate accurate information and methods to combat medical misinformation online. (Res. 408, I-20; Reaffirmed: Res. 228, A-21; Reaffirmed: Res. 421, A-21)

Competence, Self-Assessment and Self-Awareness H-140.829

The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted by society. To this end, medical schools, residency and fellowship programs, specialty boards, and other health care organizations regularly assess physicians' technical knowledge and skills

However, as an ethical responsibility competence encompasses more than medical knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues. Physicians at all stages of their professional lives need to be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

To fulfill the ethical responsibility of competence, individual physicians and physicians in training should strive to:

- (a) Cultivate continuous self-awareness and self-observation.
- (b) Recognize that different points of transition in professional life can make different demands on competence.

- (c) Take advantage of well-designed tools for self-assessment appropriate to their practice settings and patient populations.
- (d) Seek feedback from peers and others.
- (e) Be attentive to environmental and other factors that may compromise their ability to bring appropriate skills to the care of individual patients and act in the patient's best interest.
- (f) Maintain their own health, in collaboration with a personal physician, in keeping with ethics guidance on physician health and wellness.
- (g) Intervene in a timely, appropriate, and compassionate manner when a colleague's ability to practice safely is compromised by impairment, in keeping with ethics guidance on physician responsibilities to impaired colleagues.

Medicine as a profession should continue to refine mechanisms for assessing knowledge and skill and should develop meaningful opportunities for physicians and physicians in training to hone their ability to be self-reflective and attentive in the moment.

Physician Independence and Self-Governance D-225.977

Our AMA will: (1) continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance; and (2) promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures, including but not limited to hospitals, health care systems, medical groups, insurance company networks and accountable care organizations, in order to assure and be accountable for the delivery of quality health care.

Use of Practice Parameters H-410.970

Our AMA: (1) urges organizations that have developed practice parameters to recognize that practice parameters are educational tools, not mechanisms to determine reimbursement or credentialing, to assist physicians in clinical decision making and are not replacements for clinical decision making. Physicians must retain autonomy to vary from practice parameters without retribution in order to provide the quality of care that meets the individual needs of their patients; (2) encourages physicians to be cost conscious and to exercise discretion, consistent with good medical care, when implementing practice parameters; and (3) encourages physician organizations developing practice parameters to include appropriate explanatory disclaimers to ensure that practice parameters are used in a manner that is consistent with AMA policy.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 412
(N-21)

Introduced by: Young Physicians Section

Subject: Health Professional Disinformation During a Public Health Crisis

Referred to: Reference Committee D

Whereas, Our AMA has long combatted misrepresentation in science and medicine and advanced the elevation of objective evidence for “the betterment of public health”; and

Whereas, Disinformation about the SARS-CoV-2 virus and COVID-19, including transmission, treatment, and prevention via vaccination and public health initiatives such as masking, is widespread and dangerous; and

Whereas, Health professionals who peddle untested treatments and cures for COVID-19 put the public at risk; and

Whereas, Health professionals who provide vaccine exemptions for non-medical reasons and flout masking efforts put the public at risk; and

Whereas, Specialty boards share in our AMA mission to improve the betterment of public health and address physician misconduct and behavior inconsistent with ethical standards; and

Whereas, Health professionals making public statements that are directly contrary to prevailing medical evidence without new evidence to support their claims can constitute unprofessional conduct that can harm the public; therefore be it

RESOLVED, That our American Medical Association work with health professional societies to address disinformation that undermines public health initiatives. (Directive to Take Action)

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

Received: 11/06/21

AUTHORS STATEMENT OF PRIORITY

The YPS submits Health Professional Disinformation During a Public Health Crisis as a high-priority resolution. Given the spread of disinformation during the COVID-19 pandemic, loud/clear/decisive action by the AMA is needed. While we commend the AMA for taking a strong stand towards evidence-based public health information, we hope for stronger action by the AMA that mirrors that of some state licensing boards and the ABMS regarding individual health professional participation in spreading disinformation. This is urgent, timely, and highly impactful.

RELEVANT AMA POLICY

[Physician and Health Institution Publicity and Responsibility H-445.985](#)

Our American Medical Association encourages physicians when engaged in public discourse related to health and medical science to disclose whether stated positions are based on peer-reviewed evidence, standard of care, or personal opinion. (Res. 6, A-15)

[8.3 Physicians' Responsibilities in Disaster Response & Preparedness](#)

Whether at the national, regional, or local level, responses to disasters require extensive involvement from physicians individually and collectively. Because of their commitment to care for the sick and injured, individual physicians have an obligation to provide urgent medical care during disasters. This obligation holds even in the face of greater than usual risks to physicians' own safety, health, or life.

However, the physician workforce is not an unlimited resource. Therefore, when providing care in a disaster with its inherent dangers, physicians also have an obligation to evaluate the risks of providing care to individual patients versus the need to be available to provide care in the future.

With respect to disaster, whether natural or manmade, individual physicians should:

Take appropriate advance measures, including acquiring and maintaining appropriate knowledge and skills to ensure they are able to provide medical services when needed.

Collectively, physicians should:

Provide medical expertise and work with others to develop public health policies that:

- are designed to improve the effectiveness and availability of medical services during a disaster;
- are based on sound science;
- are based on respect for patients.

Advocate for and participate in ethically sound research to inform policy decisions.

[An Urgent Initiative to Support COVID-19 Vaccination and Information Programs D-440.921](#)

Our AMA will institute a program to promote the integrity of a COVID-19 vaccination information program by: (1) educating physicians on speaking with patients about COVID-19 infection and vaccination, bearing in mind the historical context of "experimentation" with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about up-to-date, evidence-based information regarding COVID-19 and associated infections as well as the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations; and (5) educating physicians and other healthcare professionals on means to disseminate accurate information and methods to combat medical misinformation online.

[Creating a Congressionally-Mandated Bipartisan Commission to Examine the U.S. Preparations for and Response to the COVID-19 Pandemic to Inform Future Efforts D-440.923](#)

Our AMA will advocate for passage of federal legislation to create a congressionally-mandated bipartisan commission composed of scientists, physicians with expertise in pandemic

preparedness and response, public health experts, legislators and other stakeholders, which is to examine the U.S. preparations for and response to the COVID-19 pandemic, in order to inform and support future public policy and health systems preparedness. 2. In advocating for legislation to create a congressionally-mandated bipartisan commission, our AMA will seek to ensure key provisions are included, namely that the delivery of a specific end product (i.e., a report) is required by the commission by a certain period of time, and that adequate funding be provided in order for the commission to complete its deliverables.

References:

1. AAEM-ACEP Joint Statement on Physician Misinformation. Accessed September 18, 2021. <https://www.aaem.org/resources/statements/joint-endorsed/physician-misinformation>.
2. Brumfiel, G. This Doctor Spread False Information About COVID. She Still Kept Her Medical License. NPR. September 14, 2021. Accessed September 18, 2021. <https://www.npr.org/sections/health-shots/2021/09/14/1035915598/doctors-covid-misinformation-medical-license>.
3. American Board of Emergency Medicine. ABEM Statement about ABEM-Certified Physicians Providing Misleading and Inaccurate Information to the Public. ABEM. August 26, 2021. Accessed September 18, 2021. <https://www.abem.org/public/news-events/news/2021/08/27/abem-statement-about-abem-certified-physicians-providing-misleading-and-inaccurate-information-to-the-public>.
4. Federation of State Medical Boards. FSMB: Spreading COVID-19 Vaccine Misinformation May Put Medical License at Risk. FSMB. July 29, 2021. Accessed September 18, 2021. <https://www.fsmb.org/advocacy/news-releases/fsmb-spreading-covid-19-vaccine-misinformation-may-put-medical-license-at-risk/>.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 413
(N-21)

Introduced by: Medical Student Section

Subject: Universal Childcare and Preschool

Referred to: Reference Committee D

1 Whereas, In the 2019-2020 school year, only 34% of 4-year-olds and 6% of 3-year-olds were
2 enrolled in state pre-kindergarten¹; and
3

4 Whereas, The COVID-19 pandemic caused a sharp decline in preschool enrollment, quality
5 standards, teacher qualifications, and state funding^{1,2}; and
6

7 Whereas, Research has demonstrated that participation in preschool improves access to
8 pediatric preventive care and is linked to decreases in child mortality, increases in
9 immunizations, reductions in hospitalizations for accidents or injuries, and additional avenues
10 for screening, diagnosis, and care for pediatric patients with ADHD³⁻⁵; and
11

12 Whereas, Early care and education programs have been shown to lead to long-term
13 improvements in cardiovascular and metabolic health through adolescence and adulthood, as
14 well as reduced smoking and obesity^{3,6-8}; and
15

16 Whereas, Universal child care and preschool are avenues for capturing child maltreatment
17 cases because of the crucial role that school personnel play in recognizing, reporting, and
18 preventing child abuse and neglect⁹; and
19

20 Whereas, Childcare attendance is associated with improved cognitive abilities and mitigates the
21 increase in externalizing behaviors observed in children exposed to early adversity¹⁰; and
22

23 Whereas, Children who participate in early childhood education have higher kindergarten scores
24 in reading, mathematics, cognitive flexibility, and approaches to learning¹¹; and
25

26 Whereas, A 2021 JAMA Pediatrics study determined that, for children of mothers with a lower
27 education level, childcare attendance was positively associated with academic achievement at
28 age 16¹²; and
29

30 Whereas, High-quality childcare and early education are shown to have positive effects on the
31 mother-child relationship, maternal wellbeing, and physical and mental, short- and long-term
32 health outcomes for children^{3,13-15}; and
33

34 Whereas, Maternal mental health, including maternal depression, and life satisfaction improved
35 after implementation of universal child care in Canada and maternal wellbeing improved after
36 implementation of publicly funded childcare in Germany¹⁶⁻¹⁷; and
37

38 Whereas, In 2020, the Department of Labor estimated that there were 20.1 million employed
39 Americans with children under the age of six¹⁸; and

1 Whereas, A 2020 study of childcare facility closures published in JAMA Health Forum indicated
2 that “state-level childcare facility closures were associated with greater reductions in
3 employment among women compared to men” for parents of children under the age of six¹⁹;
4 and

5
6 Whereas, There are significant racial and ethnic inequities in access to federal childcare
7 subsidies as compared to the national average of 12%, with only 7% of Native American and
8 Alaska Native, 6% of Hispanic/Latino, and 3% of Asian eligible children being served by the
9 Child Care Development Block Grant subsidies in 2016²⁰; and

10
11 Whereas, 57.3% of Hispanic/Latino and 60.2% of American Indian and Alaska Native
12 populations live in childcare deserts (defined as “areas with an insufficient supply of licensed
13 childcare”), compared to the overall population at 50.5%²¹; and

14
15 Whereas, Children from families with high socioeconomic status (SES) are more likely to attend
16 early childhood education programs, with 69% of kindergarteners from high SES families and
17 only 44% from low SES families¹¹; and

18
19 Whereas, The Child Care and Development Fund is the primary source of financial childcare
20 assistance for low-income families, but, according to the U.S. Department of Health & Human
21 Services, it served only 15% of the 13.3 million children meeting federal eligibility parameters in
22 2016²²; and

23
24 Whereas, Only five states, District of Columbia, New Jersey, North Carolina, Oklahoma, and
25 West Virginia, fully fund high-quality full-day pre-K, as determined by quality benchmarks set by
26 the National Institute for Early Education Research¹; and

27
28 Whereas, There is a growing recognition of the importance of universal child care and preschool
29 that is reflected by nationwide initiatives like the Senate’s Improving Child Care for Working
30 Families Act of 2021 and the Administration’s American Families Plan which will provide
31 universal free preschool and limit childcare costs to less than 7% of household income^{23,24}; and

32
33 Whereas, The American Academy of Pediatrics Council on Early Childhood published a 2016
34 position statement stating that “high-quality early education and child care for young children
35 improves physical and cognitive outcomes for the children and can result in enhanced school
36 readiness”²⁵; and

37
38 Whereas, While our AMA has some existing policies (D-200.974, H-310.912, G-600.115, H-
39 95.916, H-440.970, H-150.927, and H-245.979) supporting access to childcare for healthcare
40 professionals and patients in substance use treatment facilities, funding for Head Start (a
41 federal childcare and preschool program for low-income families), and public health protections
42 in childcare settings, our AMA does not currently have policy on universal, affordable access to
43 childcare; and

44
45 Whereas, While AMA Policy H-60.917 states that our AMA “will issue a call to action to...to
46 propose strategies...to further the access of all children to...early childhood education,” this does
47 not ask our AMA to advocate for proposed strategies currently being debated in Congress and
48 state governments, and “early childhood education” in that context appears to refer to existing
49 public education from kindergarten to third grade and not specifically childcare or preschool,
50 which are more limited in availability and require greater advocacy to expand; therefore be it

- 1 RESOLVED, That our American Medical Association advocate for universal access to high-
2 quality and affordable childcare and preschool. (Directive to Take Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 11/07/21

AUTHORS STATEMENT OF PRIORITY

Childcare and preschool provide lifelong benefits to children and their families. Racial, ethnic, and demographic inequities in access to these social services result in poor medical, psychological, and academic outcomes for children. The Build Back Better Act is currently being debated in Congress and can pass with a simple majority in the House and the Senate under budget reconciliation rules. A major provision in the plan is to invest in childcare and preschool. Existing AMA policy recognizes the importance of public education; Head Start, the federally funded early childhood education program; and paid parental leave, but our advocacy has not yet extended to the provision of universal access to childcare and preschool nationwide. With relevant policy proposals, the time is right to address these inequities and ensure that all children have the same early age access to opportunities for cognitive, emotional, and social development and academic achievement.

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RELEVANT AMA POLICY

Supporting Child Care for Health Care Professionals D-200.974

Our AMA will work with interested stakeholders to investigate solutions for innovative childcare policies and flexible working environments for all health care professionals (in particular, medical students and physician trainees). Res. 309, A-21

Preserving Childcare at AMA Meetings G-600.115

Our AMA will arrange onsite supervised childcare at no cost to members attending AMA Annual and Interim meetings. Res. 602, I-19

Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917

1. Our AMA: (a) considers continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation; (b) will issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education, including early childhood education, as one of the great unmet health and civil rights challenges of the 21st century; and (c) acknowledges the role of early childhood brain development in persistent educational and health disparities and encourage public and private stakeholders to work to strengthen and expand programs to support optimal early childhood brain development and school readiness.
2. Our AMA will work with: (a) the Health and Human Services Department (HHS) and Department of Education (DOE) to raise awareness about the health benefits of education; and (b) the Centers for Disease Control and Prevention and other stakeholders to promote a meaningful health curriculum (including nutrition) for grades kindergarten through 12.
3. Our AMA will encourage the U.S. Department of Education and Department of Labor to develop policies and initiatives in support of students from marginalized backgrounds that: (a) decrease the educational opportunity gap; (b) increase participation in high school Advanced Placement courses; and (c) increase the high school graduation rate. Res. 910, I-16; Appended: Res. 410, A-19; Appended: CME Rep. 5, A-21

Childcare Availability for Persons Receiving Substance Use Disorder Treatment H-95.916

Our AMA supports the implementation of childcare resources in existing substance use treatment facilities and acknowledges childcare infrastructure and support as a major priority in the development of new substance use programs. Res. 519, A-19

Opposition to Proposed Budget Cuts in WIC and Head Start H-245.979

The AMA opposes reductions in funding for WIC and Head Start and other programs that significantly impact child and infant health and education. Res. 246, I-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14

Parental Leave H-405.954

1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.
2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.
3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members.

Res. 215, I-16; Appended: BOT Rep. 11, A-19

Nonmedical Exemptions from Immunizations H-440.970

1. Our AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large.
Therefore, our AMA (a) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (b) supports legislation eliminating nonmedical exemptions from immunization; (c) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (d) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (e) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (f) recommends that states have in place: (i) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (ii) policies that permit immunization exemptions for medical reasons only.
2. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to eliminate non-medical exemptions from mandated pediatric immunizations. CSA Rep. B, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Res. 10, A-15; Modified: CSAPH Rep. 1, I-15; Appended: Res. 416, A-19

Strategies to Reduce the Consumption of Beverages with Added Sweeteners H-150.927

Our AMA: (1) acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption, and support evidence-based strategies to reduce the consumption of SSBs, including but not limited to, excise taxes on SSBs, removing options to purchase SSBs in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption, and the use of plain packaging; (2) encourages continued research into strategies that may be effective in limiting SSB consumption, such as controlling portion sizes; limiting options to purchase or access SSBs in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs to children; and changes to the

agricultural subsidies system; (3) encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; and (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and replacing SSBs with healthier beverage choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage choices for students. CSAPH Rep. 03, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 414
(N-21)

Introduced by: Medical Student Section

Subject: Advocacy on the US Department of Education's Spring 2022 Title IX Rule on Sexual Harassment and Assault in Education Programs

Referred to: Reference Committee D

1 Whereas, Medicine has high rates of harassment that are significantly higher than most
2 scientific fields¹⁻⁴; and

3
4 Whereas, Gender-based and sexual harassment in the workplace has been correlated with
5 burnout, lower mental health, job satisfaction, and sense of safety at work, as well as increased
6 turnover intentions, especially among female physicians^{5,6}; and

7
8 Whereas, Gender-based workplace discrimination and harassment have been shown to
9 contribute significantly to burnout, and burnout has been associated with poor levels of patient
10 care and increased risk to patient safety, while improved clinical outcomes have been
11 associated with a diverse workforce, particularly female physicians^{7,8}; and

12
13 Whereas, Title IX of the US Education Amendments of 1972 protects people from discrimination
14 based on sex in education programs or activities that receive federal financial assistance⁹; and

15
16 Whereas, Many medical schools receive and rely on federal funding, and thus are required to
17 comply with Title IX regulations^{10,11}; and

18
19 Whereas, Title IX regulations apply to hospitals with residency programs, as established in
20 *Castro v Yale University*¹²⁻¹⁵; and

21
22 Whereas, The significant amount of Title IX cases filed at higher education and medical
23 institutions have been met with serious procedural barriers¹⁶; and

24
25 Whereas, In August 2020, new Title IX Regulations created under Betsy DeVos, former United
26 States Secretary of Education, were enacted¹⁷; and

27
28 Whereas, Under new regulations, survivors have 180 days from the first instance of
29 discrimination to file a Title IX complaint against their school; yet as the Betsy DeVos-era Title
30 IX rule stands, schools can make up their own investigation timeline when a survivor reports
31 sexual violence^{17,18}; and

32
33 Whereas, Under the new regulations, schools are allowed to utilize a "clear and convincing
34 evidence" standard rather than a preponderance of the evidence standard" for sexual
35 harassment investigations, which benefits respondents rather than victims¹⁹; and

36
37 Whereas, Under the new regulations, schools are not required to investigate complaints of
38 sexual assault if the events did not occur during a school event or on school property, which

1 does not take into account harassment that occurred outside of these parameters that may still
2 impact a student's ability to participate in school¹⁹; and

3
4 Whereas, Most US schools returned to in-person curriculums in the fall of 2021, for the first time
5 since Ms. DeVos' Title IX regulations were enacted in August 2020, highlighting process issues
6 in real time^{9,20}; and

7
8 Whereas, Upon students' return to in-person classes, in October 2021, the ED Act Now group
9 convened with protests in Washington DC, hoping to address concerns and codify institutional
10 responsibilities in light of Ms. DeVos' proposed Title IX rules in a timely and urgent manner¹⁸;
11 and

12
13 Whereas, The Biden administration has pledged to re-write Title IX, but the preliminary
14 recommendations will not be released until May 2022, and medical education organizations
15 have an opportunity to take a stance on this topic²¹; and

16
17 Whereas, Researchers in our medical profession strongly recommend for a zero tolerance
18 policy for gender-based violence^{22,23}; and

19
20 Whereas, AAMC, AAOMC, and other relevant medical education bodies did NOT sign on to this
21 letter: <https://www.acenet.edu/Documents/Comments-ED-OCR-Title-IX-Hearing-061021.pdf> ,
22 despite other healthcare education associated bodies signing on²⁴;

23
24 Whereas, According to the AAMC's Medical School Graduation Questionnaire in 2017, only
25 21% of students experiencing harassment reported to administration, leaving the majority of
26 cases unreported due to students' fear of lack of accountability, fear of retaliation and
27 perception that the incident was not significant enough to report²⁵; and

28
29 Whereas, Victims of sexual harassment often will not report the harassment to their institutions
30 because of fear of retaliation such as being "labeled as a troublemaker"²⁶; and

31
32 Whereas, Medical training is fast-paced, and prolonged decisions regarding Title IX and other
33 accommodations can have a significant impact on a trainee's career and right to an education²⁷;
34 and

35
36 Whereas, Perpetrators of harassment are often asked to leave higher education institutions
37 without any questions or punishment, in order to decrease institutional liability, but this practice
38 fails to address root behaviors of the harassers²⁸; and

39
40 Whereas, *Sexual Harassment of Women: Climate, Culture and Consequences in Academic*
41 *Science, Engineering and Medicine* states that "organizational tolerance for sexually harassing
42 behavior" increases the risk of sexual harassment occurring within the organization³; and

43
44 Whereas, National Academy of Science, Engineering and Medicine (NASEM) and Association
45 of American Universities (AAU) have created validated surveys that are recommended for
46 qualitative and quantitative monitoring of sexual harassment^{3,29}; and

47
48 Whereas, Know Your IX has published a list of best practices for supporting students rights'
49 under Title IX, indicating that mental health support, timely notice and investigations,
50 accountability and prevention of retaliation were best practices in Title IX-related
51 investigations³⁰; and

Whereas, AMA Code of Ethics 9.1.3 “Sexual Harassment in the Practice of Medicine” defines sexual harassment, but does not outline best guidelines for institutional enforcement or advocate for enforcement in institutions of medical training/education;

Whereas, Our organization is committed to equal access to medical education, maintaining the diversity of the physician workforce, and selecting trainees who possess both academic and non-academic qualifications to be a physician as outlined in H-200.95, H-310.929 and H-295.995; therefore be it

RESOLVED, That our American Medical Association work with relevant stakeholders to release a statement and advocate that the US Department of Education replace their 2020 Title IX rule on sexual harassment and assault in educational settings, including undergraduate and graduate medical education, with a comprehensive rule that preserves the safety and wellbeing of all people affected by sexual assault. (Directive to Take Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 11/07/21

AUTHORS STATEMENT OF PRIORITY

Given that the Biden administration is currently reviewing the restrictive Title IX rule adopted in August 2020 and planning on releasing new recommendations by May of 2022, this issue is of timely importance that the AMA speaks on this matter and provides guiding data on the path to ending sexual harassment and violence, in accordance with the asks of this resolution. As many students returned to campuses for in-person instruction, the devastating impact of the 2020 Title IX resolution became apparent for the first time. Our AMA, the largest body of medical professionals, cannot stand by as more victims are shamed or silenced, especially when 52% of medical trainees experience harassment.

Our AMA must use its unique position at the intersection of medicine and advocacy to publicly speak on behalf of victims, particularly those in educational settings, and to contribute to this pivotal national reform. Our input on this issue will progress the development of the Biden administration’s recommendations in a meaningful way, while also elucidating the steps that the AMA and medical education bodies must take to support victims in medical education, who are not granted any protections or support under H-515.956, in support of college students, and H-80.999, in support of patients. Our AMA cannot stay silent on this issue that silences so many of our patients as well as so many of our own.

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RELEVANT AMA POLICY

H-295.955 Teacher-Learner Relationship In Medical Education

The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

CODE OF BEHAVIOR

The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.

In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.

Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.

On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.

Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients.

BOT Rep. ZZ, I-90; Reaffirmed by CME Rep. 9, A-98; Reaffirmed: CME Rep. 2, I-99; Modified: BOT Rep. 11, A-07; Reaffirmed: CME Rep. 9, A-13; Reaffirmed BOT Rep. 9, I-20

9.1.3 Sexual Harassment in the Practice of Medicine

Sexual harassment can be defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

Sexual harassment in the practice of medicine is unethical. Sexual harassment exploits inequalities in status and power, abuses the rights and trust of those who are subjected to such conduct; interferes with an individual's work performance, and may influence or be perceived as influencing professional advancement in a manner unrelated to clinical or academic

performance harm professional working relationships, and create an intimidating or hostile work environment; and is likely to jeopardize patient care. Sexual relationships between medical supervisors and trainees are not acceptable, even if consensual. The supervisory role should be eliminated if the parties wish to pursue their relationship.

Physicians should promote and adhere to strict sexual harassment policies in medical workplaces. Physicians who participate in grievance committees should be broadly representative with respect to gender identity or sexual orientation, profession, and employment status, have the power to enforce harassment policies, and be accessible to the persons they are meant to serve.

Issued: 2016

G-600.067 References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment

Our AMA will: (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; (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.

Res. 009, A-19

H-140.837 Policy on Conduct at AMA Meetings and Events

It is the policy of the American Medical Association that all attendees of AMA hosted meetings, events and other activities are expected to exhibit respectful, professional, and collegial behavior during such meetings, events and activities, including but not limited to dinners, receptions and social gatherings held in conjunction with such AMA hosted meetings, events and other activities. Attendees should exercise consideration and respect in their speech and actions, including while making formal presentations to other attendees, and should be mindful of their surroundings and fellow participants.

Any type of harassment of any attendee of an AMA hosted meeting, event and other activity, including but not limited to dinners, receptions and social gatherings held in conjunction with an AMA hosted meeting, event or activity, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA business is conducted. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an "AMA Entity"), as well as other AMA-sponsored events. The purpose of the policy is to protect participants in AMA-sponsored events from harm.

Definition

Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or otherwise, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is

placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

Sexual Harassment

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and
- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual's work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

Operational Guidelines

The AMA shall, through the Office of General Counsel, implement and maintain mechanisms for reporting, investigation, and enforcement of the Policy on Conduct at AMA Meetings and Events in accordance with the following:

1. Conduct Liaison and Committee on Conduct at AMA Meetings and Events (CCAM)

The Office of General Counsel will appoint a "Conduct Liaison" for all AMA House of Delegates meetings and all other AMA hosted meetings or activities (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel, or JAMA Editorial Boards), with responsibility for receiving reports of alleged policy violations, conducting investigations, and initiating both immediate and longer-term consequences for such violations. The Conduct Liaison appointed for any meeting will have the appropriate training and experience to serve in this capacity, and may be a third party or an in-house AMA resource with assigned responsibility for this role. The Conduct Liaison will be (i) on-site at all House of Delegates meetings and other large, national AMA meetings and (ii) on call for smaller meetings and activities. Appointments of the Conduct Liaison for each meeting shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in investigation of alleged policy violations and in decisions on consequences for policy violations.

The AMA shall establish and maintain a Committee on Conduct at AMA Meetings and Events (CCAM), to be comprised of 5-7 AMA members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees. The CCAM should include one member of the Council on Ethical and Judicial Affairs (CEJA); provided, however, that such CEJA member on the CCAM shall be recused from discussion and vote concerning referral by the CCAM of a matter to CEJA for further review and action. The remaining members may be appointed from AMA membership generally, with emphasis on maximizing the diversity of membership. Appointments to the CCAM shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in decisions on consequences for policy violations. Appointments to the CCAM should be multi-year, with staggered terms.

2. Reporting Violations of the Policy

Any persons who believe they have experienced or witnessed conduct in violation of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," during any AMA House of Delegates meeting or other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel or JAMA Editorial

Boards) should promptly notify the (i) Conduct Liaison appointed for such meeting, and/or (ii) the AMA Office of General Counsel and/or (iii) the presiding officer(s) of such meeting or activity.

Alternatively, violations may be reported using an AMA reporting hotline (telephone and online) maintained by a third party on behalf of the AMA. The AMA reporting hotline will provide an option to report anonymously, in which case the name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the Conduct Liaison may investigate.

These reporting mechanisms will be publicized to ensure awareness.

3. Investigations

All reported violations of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," pursuant to Section 2 above (irrespective of the reporting mechanism used) will be investigated by the Conduct Liaison. Each reported violation will be promptly and thoroughly investigated. Whenever possible, the Conduct Liaison should conduct incident investigations on-site during the event. This allows for immediate action at the event to protect the safety of event participants. When this is not possible, the Conduct Liaison may continue to investigate incidents following the event to provide recommendations for action to the CCAM. Investigations should consist of structured interviews with the person reporting the incident (the reporter), the person targeted (if they are not the reporter), any witnesses that the reporter or target identify, and the alleged violator.

Based on this investigation, the Conduct Liaison will determine whether a violation of the Policy on Conduct at AMA Meetings and Events has occurred.

All reported violations of the Policy on Conduct at AMA Meetings and Events, and the outcomes of investigations by the Conduct Liaison, will also be promptly transmitted to the AMA's Office of General Counsel (i.e. irrespective of whether the Conduct Liaison determines that a violation has occurred).

4. Disciplinary Action

If the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison may take immediate action to protect the safety of event participants, which may include having the violator removed from the AMA meeting, event or activity, without warning or refund.

Additionally, if the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison shall report any such violation to the CCAM, together with recommendations as to whether additional commensurate disciplinary and/or corrective actions (beyond those taken on-site at the meeting, event or activity, if any) are appropriate.

The CCAM will review all incident reports, perform further investigation (if needed) and recommend to the Office of General Counsel any additional commensurate disciplinary and/or corrective action, which may include but is not limited to the following:

- Prohibiting the violator from attending future AMA events or activities;
- Removing the violator from leadership or other roles in AMA activities;
- Prohibiting the violator from assuming a leadership or other role in future AMA activities;
- Notifying the violator's employer and/or sponsoring organization of the actions taken by AMA;
- Referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and action;
- Referral to law enforcement.

The CCAM may, but is not required to, confer with the presiding officer(s) of applicable events activities in making its recommendations as to disciplinary and/or corrective actions.

Consequence for policy violations will be commensurate with the nature of the violation(s).

5. Confidentiality

All proceedings of the CCAM should be kept as confidential as practicable. Reports, investigations, and disciplinary actions under Policy on Conduct at AMA Meetings and Events will be kept confidential to the fullest extent possible, consistent with usual business practices.

6. Assent to Policy

As a condition of attending and participating in any meeting of the House of Delegates, or any council, section, or other AMA entities, such as the RVS Update Committee (RUC), CPT Editorial Panel and JAMA Editorial Boards, or other AMA hosted meeting or activity, each attendee will be required to acknowledge and accept (i) AMA policies concerning conduct at AMA HOD meetings, including the Policy on Conduct at AMA Meetings and Events and (ii) applicable adjudication and disciplinary processes for violations of such policies (including those implemented pursuant to these Operational Guidelines), and all attendees are expected to conduct themselves in accordance with these policies.

Additionally, individuals elected or appointed to a leadership role in the AMA or its affiliates will be required to acknowledge and accept the Policy on Conduct at AMA Meetings and Events and these Operational Guidelines.

[Editor's note: Violations of this Policy on Conduct at AMA Meetings and Events may be reported at 800.398.1496 or online at <https://www.lighthouse-services.com/ama>. Both are available 24 hours a day, 7 days a week.

Please note that situations unrelated to this Policy on Conduct at AMA Meetings and Events should not be reported here. In particular, patient concerns about a physician should be reported to the state medical board or other appropriate authority.]

BOT Rep. 23, A-17; Appended: BOT Rep. 20, A-18; Modified: BOT Rep. 10, A-19I Modified: CCB Rep. 2, I-20

H-200.951, "Strategies for Enhancing Diversity in the Physician Workforce"

Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.

CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation: A-16; Modified: Res. 009, A-21; Modified: CME Rep. 5, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 415
(N-21)

Introduced by: Medical Student Section

Subject: Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV

Referred to: Reference Committee D

1 Whereas, Sexual identity is fluid and can be defined on a spectrum, ranging from exclusively
2 homosexual behavior to exclusively heterosexual behavior¹; and
3

4 Whereas, According to the U.S. National Survey of Family Growth, 17.4% of women and 6.2%
5 of men aged 18-44 report any same-sex sexual behavior at any time in their life, despite only
6 6.8% of women and 3.9% of men aged 18-44 report being homosexual, gay, lesbian, or
7 bisexual²; and
8

9 Whereas, Patients' reported sexual behavior and orientation is not always consistent with actual
10 sexual behavior as patients may not be willing to report their sexual histories accurately²; and
11

12 Whereas, In 2017, 30% of new HIV diagnoses in the United States were not attributed to the
13 men who have sex with men (MSM) demographic³; and
14

15 Whereas, From 2010-2016, African American heterosexual women accounted for the second
16 highest incidence of HIV infection after MSM⁴; and
17

18 Whereas, Black men who have sex with men and women (MSMW) have been hypothesized to
19 be the "bridge" through which HIV has been transmitted to black heterosexual men and women⁵-
20 ⁶; and
21

22 Whereas, Several studies have shown that African American MSMW may challenge targeted
23 HIV prevention approaches that focus explicitly on sexual orientation since this population may
24 not identify as gay or bisexual and is therefore unlikely to participate in programs that prioritize
25 gay community affiliation as foundations for HIV prevention⁵⁻⁶; and
26

27 Whereas, In 2017, the African American population and Hispanic population collectively
28 accounted for 69% of HIV diagnoses, despite comprising only 31% of the U.S. population³; and
29

30 Whereas, A report from the CDC concluded that increasing HIV prevention services among
31 heterosexuals at increased risk is important, especially among racial and ethnic groups
32 disproportionately affected by HIV infection, such as blacks and Hispanics/Latinos⁷; and
33

34 Whereas, In 2019, the United States Preventive Services Task Force (USPSTF) recommended
35 with an "A" rating that clinicians offer HIV pre-exposure prophylaxis (PrEP) to persons who are
36 at high risk of HIV acquisition as an evidence-based primary prevention because PrEP reduces
37 the risk of sexual transmission of HIV by about 99% when taken daily⁸⁻⁹; and

1 Whereas, While there are over 77,000 PrEP users in the United States, over 1.1 million
2 additional individuals would benefit from being on it¹⁰⁻¹³; and

3
4 Whereas, Sixty-nine percent of the individuals that could benefit from PrEP are Black or
5 Hispanic, yet these individuals comprise only 4% of the individuals who are prescribed it¹¹⁻¹²;
6 and

7
8 Whereas, PrEP uptake does not reflect the general distribution of the HIV epidemic in the
9 United States, as people of color and women bear a high HIV burden, but have a
10 disproportionately limited uptake¹⁴; and

11
12 Whereas, Only 28% of primary care physicians are comfortable with prescribing PrEP, with the
13 most frequently cited barrier to prescribing it being lack of knowledge¹⁵⁻¹⁶; and

14
15 Whereas, A 2018 study showed that medical students were unable to identify individuals at
16 highest risk of HIV acquisition and recommend PrEP accordingly¹⁷; and

17
18 Whereas, Educational interventions targeted at primary care physicians that focus on HIV
19 epidemiology, an introduction to PrEP and appropriate candidates, an overview of how to
20 prescribe PrEP, as well as recommendations on sexual-history taking have all been shown to
21 increase rates of PrEP prescribing when clinically indicated¹⁶; and

22
23 Whereas, Regardless of the patient's current stated sexual behavior, routine primary care office
24 visits are comprised of a comprehensive discussion of sexual health, sexual activity, sexuality,
25 contraception, and prevention of sexually transmitted infections/diseases (STIs), beginning as
26 early as age 11¹⁸⁻¹⁹; and

27
28 Whereas, It is considered a best practice in primary care settings to educate patients about all
29 the available options for preventing STIs, especially in sexually active adolescents and in adults
30 at increased risk for STIs¹⁸⁻¹⁹; and

31
32 Whereas, PrEP is considered to be an option for the prevention of HIV infection in seronegative
33 individuals at high risk of HIV acquisition, yet it is not routinely discussed with patients^{8,15}; and

34
35 Whereas, A study found that the strongest factor influencing PrEP uptake among majority non-
36 white heterosexual individuals at high risk of HIV, a group with disproportionately low PrEP
37 uptake, was suggestion to initiate PrEP by a healthcare provider¹⁴; and

38
39 Whereas, AMA policies H-180.944 "Plan for Continued Progress Toward Health Equity" and H-
40 350.974 "Racial and Ethnic Disparities in Health Care" has named the elimination of racial and
41 ethnic disparities in health care "an issue of highest priority" as they are a "barrier to effective
42 medical diagnosis and treatment"; and

43
44 Whereas, H-350.974 calls on the importance of "evidence-based guidelines to promote the
45 consistency and equity of care for all persons" and "supports research to identify the most
46 effective strategies for educating physicians on how to eliminate disparities in health outcomes
47 in all at-risk populations"; and

48
49 Whereas, No existing AMA policy explicitly acknowledges the disparities that exist in HIV
50 prevention and treatment nor proposes a specific intervention to reduce such disparities;
51 therefore be it

1 RESOLVED, That our American Medical Association amend Policy H-20.895 “Pre-Exposure
2 Prophylaxis (PrEP) for HIV,” by addition to read as follows:

3
4 Pre-Exposure Prophylaxis (PrEP) for HIV, H-20.895

- 5 1. Our AMA will educate physicians, physicians-in-training, and the public about the
6 effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical
7 Practice Guidelines.
8 2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
9 3. Our AMA supports the removal of insurance barriers for PrEP such as prior
10 authorization, mandatory consultation with an infectious disease specialist and
11 other barriers that are not clinically relevant.
12 4. Our AMA advocates that individuals not be denied any insurance on the basis of
13 PrEP use.
14 5. Our AMA encourages the discussion of and education about PrEP during routine
15 sexual health counseling, regardless of a patient’s current reported sexual
16 behaviors. (Modify Current HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

This resolution is pivotal if the U.S. wishes to reach or even come close to its set goal of eliminating HIV in our country by 2030. The HIV/AIDS pandemic has continued unabated and even increased during the COVID-19 pandemic. HIV researchers and infectious diseases physicians have predicted that the decreased availability of HIV treatment during the COVID-19 pandemic may set back our progress against HIV by multiple years. HIV most profoundly affects marginalized communities, and these communities are also the most likely to have barriers to access to preventive measures, especially PrEP.

This resolution aims to reduce existing disparities through universal PrEP counseling. Universal PrEP counseling would work to address the stark underutilization of PrEP by many vulnerable populations, including Black heterosexual women and queer and trans people of color. While recent years have seen significant uptake by white and wealthier members of the LGBTQ+ community, true improvement in the health of our community as a whole and addressal of the health disparities within our community requires increased PrEP knowledge and use among queer and trans people, people of color, and low-income LGBTQ+ individuals. This resolution represents a way to use patient-centered care to address an urgent and rapidly growing problem: with proper, universal counseling around preventive measures against a chronic condition with high prevalence and morbidity, patients can make their own informed decisions about what the best preventive practice looks like for their own sexual practices and their own lives.

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RELEVANT AMA POLICY

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk

for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8, I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation: A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18.

Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education H-295.878

Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues related to sexual orientation and gender identity; and (3) encourages medical education accreditation bodies to both continue to encourage and periodically reassess education on health issues related to sexual orientation and gender identity in the basic science, clinical care, and cultural competency curricula in undergraduate and graduate medical education.

Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation: A-11; Reaffirmation: A-12; Reaffirmation: A-16; Modified: Res. 16, A-18; Modified: Res. 302, I-19

Improving the Health of Black and Minority Populations H-350.972

Our AMA supports:

1. A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.
2. Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.
3. Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.
4. The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.

CLRPD Rep. 3, I-98; Reaffirmation: A-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Rep. 1, A-21

Plan for Continued Progress Toward Health Equity H-180.944

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

BOT Rep. 33, A-18

Racial and Ethnic Disparities in Health Care H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
 - a. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
 - b. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
 - c. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision-making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep. 1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21

Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895

1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
 2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
 3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
 4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.
- Res. 106, A-16; Modified: Res. 916, I-16; Appended: Res. 101, A-17

Support of a National HIV/AIDS Strategy H-20.896

1. Our AMA supports the creation of a National HIV/AIDS strategy and will work with relevant stakeholders to update and implement the National HIV/AIDS strategy.

2. Our AMA supports and will strongly advocate for the funding of plans to end the HIV epidemic that focus on: (a) diagnosing individuals with HIV infection as early as possible; (b) treating HIV infection to achieve sustained viral suppression; (c) preventing at-risk individuals from acquiring HIV infection, including through the use of pre-exposure prophylaxis; and (d) rapidly detecting and responding to emerging clusters of HIV infection to prevent transmission. Sub Res. 425, A-09; Modified: CSAPH Rep. 01, A-19; Appended: Res. 413, A-19.

HIV/AIDS Education and Training H-20.904

(1) Public Information and Awareness Campaigns

Our AMA:

a) Supports development and implementation of HIV/AIDS health education programs in the United States by encouraging federal and state governments through policy statements and recommendations to take a stronger leadership role in ensuring interagency cooperation, private sector involvement, and the dispensing of funds based on real and measurable needs. This includes development and implementation of language- and culture-specific education programs and materials to inform minorities of risk behaviors associated with HIV infection.

b) Our AMA urges the communications industry, government officials, and the health care communities together to design and direct efforts for more effective and better targeted public awareness and information programs about HIV disease prevention through various public media, especially for those persons at increased risk of HIV infection;

c) Encourages education of patients and the public about the limited risks of iatrogenic HIV transmission. Such education should include information about the route of transmission, the effectiveness of universal precautions, and the efforts of organized medicine to ensure that patient risk remains immeasurably small. This program should include public and health care worker education as appropriate and methods to manage patient concern about HIV transmission in medical settings. Statements on HIV disease, including efficacy of experimental therapies, should be based only on current scientific and medical studies;

d) Encourages and will assist physicians in providing accurate and current information on the prevention and treatment of HIV infection for their patients and communities;

e) Encourages religious organizations and social service organizations to implement HIV/AIDS education programs for those they serve.

(2) HIV/AIDS Education in Schools

Our AMA:

a) Endorses the education of elementary, secondary, and college students regarding basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies;

b) Supports efforts to obtain adequate funding from local, state, and national sources for the development and implementation of HIV educational programs as part of comprehensive health education in the schools.

(3) Education and Training Initiatives for Practicing Physicians and Other Health Care Workers

Our AMA supports continued efforts to work with other medical organizations, public health officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line health workers (specifically including those in addiction treatment and community health centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies.

CSA Rep. 4, A-03; Appended: Res. 516, A-06; Modified: CSAPH 01, A-16; Reaffirmed: Res. 916, I-16

Reference Committee E

CSAPH Report(s)

04 Pharmacovigilance

Resolution(s)

- 501 Ensuring Continued Access to Equitable Take-Home Methadone Treatment
- 502 Advocating for Heat Exposure Protections for Outdoor Workers
- 503 Marketing Guardrails for the "Over-Medicalization" of Cannabis Use
- 504 Air Pollution and COVID: A Call to Tighten Regulatory Standards
- 505 Representation of Dermatological Pathologies in Varying Skin Tones
- 506 Enhancing Harm Reduction for People Who Use Drugs
- 507# Healthy Air Quality
- 508# Personal Care Products Safety
- 509# Wireless Devices and Cell Tower Health and Safety
- 510# Opposition to Sobriety Requirement for Hepatitis C Treatment

* Contained in the Handbook Addendum

Contained in the Friday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 507
(N-21)

Introduced by: Delaware

Subject: Healthy Air Quality

Referred to: Reference Committee E

1 Whereas, Particulate matter (PM) or particle pollution is a mixture of solid particles and liquid
2 droplets found in the air that come in many sizes and shapes and can be made up of hundreds
3 of different chemicals¹; and
4

5 Whereas, Particulate matter inhaled can get deep into the lungs and even into the
6 bloodstream¹; and
7

8 Whereas, Particles less than 2.5 micrometers in diameter, also known as fine particles or PM
9 2.5, pose the greatest risk to health¹; and
10

11 Whereas, In 2016-2018, more cities had high days of ozone and short-term particle pollution
12 compared to 2015-2017 and many cities measured increased levels of year-round particle
13 pollution²; and
14

15 Whereas, Harmful revisions and setbacks to key protections currently in place or required under
16 the Clean Air Act of 1970 threaten to make air quality even worse in parts of the US²; and
17

18 Whereas, Atmospheric pollutants have been linked to a host of chronic and acute illnesses, and
19 contribute to the risk of COVID-19 complications, with preventable health, social, and economic
20 impacts³⁻⁸; and
21

22 Whereas, Evidence that both prenatal and postnatal exposures to PM 2.5 are associated with
23 later development of allergic rhinitis, a precursor to pediatric asthma, the vulnerable time
24 window may be within late gestation and the first year of life⁸; and
25

26 Whereas, Poor air and water quality disproportionately affect the economically disadvantaged
27 as well as communities of color^{3-5,7-9}; and
28

29 Whereas, Statistics for 2020 show the nation's electricity was generated from 60% of fossil
30 fuels, 20% from nuclear supplies and another 20% from renewable sources¹⁰; and
31

32 Whereas, Current technology is capable of replacing fossil fuel-generated power with renewable
33 sources^{7,11}; and
34

35 Whereas, The Sixth Assessment Report by the Intergovernmental Panel on Climate Change
36 released August 9, 2021, states that stabilizing global warming at 1.5° C, the goal of the Paris
37 Agreement, is achievable if the world acts quickly¹²; and
38

39 Whereas, Congressional action on infrastructure and transportation will have a major impact on
40 whether temperatures can remain at or under the 1.5° warming threshold; therefore be it

1 RESOLVED, That our American Medical Association work with the Office of Climate Change
2 and Health Equity to champion legislation and policies at the federal level in order to drive down
3 the generation of PM 2.5 and other pollutants by:

- 4
- 5 1. Shifting our energy generation away from polluting sources like fossil fuels and toward less
6 polluting renewables; and
 - 7 2. Shifting our agricultural practices away from traditional industrial practices like the use of
8 excessive nitrate fertilizers and toward regenerative practices; and
 - 9 3. Shifting other industries toward proper capture and disposal of waste to minimize the
10 release of fine particulate pollution. (Directive to Take Action)

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

Received: 10/28/21

AUTHORS STATEMENT OF PRIORITY

Air pollution is the leading environmental health risk humans face. The combined effects of outdoor and household air pollution cause around seven million (one in eight) premature deaths every year, largely as a result of increased mortality from stroke, heart disease, lung disease, and cancers.

The annual *Lancet* Countdown on health and climate change provided an assessment concluding the world is not on track to meet the 1.5°C limit on warming, nor the 2015 Paris Agreement limit of below 2°C. The USA is one of five countries that has the greatest greenhouse gas emissions. Climate change is set to become the “defining narrative of human health.”

Research sheds light on the links between air pollution and severe illness from COVID-19. A small increase in long-term average exposure to fine particle pollution is associated with an 11% increase in the COVID-19 death rate. Adding to the evidence on the connection between racial disparities, air pollution, and COVID-19, there is a 49% increase in the COVID-19 death rate in counties with elevated fine particle pollution and that had a higher Black population.

We request that our resolution be considered an urgent priority for the upcoming Interim Meeting. There is support from the Biden Administration to confront the climate crisis, to include protecting the air from harmful pollution. The time is now to make important changes for the health of our patients and put research ahead of politics to make significant, timely changes to save our planet.

References:

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6. Crimmins A, Balbus J, Gamble JL, et al. (2016). The Impacts of Climate Change on Human Health in the United States: A Scientific Assessment. In: *Climate and Health Assessment*. Washington, DC: US Global Change Research Program, 2016. doi: <http://dx.doi.org/10.7930/J0R49NQX>.
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11. In Hawken, P. (2017). Drawdown: The most comprehensive plan ever proposed to reverse global warming.
12. Intergovernmental Panel on Climate Change, 2021: Summary for Policymakers. In: *Climate Change 2021: The Physical Science Basis. Contribution of Working Group I to the Sixth Assessment Report of the Intergovernmental Panel on Climate Change* [Masson-Delmotte, V., P. Zhai, A. Pirani, S. L. Connors, C. Péan, S. Berger, N. Caud, Y. Chen, L. Goldfarb, M. I. Gomis, M. Huang, K. Leitzell, E. Lonnoy, J.B.R. Matthews, T. K. Maycock, T. Waterfield, O. Yelekçi, R. Yu and B. Zhou (eds.)]. Cambridge University Press. In Press.

Preventing Death and Disability Due to Particulate Matter Produced by Automobiles H-135.915

Our AMA will: (1) promote policies at all levels of society and government that educate and encourage policy makers to limit or eliminate disease causing contamination of the environment by gasoline and diesel combustion-powered automobiles, advocating for the development of alternative means for automobile propulsion and public transportation; and (2) support individual states' legal efforts to retain authority to set vehicle tailpipe emission standards that are more stringent than federal standards.

Citation: Res. 915, I-19

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies H-135.921

1. Our AMA will choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption.
2. Our AMA will support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers.

Citation: BOT Rep. 34, A-18

AMA Advocacy for Environmental Sustainability and Climate H-135.923

Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.

Citation: Res. 924, I-16; Reaffirmation: I-19

EPA and Green House Gas Regulation H-135.934

1. Our AMA supports the Environmental Protection Agency's authority to promulgate rules to regulate and control green house gas emissions in the United States.
2. Our AMA: (a) strongly supports evidence-based environmental statutes and regulations intended to regulate air and water pollution and to reduce greenhouse gas emissions; and (b) will advocate that environmental health regulations should only be modified or rescinded with scientific justification.

Citation: Res. 925, I-10; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14;

Appended: Res. 523, A-17

Global Climate Change and Human Health H-135.938

Our AMA:

1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will

create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.

2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.

3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.

4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.

5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.

6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.

Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19

Protective NAAQS Standard for Fine Particulate Matter (PM 2.5) H-135.946

Our AMA supports more stringent air quality standards for particulate matter. We specifically request a NAAQS that provides improved protection for our patients which includes:

- 12 µg/m³ for the average annual standard
- 25 µg/m³ for the 24-hour standard
- 99th percentile used for compliance determination.

Citation: BOT Action in response to referred for decision Res. 720, I-05; Reaffirmed in lieu of Res. 507, A-09; Modified: CSAPH Rep. 01, A-19

Protective NAAQS Standard for Particulate Matter (PM 2.5 & PM 10) D-135.978

At such time as a new EPA Proposed Rule on National Ambient Air Quality Standards for Particulate Matter is published, our AMA will review the proposal and be prepared to offer its support for comments developed by the American Thoracic Society and its sister organizations.

Citation: BOT action in response to referred for decision Res. 926, I-10; Reaffirmed: Res. 915, I-19

Support the Health Based Provisions of the Clean Air Act H-135.950

Our AMA opposes legislation to weaken the existing provisions of the Clean Air Act.

Citation: Res. 417, A-03; Reaffirmation A-05; Reaffirmation I-11; Modified: CSAPH Rep. 1, A-21

Environmental Preservation H-135.972

It is the policy of the AMA to support state society environmental activities by:

- (1) identifying areas of concern and encouraging productive research designed to provide authoritative data regarding health risks of environmental pollutants;
- (2) encouraging continued efforts by the CSAPH to prepare focused environmental studies, where these studies can be decisive in the public consideration of such problems;
- (3) maintaining a global perspective on environmental problems;
- (4) considering preparation of public service announcements or other materials appropriate for public/patient education; and

(5) encouraging state and component societies that have not already done so to create environmental committees.

Citation: Res. 52, A-90; Reaffirmed: Sunset Report, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Clean Air H-135.979

Our AMA supports cooperative efforts with the Administration, Congress, national, state and local medical societies, and other organizations to achieve a comprehensive national policy and program to address the adverse health effects from environmental pollution factors, including air and water pollution, toxic substances, the "greenhouse effect," stratospheric ozone depletion and other contaminants.

Citation: Sub. Res. 43, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed in lieu of Res. 507, A-09; Reaffirmed in lieu of Res. 509, A-09; Reaffirmed: CSAPH Rep. 01, A-19

Stewardship of the Environment H-135.973

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation; (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

Citation: CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16

Global Climate Change - The "Greenhouse Effect" H-135.977

Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting; (2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production; (3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity; (4) encourages research and development programs for improving the utilization

efficiency and reducing the pollution of fossil fuels; and (5) encourages humanitarian measures to limit the burgeoning increase in world population.

Citation: (CSA Rep. E, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 408, A-14)

Federal Clean Air Legislation H-135.984

1. Our AMA urges the enactment of comprehensive clear ambient air legislation which will lessen risks to human health.

2. Our AMA will: (a) oppose legislative or regulatory changes that would allow power plants to avoid complying with new source review requirements to install air pollution control equipment when annual pollution emissions increase; and (b) work with other organizations to promote a public relations campaign, strongly expressing our opposition to EPA's Affordable Clean Energy rule and its proposed amendments of the New Source Review requirements under the Clean Air Act.

Citation: Res. 142, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-07; Reaffirmed in lieu of Res. 507, A-09; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation A-13; Reaffirmation A-14; Appended: Res. 917, I-18

Clean Air H-135.991

(1) The AMA supports setting the national primary and secondary ambient air quality standards at the level necessary to protect the public health. Establishing such standards at the level necessary to protect the public health. Establishing such standards at a level "allowing an adequate margin of safety," as provided in current law, should be maintained, but more scientific research should be conducted on the health effects of the standards currently set by the EPA.

(2) The AMA supports continued protection of certain geographic areas (i.e., those with air quality better than the national standards) from significant quality deterioration by requiring strict, but reasonable, emission limitations for new sources.

(3) The AMA endorses a more effective hazardous pollutant program to allow for efficient control of serious health hazards posed by airborne toxic pollutants.

(4) The AMA believes that more research is needed on the causes and effects of acid rain, and that the procedures to control pollution from another state need to be improved.

(5) The AMA believes that attaining the national ambient air quality standards for nitrogen oxides and carbon monoxide is necessary for the long-term benefit of the public health. Emission limitations for motor vehicles should be supported as a long-term goal until appropriate peer-reviewed scientific data demonstrate that the limitations are not required to protect the public health.

Citation: (BOT Rep. R, A-82; Reaffirmed: CLRPD Rep. A, I-92; Amended: CSA Rep. 8, A-03; Reaffirmation I-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation I-09; Reaffirmation A-14)

Pollution Control and Environmental Health H-135.996

Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in pollution control and improvement of environmental health.

Citation: Sub. Res. 40, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Reducing Sources of Diesel Exhaust D-135.996

Our AMA will: (1) encourage the US Environmental Protection Agency (EPA) to set and enforce the most stringent feasible standards to control pollutant emissions from both large and small non-road engines including construction equipment, farm equipment, boats and trains; (2) encourage all states to continue to pursue opportunities to reduce diesel exhaust pollution, including reducing harmful emissions from glider trucks and existing diesel engines; (3) call for

all trucks traveling within the United States, regardless of country of origin, to be in compliance with the most stringent and current diesel emissions standards promulgated by US EPA; and (4) send a letter to US EPA Administrator opposing the EPA's proposal to roll back the glider Kit Rule which would effectively allow the unlimited sale of re-conditioned diesel truck engines that do not meet current EPA new diesel engine emission standards.

Citation: Res. 428, A-04; Reaffirmed in lieu of Res. 507, A-09; Reaffirmation A-11; Reaffirmation A-14; Modified: Res. 521, A-18

Research into the Environmental Contributors to Disease D-135.997

Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease as a priority public health issue; and (3) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.

Citation: Res. 402, A-03; Appended: Res. 927, I-11; Reaffirmed in lieu of: Res. 505, A-19

AMA Position on Air Pollution H-135.998

Our AMA urges that:

(1) Maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties.

(2) Community control programs should be implemented wherever air pollution produces widespread environmental effects or physiological responses, particularly if these are accompanied by a significant incidence of chronic respiratory diseases in the affected community.

(3) Prevention programs should be implemented in areas where the above conditions can be predicted from population and industrial trends.

(4) Governmental control programs should be implemented primarily at those local, regional, or state levels which have jurisdiction over the respective sources of air pollution and the population and areas immediately affected, and which possess the resources to bring about equitable and effective control.

Citation: BOT Rep. L, A-65; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-14; Reaffirmation A-16; Reaffirmed: BOT Rep. 29, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 508
(N-21)

Introduced by: Pennsylvania

Subject: Personal Care Products Safety

Referred to: Reference Committee E

1 Whereas, The Federal Food, Drug, and Cosmetic (FD&C) Act that is designed to ensure the
2 safety of personal care products, referred to as "cosmetics" – including makeup, fragrance,
3 lotion, toothpaste, body wash, shampoo, deodorant and more – has remained largely
4 unchanged since the law was enacted in 1938;¹ and

5
6 Whereas, FDA can pursue enforcement action against products on the market that are
7 "adulterated" or "misbranded" and against firms or individuals who violate the law,
8 manufacturers are not required to register in the Voluntary Cosmetic Registration Program and
9 FDA estimates that only one-third of firms file cosmetic product ingredient statements;² and

10
11 Whereas, Although companies and individuals who manufacture or market cosmetics have a
12 legal responsibility to ensure the safety of their products, and the Cosmetic Ingredient Review
13 (CIR) Expert Panel that includes dermatologists, pathologists, toxicologists, and chemists set
14 standards for components of cosmetics, there are currently no legal requirements for cosmetic
15 manufacturers who market products to American consumers to test their products for safety;^{1, 3}
16 and

17
18 Whereas, FDA lacks authority to issue mandatory recalls of products based on safety concerns
19 and can only warn consumers about contaminated products; and cosmetic firms are not
20 required to initiate recalls when FDA becomes aware of adulterated or misbranded cosmetic
21 products on the market;² and

22
23 Whereas, Cosmetic firms are not required to provide any safety information to FDA even if
24 requested by FDA during an inspection;² and

25
26 Whereas, States may have more extensive requirements for cosmetic manufacturers,
27 distributors, and packagers than exist federally,⁴ while a nationwide standard would enable
28 more uniform regulatory oversight; and

29
30 Whereas, FDA regulatory oversight authority is limited and FDA faces challenges in identifying
31 and analyzing safety signals due to its lack of reliable and complete serious adverse event report
32 data;² and

33
34 Whereas, Firms are not required to follow FDA draft guidance on good manufacturing practices
35 (GMPs) for cosmetics products;² and

36
37 Whereas, The program for cosmetics at the Center for Food Safety and Applied Nutrition, FDA's
38 lead Center for the regulation of cosmetics, was approximately \$10 million or about three
39 percent of the Center's budget, despite 2,727,847 lines of cosmetics products imported into the

1 United States from 177 countries in FY 2018, an increase of more than one million lines of
2 annual cosmetic imports since one decade prior;² and
3

4 Whereas, Based on different regulatory frameworks, there are few restrictions on materials that
5 a cosmetic manufacturer may use as a cosmetic ingredient without premarket approval from
6 FDA,^{2, 5, 6} where the United States prohibits or restricts 11 types of harmful ingredients from
7 cosmetics, while the European Union has banned or restricted more than 1,300 chemicals⁷
8 often due to absence of safety data rather than data that shows harm;⁸ and
9

10 Whereas, Decisions should be evidence-based; 595 cosmetic manufacturers have reported
11 using 88 chemicals that have been linked to cancer, birth defects or reproductive harm in more
12 than 73,000 products since 2009,^{4, 9} however, FDA has testified that most cosmetics on the
13 market in the United States are safe and in rare cases when safety issues arise many firms
14 work with FDA to address them;² in addition a causative relationship between endocrine
15 disruption and cancer and the concentration of certain ingredients in cosmetic products “has not
16 been proven scientifically;”^{10, 11} and
17

18 Whereas, Chemical use and concentration should be considered; researchers found that
19 permanent hair dye and straighteners were associated with an increased risk for breast cancer
20 ^{12, 13} and formaldehyde found in hair products can expose salon workers to health risks,¹⁴
21 however, parabens and formaldehyde releasers prevent severe infections and complications
22 such as the *Pseudomonas*-induced corneal ulcers from inadequately preserved mascara;^{15, 16}
23 and
24

25 Whereas, FDA confirmed the presence of asbestos in makeup products sold by two different
26 retail stores,^{17, 18, 19, 20} and asbestos exposure is associated with mesothelioma and cancers of
27 the lung, larynx, and ovary; and linked to increased risks of cancers of the stomach, pharynx,
28 and colorectum;²¹ and
29

30 Whereas, FDA discovered elevated lead levels in a bentonite clay product sold online and in
31 retail outlets, and lead poisoning can lead to anemia, weakness, kidney and brain damage, and
32 death; and pregnant women who are exposed to lead will also expose their unborn child, which
33 can cause potentially serious health complications;^{22, 23} and
34

35 Whereas, Restrictions should be evidence based; for example, propyl paraben is used in a wide
36 range of products, a finding of questionable significance in a topically applied personal care
37 product since parabens are poorly absorbed percutaneously, ¹⁰ studies have shown that some
38 parabens injected in very high doses were found to be thousands to millions of times weaker
39 than estradiol in rats and yeast cells,^{11, 24} a study that claimed to find parabens in human breast
40 tumors lacked a control group and parabens were found in blank samples,^{11, 25} and the CIR
41 extensively reviewed the scientific literature on paraben safety and concluded that the parabens
42 as currently used in personal care products in the United States are safe;¹⁰ and
43

44 Whereas, AMA policy H-440.855 supports that FDA should be able to recall cosmetic products
45 that it deems to be harmful and supports creation of a publicly available registry, however, the
46 registry remains voluntary with limited participation by manufacturers; therefore be it

1 RESOLVED, That our American Medical Association advocate that the Food and Drug
2 Administration (FDA) be given the appropriate resources and authority to effectively regulate
3 and enforce standards for personal care products, including being authorized to mandate
4 registration and reporting by manufacturers, conduct appropriate inspections of manufacturing
5 facilities, ensure robust review of product safety, and require adherence with Good
6 Manufacturing Practices while allowing flexibility for small business to comply; and reaffirm
7 support for providing the FDA with sufficient authority to recall cosmetic products that it deems
8 to be harmful. (Directive to Take Action)

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

Received: 11/03/21

AUTHORS STATEMENT OF PRIORITY

Safety concerning products in personal cosmetics sold to American consumers is of utmost importance to both those who use them, and their physicians, who are responsible for the health and safety to some degree of all patients. Federal law designed to make sure laws are safe in this regard have not changed since 1938. Over time, only 11 chemicals identified in American cosmetics have been banned, as opposed to more than 1,300 in Europe. Clearly, we are way behind in providing safe cosmetics for American citizens. The personal care products needing safety scrutiny include hair, lotion, makeup, toothpaste, shampoo, deodorant, body wash and fragrance – all staples of use by millions of people in our country. Known carcinogenic chemicals previously identified in cosmetics include asbestos, hair dye and hair straighteners; lead, propyl paraben and formaldehyde are others with known adverse health effects that have been identified. Clearly, this is a public health hazard of extreme proportions that can be begun to be addressed by introducing new bipartisan legislation that requires the FDA to evaluate a minimum of 5 ingredients found in personal care products sold in the U.S. It behooves the AMA to take the lead in investigating the scope and extent of possible harm and injury of personal care safety products to U.S. consumers, who are all our patients.

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- ² <https://www.fda.gov/news-events/congressional-testimony/building-consumer-confidence-empowering-fda-improve-cosmetic-safety-12042019>
- ³ <https://www.cir-safety.org/about>
- ⁴ <https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/CSCP/Pages/SummaryData.aspx>
- ⁵ <https://www.fda.gov/cosmetics/resources-consumers-cosmetics/cosmetics-safety-qa-prohibited-ingredients>
- ⁶ <https://www.fda.gov/cosmetics/cosmetics-laws-regulations/prohibited-restricted-ingredients-cosmetics>
- ⁷ <https://data.europa.eu/euodp/en/data/dataset/cosmetic-ingredient-database-2-list-of-substances-prohibited-in-cosmetic-products>
- ⁸ <https://echa.europa.eu/regulations/reach/understanding-reach>
- ⁹ <https://www.ewg.org/californiacosmetics/toxic20>
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<https://journals.lww.com/dermatitis/Fulltext/2019/01000/Parabens.2.aspx>
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- ¹² <https://www.nih.gov/news-events/news-releases/permanent-hair-dye-straighteners-may-increase-breast-cancer-risk>
- ¹³ https://onlinelibrary.wiley.com/doi/epdf/10.1002/ijc.32738?referrer_access_token=MRQfKrgWgxxEZpOtD4h2oU4keas67K9QMdWULTWMO8N4v3ZOmabsczOLk9UPFn8NYxbj0kxwBqSFQYWXbtah9oioMvjgU-iBiUuRNVJCjWVTtDbFmTuvyBFS_ieBUN-34oS2SyyJ2V8GiuJcVe0VQ%3D%3D
- ¹⁴ <https://www.osha.gov/SLTC/hairsalons/index.html>
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- ¹⁷ <https://www.fda.gov/food/cfsan-constituent-updates/fda-alerts-consumers-about-cosmetic-products-recalled-due-presence-asbestos>

¹⁸ <https://www.fda.gov/news-events/press-announcements/statement-fda-commissioner-scott-gottlieb-md-and-susan-mayne-phd-director-center-food-safety-and>

¹⁹ <https://www.nytimes.com/2019/03/05/business/claires-cosmetics-asbestos-fda.html>

²⁰ <https://www.fda.gov/media/122413/download>

²¹ <https://www.cancer.gov/about-cancer/causes-prevention/risk/substances/asbestos/asbestos-fact-sheet#what-are-the-health-hazards-of-exposure-to-asbestos>

²² <https://www.cdc.gov/niosh/topics/lead/health.html>

²³ <https://www.cdc.gov/nceh/lead/prevention/health-effects.htm>

²⁴ Routledge EJ, et al. Some Alkyl Hydroxy Benzoate Preservatives (Parabens) Are Estrogenic. *Toxicology and Applied Pharmacology*. 1998 Nov; 153 (1): 12-19. <https://doi.org/10.1006/taap.1998.8544>

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 509
(N-21)

Introduced by: Pennsylvania

Subject: Wireless Devices and Cell Tower Health and Safety

Referred to: Reference Committee E

1 Whereas, Industry propaganda is masking and mitigating the scientific evidence showing
2 concerning biological effect to pulsated microwave and millimeter wave electromagnetic fields
3 (EMF), the type of radiation emitted from all of our wireless devises (cell phones, cell phone
4 towers, WiFi, computers, smart TV, smart meters, bluetooth, etc); and
5

6 Whereas, Most citizens are under the false impression that there are bonafide safety guidelines
7 set forth by the FCC. The safety guidelines, established in 1996 under the leadership of
8 telecommunications lobbyist Tom Wheeler, are ONLY based on an erroneous assumption that
9 microwaves are dangerous when they heat liquids up (so-called "thermal" EMF), much like a
10 microwave oven; and
11

12 Whereas, Now there is overwhelming scientific evidence that non-thermal EMFs can cause
13 significant health effects at levels that are orders of magnitudes lower than those allowed by
14 these FCC guidelines; and
15

16 Whereas, The data shows that fetuses and children are far more vulnerable to these effects, as
17 they have higher surface to volume ratios, high densities of stem cells, a developing brain, and
18 tissue with greater extracellular water leading to deeper penetration effects; and
19

20 Whereas, Based on the 1996 Telecommunications Act, local jurisdictions do not have the right
21 to approve or disapprove the placement of cell tower based on safety or health reasons. In the
22 last two years, Verizon and AT&T have tried twice to convince the PA General Assembly to
23 approve a bill that further preempts municipal rights for managing 5G cell towers in the public
24 rights-of-way; therefore be it
25

26 RESOLVED, That our American Medical Association oppose legislation that blocks the public's
27 right to guard its own safety and health regarding cell tower placement (New HOD Policy); and
28 be it further
29

30 RESOLVED, That our AMA promote ways to reduce radiation exposure from wireless devices,
31 especially for pregnant women and children (wired devices preferable to wireless, shielding,
32 etc.). (Directive to Take Action)

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

Received: 11/03/21

AUTHORS STATEMENT OF PRIORITY

With the pervasiveness of wireless communication in our present-day society, the resolution is concerned with the possible effects of EMF (electromagnetic field) on humans, particularly the more vulnerable such as children and fetuses.

It is felt that the standards for such safety, established in 1996, were biased by lobbyist, and exclusive of other scientific criteria. Furthermore, the telecommunications act of 1996 usurps local jurisdiction on the placement of telecommunication towers.

It is therefore requested that our AMA oppose legislation that may block the public's "access to know" in these matters and foster shielding of EMF effects from wireless devices.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 510
(N-21)

Introduced by: Medical Student Section

Subject: Opposition to Sobriety Requirement for Hepatitis C Treatment

Referred to: Reference Committee E

1 Whereas, The annual incidence rate of Hepatitis C Virus (HCV) infection in the United States
2 has tripled in the last decade and conservative estimates place prevalence at 2.4 million people
3 in the United States¹⁻⁴; and
4

5 Whereas, Under current HCV management protocols, 320,000 patients are projected to die,
6 157,000 to develop hepatocellular carcinoma, and 203,000 to develop decompensated cirrhosis
7 during the next 35 years⁵⁻⁶; and
8

9 Whereas, Morbidity and mortality associated with HCV can be prevented with early diagnosis
10 and treatment using direct acting antivirals (DAAs), which cure over 95% of those with HCV⁷⁻¹⁰;
11 and
12

13 Whereas, Injection drug use is the largest driving factor for HCV spread, leading to
14 approximately 50% of persons who inject drugs (PWID) being infected with HCV relative to 1%
15 of the general population in the United States¹¹⁻¹³; and
16

17 Whereas, In spite of their vulnerability to HCV, PWIDs face larger barriers to accessing
18 treatment, as some Medicaid groups require abstinence from alcohol and substance use for up
19 to six months prior to receiving DAA therapy^{4, 15-16}; and
20

21 Whereas, Those with substance use disorder have the same HCV cure rates as their healthy
22 counterparts and were shown to have high adherence to treatment and low 6 month reinfection
23 rates¹²⁻¹⁴; and
24

25 Whereas, The Social Security Act states that requirements by the States for abstinence “should
26 not result in the denial of access to effective, clinically appropriate, and medically necessary
27 treatments using DAA drugs for beneficiaries with chronic HCV infections”¹⁷⁻²⁰; and
28

29 Whereas, National Viral Hepatitis Roundtable (NVHR) and the Center for Health Law and Policy
30 Innovation (CHLPI) at Harvard Law School report that state laws requiring abstinence greatly
31 limit those who receive Hepatitis C treatment⁴; and
32

33 Whereas, The Centers for Medicare & Medicaid Services (CMS), US Department of Veteran
34 Affairs, and other leading professional associations of Medicaid providers have stated that
35 sobriety restrictions are an unnecessary restriction to care²¹⁻²²; and
36

37 Whereas, In Summer 2019 the State of Louisiana embarked on a journey to eliminate HCV in
38 their Medicaid and Department of Corrections populations from 2019-2024 by partnering with
39 Aseguia Pharmaceuticals to provide the DAA generic Epclusa to this patient population at no
40 cost to the patient²³; and

1 Whereas, To reach this goal, the LA Department of Health (LDH) and Asegua agreed upon a
2 set dollar amount for an unlimited supply of the drug to increase access to this treatment, and
3 the LDH waived prior-authorization restrictions, such as abstaining from drugs, alcohol, and
4 presenting considerable liver damage²³; and
5

6 Whereas, In the court case *JEM v Kinkade* (2:16-cv-04273), the court ruled that Missouri
7 Medicaid's sobriety restrictions violated the Medicaid Act²⁴; and
8

9 Whereas, In *Postawko v Missouri Department of Corrections* No. 17-3029 (8th Cir. 2018),
10 incarcerated plaintiffs argued that sobriety restrictions violated the Eighth Amendment²⁵; and
11

12 Whereas, Furthermore abstinence policies prior to treatment are in contradiction to the
13 *Recommendations for Testing, Managing, and Treating Hepatitis C* published jointly by the
14 American Association for the Study of Liver Diseases (AASLD) and the Infectious Diseases
15 Society of America (IDSA)²⁶; and
16

17 Whereas, Not providing Hepatitis C treatment to those with Substance Use Disorder is
18 discriminatory towards patients with a substance abuse disorder and may violate the Americans
19 with Disabilities Act (ADA), prompting The Center for Health Law and Policy Innovation (CHLPI)
20 of Harvard Law School to recently ask the Department of Justice to investigate this matter¹⁵;
21 and
22

23 Whereas, As of 2020, 26% of state Medicaid programs still impose a sobriety requirement for
24 patients prior to providing life-saving HCV therapy^{21, 27-30}; and
25

26 Whereas, HCV prevalence among people who inject drugs in Australia has been halved (from
27 51% in 2015 to 18% in 2019) primarily by increasing DAA treatment in injection drug users,
28 resulting in an added benefit of decreasing HCV transmission to younger injection drug users³¹;
29 and
30

31 Whereas, Unrestricted HCV treatment in India has proven to be highly cost-effective with cost-
32 savings within 14 years, despite rate of recurrence³²; and
33

34 Whereas, Studies in the U.S. have shown that HCV DAA treatment specifically in PWIDs is a
35 cost-effective strategy to reduce the HCV burden³³; and
36

37 Whereas, Those with HCV are at an increased risk of serious illness from COVID-19 and
38 withholding lifesaving treatment for HCV during the COVID-19 pandemic due to sobriety
39 requirements could increase morbidity and mortality³⁴; and
40

41 Whereas, The AMA advocates for Hepatitis C Virus Education, Prevention, Screening and
42 Treatment (H-440.845), but does not address barriers to treatment such as sobriety
43 requirements; therefore be it

1 RESOLVED, That our American Medical Association amend Policy H-440.845, "Advocacy for
2 Hepatitis C Virus Education, Prevention, Screening and Treatment,, by the addition and deletion
3 to read as follows:

4
5 **Advocacy for Hepatitis C Virus Education, Prevention, Screening**
6 **and Treatment, H-440.845**
7

8 Our AMA will: (1) encourage the adoption of birth year-based screening practices for
9 hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC)
10 recommendations; (2) encourage the CDC, Indian Health Service (IHS) and state
11 Departments of Public Health to develop and coordinate Hepatitis C Virus infection
12 educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention,
13 screening, and treatment programs that are targeted toward maximum public health
14 benefit; (4) advocate, in collaboration with state and specialty medical societies, as well
15 as patient advocacy groups, for the elimination of sobriety requirements, fibrosis
16 restrictions, and prescriber restrictions for coverage of HCV treatment by public and
17 private payors; (54) support programs aimed at training providers in the treatment and
18 management of patients infected with HCV; (65) support adequate funding by, and
19 negotiation for affordable pricing for HCV antiviral treatments between the government,
20 insurance companies, and other third party payers, so that all Americans for whom HCV
21 treatment would have a substantial proven benefit will be able to receive this treatment;
22 (76) recognize correctional physicians, and physicians in other public health settings, as
23 key stakeholders in the development of HCV treatment guidelines; (87) encourage
24 equitable reimbursement for those providing treatment; (9) encourage the allocation of
25 targeted funding to increase HCV treatment for IHS patients insured by plans subject to
26 HCV treatment restrictions. (Modify Current HOD Policy)

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

Received: 11/07/21

AUTHORS STATEMENT OF PRIORITY

The introduction of direct-acting antivirals (DAAs) has dramatically changed the treatment and prognosis of patients with active Hepatitis C virus (HCV) infection. However, many state Medicaid programs continue to deploy non-medically indicated restrictions which limit access to care for low-income patients. While these restrictions were initially created as a cost-saving measure, these restrictions have significant implications for the morbidity and mortality of patients with HCV, perpetuate stigma against individuals with substance use disorders, and exacerbate inequities among American Indian/Alaskan Native patients seeking HCV care. The AMA can and should take stronger action to advocate for comprehensive coverage of DAAs for HCV, so that socioeconomic status, insurance status, and discriminatory benefit design are no longer barriers to the patient-physician relationship and patient-centered decisions to offer HCV treatment. This expansion of policy will ensure that our AMA can fully join other patient and provider advocacy groups in fighting for equitable access to HCV treatment.

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RELEVANT AMA POLICY

Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment H-440.845

Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) support programs aimed at training providers in the treatment and management of patients infected with HCV; (5) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between the government, insurance companies, and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; (6) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines; and (7) encourage equitable reimbursement for those providing treatment. Res. 906, I-12; Modified: Res. 511, A-15; Modified: Res. 410, A-17

Substance Use and Substance Use Disorders H-95.922

Our AMA:

- (1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders;
- (2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and
- (3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.
- CSAPH Rep. 01, A-18; Reaffirmed: BOT Rep. 14, I-20

Federal Drug Policy in the United States H-95.981

The AMA, in an effort to reduce personal and public health risks of drug abuse, urges the formulation of a comprehensive national policy on drug abuse, specifically advising that the federal government and the nation should: (1) acknowledge that federal efforts to address illicit drug use via supply reduction and enforcement have been ineffective (2) expand the availability and reduce the cost of treatment programs for substance use disorders, including addiction; (3) lead a coordinated approach to adolescent drug education; (4) develop community-based prevention programs for youth at risk; (5) continue to fund the Office of National Drug Control Policy to coordinate federal drug policy; (6) extend greater protection against discrimination in the employment and provision of services to drug abusers; (7) make a long-term commitment to expanded research and data collection; (8) broaden the focus of national and local policy from drug abuse to substance abuse; and (9) recognize the complexity of the problem of substance abuse and oppose drug legalization.

BOT Rep. NNN, A-88; Reaffirmed: CLRPD 1, I-98 ;Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 2, I-13; Reaffirmed: BOT Rep. 14, I-20

Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of Incarcerated Persons H-430.985

Our AMA: (1) supports the implementation of routine screening for Hepatitis C virus (HCV) in prisons; (2) will advocate for the initiation of treatment for HCV when determined to be appropriate by the treating physician in incarcerated patients with the infection who are seeking treatment; and (3) supports negotiation for affordable pricing for therapies to treat and cure HCV among correctional facility health care providers, correctional facility health care payors, and drug companies to maximize access to these disease-altering medications.

Res. 404, A-17

Reference Committee F

BOT Report(s)

- 18 Financial Protections for Doctors in Training
- 19 Advocacy for Physicians with Disabilities

CLRPD Report(s)

- 01 Minority Affairs Section Five-Year Review
- 02 Integrated Physician Practice Section - Five-Year Review

HOD Comm on Compensation of the Officers

- 01 Report of the House of Delegates Committee on the Compensation of the Officers

Resolution(s)

- 601 "Virtual Water Cooler" for our AMA
- 602 Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings
- 603 Abolishment of the Resolution Committee
- 604 The Critical Role of Physicians in the COVID-19 Pandemic
- 605 Formalization of the Resolution Committee as a Standing Committee of the American Medical Association House of Delegates
- 606 Increasing the Effectiveness of Online Reference Committee Testimony
- 607 AMA Urges Health and Life Insurers to Divest From Investments in Fossil Fuels
- 608 Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis
- 609 Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Emergency
- 610 Creation of Employed Physician Section
- 611* September 11th as a National Holiday
- 612* UN International Radionuclide Therapy Day Recognition
- 613* Due Process at our AMA
- 614* Insurance Industry Behaviors
- 615* Employed Physicians
- 616* Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology System
- 617* Together We are Stronger Marketing Campaign
- 618# Dissolution of the Resolution Committee
- 619# Continuing Equity Education

* Contained in the Handbook Addendum

Contained in the Friday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 618
(N-21)

Introduced by: Resident and Fellow Section

Subject: Dissolution of the Resolution Committee

Referred to: Reference Committee F

1 Whereas, One of the central tenets of parliamentary procedure, including the parliamentary
2 authority of the AMA, The American Institute of Parliamentarians Standard Code of
3 Parliamentary Procedure (B-11.1, G-600.054), is to protect the rights of minority viewpoints¹;
4 and

5
6 Whereas, Robust, “actualized” democracies, defined as “the ideal in which all citizens share full,
7 informed, equal participation in decision making,” have been touted as superior forms of
8 government with the best potential for freedom of expression and action, protection of human
9 rights, and transparent and responsive governance²⁻⁶; and

10
11 Whereas, A 2019 study published in *The Lancet* found that “when enforced by free and fair
12 elections, democracies are more likely than autocracies to lead to health gains for causes of
13 mortality (i.e., cardiovascular diseases and transport injuries) that have not been heavily
14 targeted by foreign aid and require health-care delivery”⁷; and

15
16 Whereas, The United Nations recognizes the value of democracy and “promotes democratic
17 governance as a set of values and principles that should be followed for greater participation,
18 equality, security and human development”⁸; and

19
20 Whereas, At the Annual 2002 House of Delegates, Board of Trustees Report 23 was adopted,
21 which included a recommendation establishing a Resolution Committee “to ensure that the
22 emphasis of the Interim Meeting is placed on advocacy and legislation”⁹; and

23
24 Whereas, At the Annual 2003 House of Delegates, Council on Constitution and Bylaws Report 2
25 was adopted, which codified the establishment of the Interim Meeting focus as currently
26 reflected in B-2.13.3; and

27
28 Whereas, The number of resolutions not considered based on Resolutions Committee
29 recommendations for the past eight Interim Meetings has never exceeded 10 (2 at the Interim
30 2019 House of Delegates, 8 at the Interim 2018 House of Delegates, 4 at the Interim 2017
31 House of Delegates, 3 at the Interim 2016 House of Delegates, 9 at the Interim 2015 House of
32 Delegates, 8 at the Interim 2014 House of Delegates, 10 at the Interim 2013 House of
33 Delegates, and 9 at the Interim 2012 House of Delegates)¹¹, indicating that it has not been
34 substantively constraining the business of the House of Delegates; and

35
36 Whereas, In reflecting upon the formation of the Resolution Committee, the Report of the
37 Executive Vice President at the Interim 2002 House of Delegates noted that “while I appreciate
38 the need to streamline, I strongly believe that everything the AMA does is advocacy,” and
39 elaborated that “this includes activities you might not initially view as advocacy, like the public
40 stances we take on issues of public health and science”¹²; and

Whereas, AMA policy G-600.060, "Introducing Business to the AMA House", reaffirms the AMA's commitment to democracy and directs the AMA to "continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates"; and

Whereas, AMA policy G-640.020, "Political Action Committees and Contributions", "opposes legislative initiatives that improperly limit individual and collective participation in the democratic process"; and

Whereas, The AMA Bylaws dictate that "Reports, recommendations, resolutions, or other new business presented prior to the recess of the opening session of the House of Delegates shall be referred to an appropriate reference committee for hearings and report, subject to acceptance as business of the House of Delegates" (B-2.11.4), to allow for full consideration of each item; therefore be it

RESOLVED, That our American Medical Association remove the Interim Meeting focus requirement by amending the AMA Bylaws B-2.12.1.1 "Business of Interim Meeting," as follows by deletion:

~~2.12.1.1 Business of Interim Meeting.~~

~~The business of an Interim Meeting shall be focused on advocacy and legislation. Resolutions pertaining to ethics, and opinions and reports of the Council on Ethical and Judicial Affairs, may also be considered at an Interim Meeting. Other business requiring action prior to the following Annual Meeting may also be considered at an Interim Meeting. In addition, any other business may be considered at an Interim Meeting by majority vote of delegates present and voting; and be it further~~

RESOLVED, That our AMA dissolve the Resolution Committee by amending the AMA Bylaws B-2.13.3, "Resolution Committee," as follows by deletion:

~~Resolution Committee. B-2.13.3~~

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

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

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

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

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

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

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

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

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

Received: 11/06/21

AUTHORS STATEMENT OF PRIORITY

Currently accepted business for the House of Delegates includes a resolution about making the Resolution Committee permanent. Our resolution regarding the opposing stance on the exact same priority subject will not necessarily be part of that conversation or vote, and should receive a separate hearing during this meeting. By limiting the business heard at each meeting to an unprecedented extent, the democratic process of the HOD has been undermined and numerous relevant and time-sensitive resolutions have not been heard while many reaffirmations have occurred. This directly harms efforts to improve priority issues of trainees and physicians in general, shown by the acceptance of zero RFS resolutions by the Resolution Committee for this meeting. If a single resolution from the RFS is accepted for business during this meeting, we request that it be this one.

1. American Institute of Parliamentarians. *American Institute of Parliamentarians Standard Code of Parliamentary Procedure*. New York, New York: McGraw-Hill; 2012.
2. Moghaddam FM. *The Psychology of Democracy*. Washington, DC: American Psychological Association; 2016.
3. Mandel DR. Threats to Democracy: A Judgment and Decision-Making Perspective. *Analyses of Social Issues and Public Policy*. 2005;5(1):209-222. doi:10.1111/j.1530-2415.2005.00067.x
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10. Council on Constitution and Bylaws Report 2, American Medical Association Annual 2003 House of Delegates. <https://ama.nmtvault.com/jsp/browse.jsp>. Accessed March 18, 2021.
11. American Medical Association Archives. <https://ama.nmtvault.com/jsp/browse.jsp>. Accessed March 18, 2021.
12. Report of the Executive Vice President, American Medical Association Interim 2002 House of Delegates. <https://ama.nmtvault.com/jsp/browse.jsp>. Accessed March 18, 2021.

Resolution Committee. B-2.13.3

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

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

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

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

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

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

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

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

Parliamentary Procedure. B-11.1

In the absence of any provisions to the contrary in the Constitution and these Bylaws, all general meetings of the AMA and all meetings of the House of Delegates, of the Board of Trustees, of Sections and of councils and committees shall be governed by the parliamentary rules and usages contained in the then current edition of The American Institute of Parliamentarians Standard Code of Parliamentary Procedure.

Procedures of the House of Delegates G-600.054

1. Our AMA reaffirms The American Institute of Parliamentarians Standard Code of Parliamentary Procedure as our parliamentary authority, including the use of the motion to table and the motion to adopt in-lieu-of, and treat amendments by substitution as first-order amendments.
2. The rules and procedures of the House of Delegates will be amended as follows:
 - A. The motion to table a report or resolution that has not yet been referred to a reference committee is not permitted and will be ruled out of order.
 - B. A new motion is added to the House of Delegates Reference Manual, Object to Consideration. If a Delegate objects to consideration of an item of business by our HOD, the correct motion is to Object to Consideration. The motion cannot interrupt a speaker, requires a second, cannot be amended, takes precedence over all subsidiary motions and cannot be renewed. The motion requires a 3/4 vote for passage. Debate is restricted to why the item should not be considered.
3. The procedures of our House of Delegates distinguish between a motion to refer, which is equivalent to a motion to refer for report, and a motion to refer for decision and that the motion to refer for decision be one step higher in precedence.
4. The procedures of our House of Delegates specify that both sides must have been heard before a motion to close debate is in order and that absent an express reference to "all pending matters" the motion applies only to the matter under debate.
5. The procedures of our House of Delegates clarify that adjournment of any House of Delegates meeting finalizes all matters considered at that meeting, meaning that items from one meeting are not subject to a motion to recall from committee, a motion to reconsider or any other motion at a succeeding meeting.
6. The Council on Constitution and Bylaws, in consultation with the speakers, will review the House of Delegates Reference Manual and revise it accordingly. [Report of the Speakers: Rep. 02, A-16; Modified: CCB Rep. 01, A-17]

Introducing Business to the AMA House G-600.060

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

1. Delegates submitting resolutions have a responsibility to review the Resolution checklist and verify that the resolution is in compliance. The Resolution checklist shall be distributed to all delegates and organizations in the HOD prior to each meeting, as well as be posted on the HOD website.
2. An Information Statement can be used to bring an issue to the awareness of the HOD or the public, draw attention to existing policy for purposes of emphasis, or simply make a statement. Such items will be included in the section of the HOD Handbook for informational items and include appropriate attribution but will not go through the reference committee process, be voted on in the HOD or be incorporated into the Proceedings. If an information statement is extracted, however, it will be managed by the Speaker in an appropriate manner, which may include a simple editorial correction up to and including withdrawal of the information statement.

3. Required information on the budget will be provided to the HOD at a time and format more relevant to the AMA budget process.
4. At the time the resolution is submitted, delegates introducing an item of business for consideration of the House of Delegates must declare any commercial or financial conflict of interest they have as individuals and any such conflict of interest must be noted on the resolution at the time of its distribution.
5. The submission of resolutions calling for similar action to what is already existing AMA policy is discouraged. Organizations represented in the House of Delegates are responsible to search for alternative ways to obtain AMA action on established AMA policy, especially by communicating with the Executive Vice President. The EVP will submit a report to the House detailing the items of business received from organizations represented in the House which he or she considers significant or when requested to do so by the organization, and the actions taken in response to such contacts.
6. Our AMA will continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates.
7. Our AMA encourages organizations and Sections of the House of Delegates to exercise restraint in submitting items on the day preceding the opening of the House.
8. Resolutions will be placed on the Reaffirmation Consent Calendar when they are identical or substantially identical to existing AMA policy. For resolutions placed on the Reaffirmation Consent Calendar, the pertinent existing policy will be clearly identified by reference to the Policy Database identification number. When practical, the Reaffirmation Consent Calendar should also include a listing of the actions that have been taken on the current AMA policies that are equivalent to the resolutions listed. For resolutions on the Reaffirmation Consent Calendar which are not extracted, the existing, pertinent AMA policy will be deemed to be reaffirmed in lieu of the submitted resolution which resets the sunset clock for ten years.
9. Updates on referred resolutions are included in the chart entitled "Implementation of Resolutions," which is made available to the House. [Sub. Res. 120, A-84; BOT Rep. D and CLRPD Rep. C, I-91; CLRPD Rep. 3 - I-94; CLRPD Rep. 5, I-95; Res. 614, and Special Advisory Committee to the Speaker of the House of Delegates, I-99; Res. 604, I-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CLRPD Rep. 2, A-03; Reaffirmed: BOT Rep. 19, A-04; CC&B Rep. 3, I-08; Modified: CCB/CLRPD Rep. 1, A-12]

Meetings of the House of Delegates. B-2.12

- 2.12.1 Regular Meetings of the House of Delegates. The House of Delegates shall meet twice annually, at an Annual Meeting and an Interim Meeting.
 - 2.12.1.1 Business of Interim Meeting. The business of an Interim Meeting shall be focused on advocacy and legislation. Resolutions pertaining to ethics, and opinions and reports of the Council on Ethical and Judicial Affairs, may also be considered at an Interim Meeting. Other business requiring action prior to the following Annual Meeting may also be considered at an Interim Meeting. In addition, any other business may be considered at an Interim Meeting by majority vote of delegates present and voting.
 - 2.12.2 Special Meetings of the House of Delegates. Special Meetings of the House of Delegates shall be called by the Speaker on written or electronic request by one-third of the members of the House of Delegates, or on request of a majority of the Board of Trustees. When a special meeting is called, the Executive Vice President of the AMA shall mail a notice to the last known address of each member of the House of Delegates at least 20 days before the special meeting is to be held. The notice shall specify the time and place of meeting and the purpose for which it is called, and the House of Delegates shall consider no business except that for which the meeting is called.
 - 2.12.3 Locations. The House of Delegates shall meet in cities selected by the Board of Trustees.

2.12.3.1 Invitation from Constituent Association. A constituent association desiring a meeting within its borders shall submit an invitation in writing, together with significant data, to the Board of Trustees. The dates and the city selected may be changed by action of the Board of Trustees at any time, but not later than 60 days prior to the dates selected for that meeting.

2.12.4 Meetings.

2.12.4.1 Open. The House of Delegates may meet in an open meeting to which any person may be admitted. By majority vote of delegates present and voting, an open meeting may be moved into either a closed or an executive meeting.

2.12.4.2 Closed. A closed meeting shall be restricted to members of the AMA, and to employees of the AMA and of organizations represented in the House of Delegates.

2.12.4.3 Executive. An executive meeting shall be limited to the members of the House of Delegates and to such employees of the AMA necessary for its functioning.

Political Action Committees and Contributions G-640.020

Our AMA: (1) Believes that better-informed and more active citizens will result in better legislators, better government, and better health care;

(2) Encourages AMA members to participate personally in the campaign of their choice and strongly supports physician/family leadership in the campaign process;

(3) Opposes legislative initiatives that improperly limit individual and collective participation in the democratic process;

(4) Supports AMPAC's policy to adhere to a no Rigid Litmus Test policy in its assessment and support of political candidates;

(5) Encourages AMPAC to continue to consider the legislative agenda of our AMA and the recommendations of state medical PACs in its decisions;

(6) Urges members of the House to reaffirm their commitment to the growth of AMPAC and the state medical PACs;

(7) Will continue to work through its constituent societies to achieve a 100 percent rate of contribution to AMPAC by members; and

(8) Calls upon all candidates for public office to refuse contributions from tobacco companies and their subsidiaries. [BOT Rep. II and Res. 119, I-83; Res. 175, A-88; Reaffirmed: Sunset Report, I-98; Sub. Res. 610, A-99; Res. 610, I-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CC&B Rep. 2, A-11]

Guiding Principles for House Elections G-610.021

The following principles provide guidance on how House elections should be conducted and how the selection of AMA leaders should occur:

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

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

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

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

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

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

[CLRPD Rep. 4, I-01; Reaffirmed: CC&B Rep. 2, A-11]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 619
(N-21)

Introduced by: Minority Affairs Section

Subject: Continuing Equity Education

Referred to: Reference Committee F

Whereas, The AMA has recently taken significant steps to achieve optimal health for all in the areas of scholarship, research, philanthropy, advocacy, healthcare delivery, and practice through the adoption and implementation of policies, processes, and programs that center equity, such as the founding of the AMA Center for Health Equity and adoption of several racial justice and equity-oriented policies by the House of Delegates¹; and

Whereas, In May 2021, the Center for Health Equity released its three-year organizational strategic action plan to embed racial justice and advance health equity within the AMA and across medicine, and has since taken the initial steps to operationalize this mission, including the collaborative release of *Advancing Health Equity: A Guide to Language, Narrative and Concepts* to provide a shared framework for the discussion of health equity issues²⁻⁴; and

Whereas, In response to member requests to expand and deepen their understanding of health equity and racial justice, the AMA Board of Trustees and Speakers arranged for the convening of an Open Forum on Health Equity during the November 2021 Special Meeting of the House of Delegates to facilitate additional opportunities for education and discussion among membership^{5,6}; therefore be it

RESOLVED, That our American Medical Association establish an Open Forum on Health Equity, to be held annually at a House of Delegates Meeting, for members to directly engage in educational discourse and strengthen organizational capacity to advance and operationalize equity. (Directive to Take Action)

Fiscal Note: Estimated cost to implement resolution is \$50,000 annually.

Received: 11/07/21

AUTHORS STATEMENT OF PRIORITY

Establishing an annual Health Equity Forum is an actionable directive that expands upon and supports ongoing initiatives to advance health equity while presenting a unique opportunity to promote capacity building and member-driven transformation from within and across the AMA.

To guide our AMA's transformational work, we must recognize we "all have a role in disrupting and dismantling systems that produce harm as well as find ways to reimagine and rebuild these systems to ensure justice, compassion, and equitable care." Members can further do their "part by gaining knowledge and learning skills to advance equity across the health system," as suggested in our Speakers' Letter.

Prioritizing equity starts with us!

References:

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2. American Medical Association. AMA releases plan dedicated to embedding racial justice and advancing health equity. Published May 11, 2021. Accessed November 1, 2021. <https://www.ama-assn.org/press-center/press-releases/ama-releases-plan-dedicated-embedding-racial-justice-and-advancing>
3. American Medical Association. Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity. Published May 11, 2021. Accessed November 1, 2021. <https://www.ama-assn.org/system/files/2021-05/ama-equity-strategic-plan.pdf>
4. Association of American Medical Colleges. American Medical Association. Advancing Health Equity: A Guide to Language, Narrative, and Concepts. Published October 28, 2021. Accessed November 1, 2021. <https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf>
5. Kridel, R. A Communication from the Board Chair. *American Medical Association*. June 1, 2021.
6. Scott, B. Egbert, L. Speakers' Letter Special Meeting of the AMA House of Delegates November 12-16, 2021. American Medical Association. October 12, 2021.

RELEVANT AMA POLICY**Plan for Continued Progress Toward Health Equity D-180.981**

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

Citation: BOT Rep. 33, A-18

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA 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.

Citation: Res. 5, I-20

Racial Essentialism in Medicine D-350.981

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.

Citation: Res. 10, I-20

Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice H-65.953

1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.

2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.

3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category “race” can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.

4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.

Citation: Res. 11, I-20

Racial and Ethnic Disparities in Health Care H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

2. The AMA emphasizes three approaches that it believes should be given high priority:

A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

3. Our AMA encourages the development of evidence-based performance measures that

adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

Citation: CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21

Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions H-65.951

Our AMA adopted the following guidelines for healthcare organizations and systems, including academic medical centers, to establish policies and an organizational culture to prevent and address systemic racism, explicit and implicit bias and microaggressions in the practice of medicine:

GUIDELINES TO PREVENT AND ADDRESS SYSTEMIC RACISM, EXPLICIT BIAS AND MICROAGGRESSIONS IN THE PRACTICE OF MEDICINE

Health care organizations and systems, including academic medical centers, should establish policies to prevent and address discrimination including systemic racism, explicit and implicit bias and microaggressions in their workplaces.

An effective healthcare anti-discrimination policy should:

- Clearly define discrimination, systemic racism, explicit and implicit bias and microaggressions in the healthcare setting.
- Ensure the policy is prominently displayed and easily accessible.
- Describe the management's commitment to providing a safe and healthy environment that actively seeks to prevent and address systemic racism, explicit and implicit bias and microaggressions.
- Establish training requirements for systemic racism, explicit and implicit bias, and microaggressions for all members of the healthcare system.
- Prioritize safety in both reporting and corrective actions as they relate to discrimination, systemic racism, explicit and implicit bias and microaggressions.
- Create anti-discrimination policies that:
 - Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.).
 - Define expected and prohibited behavior.
 - Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and implicit bias and microaggressions.
 - Ensure privacy and confidentiality to the reporter.
 - Provide a confidential method for documenting and reporting incidents.
 - Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action.
- These policies should include:
 - Taking every complaint seriously.
 - Acting upon every complaint immediately.
 - Developing appropriate resources to resolve complaints.
 - Creating a procedure to ensure a healthy work environment is maintained for complainants

and prohibit and penalize retaliation for reporting.

- Communicating decisions and actions taken by the organization following a complaint to all affected parties.

- Document training requirements to all the members of the healthcare system and establish clear expectations about the training objectives.

In addition to formal policies, organizations should promote a culture in which discrimination, including systemic racism, explicit and implicit bias and microaggressions are mitigated and prevented. Organized medical staff leaders should work with all stakeholders to ensure safe, discrimination-free work environments within their institutions.

Tactics to help create this type of organizational culture include:

- Surveying staff, trainees and medical students, anonymously and confidentially to assess:
 - Perceptions of the workplace culture and prevalence of discrimination, systemic racism, explicit and implicit bias and microaggressions.
 - Ideas about the impact of this behavior on themselves and patients.
- Integrating lessons learned from surveys into programs and policies.
- Encouraging safe, open discussions for staff and students to talk freely about problems and/or encounters with behavior that may constitute discrimination, including racism, bias or microaggressions.
- Establishing programs for staff, faculty, trainees and students, such as Employee Assistance Programs, Faculty Assistance Programs, and Student Assistance Programs, that provide a place to confidentially address personal experiences of discrimination, systemic racism, explicit or implicit bias or microaggressions.
- Providing designated support person to confidentially accompany the person reporting an event through the process.

Citation: Res. 003, A-21

Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984

Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.

Citation: BOT Action in response to referred for decision Res. 602, I-15

Underrepresented Student Access to US Medical Schools H-350.960

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students; (3) recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; and (5) recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations.

Citation: Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15; Appended: CME Rep. 5, A-21

Promising Practices Among Pathway Programs to Increase Diversity in Medicine D-350.980

Our AMA will establish a task force to guide organizational transformation within and beyond the AMA toward restorative justice to promote truth, reconciliation, and healing in medicine and medical education.

Citation: CME Rep. 5, A-21

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

Citation: CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21

Training Physicians and Physicians-in-Training in the Art of Public Speaking H-445.984

1. Physicians who want to learn more about public speaking can leverage existing resources both within and outside the AMA. AMA can make public speaking tips available through online tools and resources that would be publicized on our website. Physicians and physicians-in-training who want to publicly communicate about the AMA's ongoing work are invited to learn more through the AMA Ambassador program.

Meanwhile, STEPS Forward provides helpful tips to physicians and physicians-in-training wanting to improve communication within their practice and AMPAC is available for physicians and physicians-in-training who want to advocate and communicate about the needs of patients, physicians, and physicians-in-training in the pursuit of public office. There are also resources provided to physicians and physicians-in-training at various Federation organizations and through the American Association of Physician Leadership (AAPL) to support those who are interested in training of this nature.

Because public speaking is a skill that is best learned through practice and coaching in a small group or one-on-one setting, we also encourage individuals to pursue training through their state or specialty medical society or through a local chapter of Toastmasters International.

The Board of Trustees recommends that the AMA's Enterprise Communications and Marketing department work to develop online tools and resources that would be published on the AMA website to help physicians and physicians-in-training learn more about public speaking.

2. Our AMA will offer live education sessions at least annually for AMA members to develop their public speaking skills.

Citation: BOT Rep. 10, I-18

Activities of the Council on Legislation G-615.071

1. Our AMA Council on Legislation (COL) will continue to convene forums at AMA meetings to provide members of the Federation an opportunity to hear about and discuss major and emerging legislative and regulatory issues important to physicians and patients.

2. The COL will be represented at AMA-convened meetings focused on advocacy, such as the State Legislative Strategy Conference and National Advocacy Conference.

3. COL members will actively represent, at the discretion of the Chair of the Board of Trustees, our AMA before state and federal government committees and agencies.

Citation: (BOT Rep. 12, A-07; Reaffirmed: BOT Rep. 4, I-10; Modified: CCB/CLRPD Rep. 3, A-12)

Reference Committee G

CMS Report(s)

- 02 Access to Health Plan Information Regarding Lower-Cost Prescription Options
- 04 Financing of Home and Community-Based Services

Joint Report(s)

- 01 CMS/CSAPH Joint Report - Reducing Inequities and Improving Access to Insurance for Maternal Health Care

Resolution(s)

- 701 Coverage of Pregnancy-Associated Healthcare for 12 Months Postpartum for Uninsured Patients who are Ineligible for Medicaid
- 702 System Wide Prior and Post-Authorization Delays and Effects on Patient Care Access
- 703 Clear Statement Regarding the Use of CPT E/M Outpatient Visit Codes
- 704 Expanding the AMA's Study on the Economic Impact of COVID-19
- 705 Advocating for Program Stability in the Merit-Based Incentive Payment System
- 706 Support for State Medical Record Retention Laws
- 707* Fifteen Month Lab Standing Orders
- 708* Insurance Coverage for Scalp Cooling (Cold Cap) Therapy
- 709* Prior Authorization - CPT Codes for Fair Compensation
- 710* Physician Burnout is an OSHA Issue
- 711# Hospital System Consolidation
- 712# Advocacy of Private Practice Options for Health Care Operations in Large Corporations

* Contained in the Handbook Addendum

Contained in the Friday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 711
(N-21)

Introduced by: Private Practice Physician Section

Subject: Health System Consolidation

Referred to: Reference Committee G

Whereas, The COVID-19 pandemic resulted in unprecedented human suffering on a scale unbeknownst to modern society since the 1918 Flu Pandemic with over 700,000 Americans dead nationwide while physicians suffered moral injury, burnout, exhaustion, and depression due to a lack of preparedness; and

Whereas, The healthcare delivery system faced massive operational challenges¹, stimulating policymakers to re-examine care delivery markets, including the harms of health system consolidation and mergers²; and

Whereas, In a large part because of mergers, the majority of Americans now live in highly concentrated health care delivery markets³, including both hospital systems and health systems, the latter comprised of both outpatient practice chains, hospitals, and other healthcare service markets; and

Whereas, The harms of healthcare delivery consolidation and mergers are significant and directly negatively affect patients. Specific harms are numerous and well-documented⁴, including a lack of quality benefits and decrements in patient experience⁵, higher hospital prices⁶, decreasing patient access and driving rising health insurance premiums, both of which harm patients; and

Whereas, Increasing consolidation of physicians into health systems^{7,8} decreases physician control over medical practice, hampers independent practice and choices over how and where

¹ Ramachandran, S., et al; "Coronavirus cases strain New York City hospitals: 'We're getting pounded'"; The Wall Street Journal; May 20, 2020. <https://www.wsj.com/articles/coronavirus-cases-strain-new-york-city-hospitals-were-getting-pounded-11584719908> Accessed 10/17/21

² United States Senate Committee on the Judiciary; "Antitrust applied: Hospital consolidation concerns and solutions"; May 19, 2021. <https://www.judiciary.senate.gov/meetings/antitrust-applied-hospital-consolidation-concerns-and-solutions>. Accessed 10/17/21

³ Health Care Cost Institute; "Hospital concentration index: An analysis of U.S. hospital market consolidation"; <https://healthcostinstitute.org/hcci-origins/hmi-interactive#HMI-Concentration-Index> Accessed 10/17/21

⁴ Schwartz, K., et al; "What we know about provider consolidation"; Kaiser Family Foundation; Sep 2, 2020. <https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/> Accessed 10/17/21

⁵ Beaulieu, N., et al; (2020); "Changes in quality of care after hospital mergers and acquisitions"; The New England Journal of Medicine; 382: 51-59. <https://www.nejm.org/doi/full/10.1056/NEJMsa1901383> Accessed 10/17/21

⁶ Gaynor, M. & Town, R.; "The impact of hospital consolidation"; Robert Wood Johnson Foundation; June 1, 2012; <https://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html> Accessed 10/17/21

⁷ Furukawa, M., et al; (2020); "Consolidation of providers in health systems increased substantially, 210-18"; Health Affairs; 39, 8. <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.00017> Accessed 10/17/21

⁸ Giber, K., et al; "Physician employment: The path forward in the COVID-19 era"; McKinsey & Company; July, 2020; <https://www.mckinsey.com/~media/McKinsey/Industries/Healthcare%20Systems%20and%20Services/Our%20Insights/Physician%20employment%20The%20path%20forward%20in%20the%20COVID%2019%20era/physician-employment-the-path-forward-in-the-covid-19-era.pdf?shouldIndex=false> Accessed 10/17/21

1 physicians practice medicine⁹, and places corporations at the center of the patient-physician
2 relationship, thus driving burnout due to a loss of control over the public environment¹⁰; and
3

4 Whereas, Systemic harms of health system and hospital consolidation are more insidious and
5 long-term, including a loss of innovation in care delivery and productivity as manifested by over
6 twenty years of absent labor productivity growth, a finding unparalleled by other industries¹¹;
7 and
8

9 Whereas, Health care delivery consolidation is a bipartisan problem, acknowledged by both
10 Democrats¹² and Republicans¹³; and
11

12 Whereas, The AMA is a national leader in addressing consolidation in healthcare and binging
13 the patient voice to these conversations with its "Competition in health insurance: A
14 comprehensive study of U.S. Markets" now in its twentieth year¹⁴. The AMA successfully used
15 this study in 2016 to conduct further analyses to assist the U.S. Department of Justice and
16 National Association of Attorneys General to successfully challenge the Anthem-Cigna and
17 Aetna-Humana mergers¹⁵; therefore be it
18

19 RESOLVED, That our American Medical Association undertake an annual report assessing
20 nationwide health system and hospital consolidation in order to assist policymakers and the
21 federal government in assessing healthcare consolidation for the benefit of patients and
22 physicians who face an existential threat from healthcare consolidation. (Directive to Take
23 Action)

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

Received: 11/07/21

AUTHORS STATEMENT OF PRIORITY

Health system consolidation continues at a rapid pace and lack of competition has adversely affected patient access to care especially in rural areas and increased physician burnout. Health system consolidation has also contributed to the rapid closure and acquisition of independent practices to private equity and health systems. We need more data and analysis of health system consolidation as soon as possible to assist policymakers to prevent the many detrimental effects consolidation has had on our patients and profession.

⁹ Kane, C.; "Recent changes in physician practice relationships: Private practice dropped to less than 50 percent of physicians in 2020"; American Medical Association; May, 2021; <https://www.ama-assn.org/system/files/2021-05/2020-prp-physician-practice-arrangements.pdf> Accessed 10/17/21

¹⁰ National Academies of Sciences, Engineering, and Medicine; 2019; *Taking action against clinician burnout: A systems approach to professional well-being*; Washington, DC: The National Academies Press. <https://www.ncbi.nlm.nih.gov/books/NBK552615/> Accessed 10/17/21

¹¹ Kocher, R. & Sahni, N.R.; (2011) "Rethinking health care labor"; The New England Journal of Medicine; 365: 1370-1372. <https://www.nejm.org/doi/full/10.1056/nejmp1109649> Accessed 10/17/21

¹² Gee, E. & Gurwitz, E.; "Provider consolidation drives up health care costs"; Center for American Progress; Dec 5, 2018. <https://www.americanprogress.org/issues/healthcare/reports/2018/12/05/461780/provider-consolidation-drives-health-care-costs/> Accessed 10/17/21

¹³ Miller, T.P.; "More consolidation and more 'political' competition, less patient-centered market competition"; American Enterprise Institute; Sep 19, 2013. <https://www.aei.org/research-products/testimony/more-consolidation-and-more-political-competition-less-patient-centered-market-competition/> Accessed 10/17/21

¹⁴ American Medical Association Division of Economic and Health Policy Research; (2021); "Competition in health insurance: A comprehensive study of U.S. Markets – 2021 update"; American Medical Association. <https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf> Accessed 10/17/21

¹⁵ American Medical Association; "Ensuring health insurance competition"; American Medical Association; <https://www.ama-assn.org/delivering-care/patient-support-advocacy/ensuring-health-insurance-competition> Accessed 10/17/21

RELEVANT AMA POLICY

Hospital Consolidation H-215.960

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

Citation: CMS Rep. 07, A-19

Health Care Entity Consolidation D-383.980

Our AMA will (1) study the potential effects of monopolistic activity by health care entities that may have a majority of market share in a region on the patient-doctor relationship; and (2) develop an action plan for legislative and regulatory advocacy to achieve more vigorous application of antitrust laws to protect physician practices which are confronted with potentially monopolistic activity by health care entities.

Citation: BOT Rep. 8, I-15

Hospital Merger Study H-215.969

1 It is the policy of the AMA that, in the event of a hospital merger, acquisition, consolidation, or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues:

- (A) medical staff representation on the board of directors;
- (B) clinical services to be offered by the institutions;
- (C) process for approving and amending medical staff bylaws;
- (D) selection of the medical staff officers, medical executive committee, and clinical department chairs;
- (E) credentialing and recredentialing of physicians and limited licensed providers;
- (F) quality improvement;
- (G) utilization and peer review activities;
- (H) presence of exclusive contracts for physician services and their impact on physicians' clinical privileges;
- (I) conflict resolution mechanisms;
- (J) the role, if any, of medical directors and physicians in joint ventures;
- (K) control of medical staff funds;
- (L) successor-in-interest rights;
- (M) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals; and

2. Our AMA will work to ensure, through appropriate state oversight agencies, that where hospital mergers and acquisitions may lead to restrictions on reproductive health care services, the merging entity shall be responsible for ensuring continuing community access to these services.

Citation: CMS Rep. 5, I-01; Reaffirmed: CMS Rep. 7, A-11; Appended: Res. 3, I-13; Reaffirmed: CMS Rep. 07, A-19

Physicians' Ability to Negotiate and Undergo Practice Consolidation H-383.988

Our AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and (3) find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare.

Citation: Res. 299, A-12; Reaffirmed: Res. 206, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 712
(N-21)

Introduced by: Private Practice Physician Section

Subject: Advocacy of Private Practice Options for Healthcare Operations in Large Corporations

Referred to: Reference Committee G

Whereas, Amazon has begun to develop primary care centers as a part of a major internal investment called Amazon Care¹ specifically targeting the largest workforce in America via on-demand virtual primary care as well as in-person primary care clinics across their fulfillment centers in partnership with Crossover Health² for their employees across the country; and

Whereas, Amazon's own business model that brought them success is actually based upon giving diverse small businesses access to consumer sales and services globally; and

Whereas, When it came to the healthcare of their own employees, Amazon moved to enact a wholly internal employment model rather than one that incorporated local healthcare small businesses; and

Whereas, Amazon could have had a much more diverse, inclusive, and broad-based approach to the healthcare evolution of the care for their own employees with focused advocacy and guidance from the AMA; and

Whereas, Several other large corporations like Walmart, CVS, Walgreens, Livongo, and other Fortune 500 companies are expanding their corporate reach into the healthcare delivery system in a shift for the entire healthcare industry; and

Whereas, These business line shifts represent major opportunities for the "House of Medicine" to education corporate America on the value of diverse models of care on the frontline and promote better access to these models for patients; therefore be it

RESOLVED, That our American Medical Association study the best method to create pilot programs which advance the advocacy of private practice and small business medicine within the rapidly growing area of internal healthcare within Fortune 500 corporations in American with a report back at the 2022 Annual Meeting (Directive to Take Action); and be it further

RESOLVED, That our AMA prioritize advocacy efforts that emphasize small private practice utilization within the investment and business efforts that Fortune 500 corporations are currently undertaking into the healthcare industry. (Directive to Take Action)

¹ Amazon, "Amazon Care to launch across U.S. this summer, offering millions of individuals and families immediate access to high-quality medical care and advice—24 hours a day, 365 days a year," March 17, 2021. Accessed 10/13/2021: <https://www.aboutamazon.com/news/workplace/amazon-care-to-launch-across-u-s-this-summer-offering-millions-of-individuals-and-families-immediate-access-to-high-quality-medical-care-and-advice-24-hours-a-day-365-days-a-year>

² Bowman, J. "Amazon has a new partner in its health care assault"; The Motley Fool; July 18, 2021; Accessed 10/13/21: <https://www.fool.com/investing/2020/07/18/amazon-has-a-new-partner-in-its-health-care-assault.aspx>

Modest - between \$1,000 - \$5,000

Received: 11/07/21

AUTHORS STATEMENT OF PRIORITY

Major decisions made recently by large American corporations regarding their forays into the healthcare industry were only magnified during the pandemic and have revealed how little importance they place in actually partnering with small independent medical practices across the country. Even Amazon, for example, whose core model is about small businesses using them as a portal, ignored local medical practices in their roll out of clinics across the nation. Many other corporations have done the same. It's long overdue that our AMA expand our advocacy efforts for our physicians into this area.

If physicians had a seat at that corporate table, during major consolidations and new healthcare industry ventures that these companies are rolling out in lightning speed, partnerships with private practice would be naturally realized rather than cannibalized from locality to locality.

The AMA is the best if not the only organization that could launch such advocacy fairly and productively for all physicians. It is beyond urgent and timely that the AMA make up for lost time in advocacy and study the best areas for pilot programs engaging these large companies.

RELEVANT AMA POLICY

Principles on Corporate Relationships G-630.040

The House of Delegates adopts the following revised principles on Corporate Relationships. The Board will review them annually and, if necessary, make recommendations for revisions to be presented to the House of Delegates.

(1) GUIDELINES FOR AMA CORPORATE RELATIONSHIPS. Principles to guide AMA's relationships with corporate America were adopted by our AMA House of Delegates at its December 1997 meeting and slightly modified at the June 1998 meeting. Subsequently, they have been edited to reflect the recommendations from the Task Force on Association/Corporate Relations, including among its members experts external to our AMA. Minor edits were also adopted in 2002. The following principles are based on the premise that in certain circumstances, our AMA should participate in corporate arrangements when guidelines are met, which can further our AMA's core strategic focus, retain AMA's independence, avoid conflicts of interest, and guard our professional values.

(2) OVERVIEW OF PRINCIPLES. The AMA's principles to guide corporate relationships have been organized into the following categories: General Principles that apply to most situations; Special Guidelines that deal with specific issues and concerns; Organizational Review that outlines the roles and responsibilities of the Board of Trustees, AMA Management and other staff units. These guidelines should be reviewed over time to assure their continued relevance to the policies and operations of our AMA and to our business environment. The principles should serve as a starting point for anyone reviewing or developing AMA's relationships with outside groups.

(3) GENERAL PRINCIPLES. Our AMA's vision and values statement and strategic focus should provide guidance for externally funded relationships. Relations that are not motivated by the association's mission threaten our AMA's ability to provide representation and leadership for the profession.

(a) Our AMA's vision and values and strategic focus ultimately must determine whether a proposed relationship is appropriate for our AMA. Our AMA should not have relationships with organizations or industries whose principles, policies or actions obviously conflict with our AMA's vision and values. For example, relationships with producers of products that harm the public health (e.g., tobacco) are not appropriate for our AMA. Our AMA will proactively choose its priorities for external relationships and collaborate in those that fulfill these priorities.

(b) The relationship must preserve or promote trust in our AMA and the medical profession. To be effective, medical professionalism requires the public's trust. Corporate relationships that could undermine the public's trust in our AMA or the profession are not acceptable. For example, no relationship should raise questions about the scientific content of our AMA's health information publications, AMA's advocacy on public health issues, or the truthfulness of its public statements.

(c) The relationship must maintain our AMA's objectivity with respect to health issues. Our AMA accepts funds or royalties from external organizations only if acceptance does not pose a conflict of interest and in no way impacts the objectivity of the association, its members, activities, programs, or employees. For example, exclusive relationships with manufacturers of health-related products marketed to the public could impair our AMA's objectivity in promoting the health of America. Our AMA's objectivity with respect to health issues should not be biased by external relationships.

(d) The activity must provide benefit to the public's health, patients' care, or physicians' practice. Public education campaigns and programs for AMA or Federation members are potentially of significant benefit. Corporate-supported programs that provide financial benefits to our AMA but no significant benefit to the public or direct professional benefits to AMA or Federation members are not acceptable. In the case of member benefits, external relations must not detract from AMA's professionalism.

(4) SPECIAL GUIDELINES. The following guidelines address a number of special situations where our AMA cannot utilize external funding. There are specific guidelines already in place regarding advertising in publications.

(a) Our AMA will provide health and medical information, but should not involve itself in the production, sale, or marketing to consumers of products that claim a health benefit. Marketing health-related products (e.g., pharmaceuticals, home health care products) undermines our AMA's objectivity and diminishes its role in representing healthcare values and educating the public about their health and healthcare.

(b) Activities should be funded from multiple sources whenever possible. Activities funded from a single external source are at greater risk for inappropriate influence from the supporter or the perception of it, which may be equally damaging. For example, funding for a patient education brochure should be done with multiple sponsors if possible. For the purposes of this guideline, funding from several companies, but each from a different and non-competing industry category (e.g., one pharmaceutical manufacturer and one health insurance provider), does not constitute multiple-source funding. Our AMA recognizes that for some activities the benefits may be so great, the harms so minimal, and the prospects for developing multiple sources of funding so unlikely that single-source funding is a reasonable option. Even so, funding exclusivity must be limited to program only (e.g., asthma conference) and shall not extend to a therapeutic category (e.g., asthma). The Board should review single-sponsored activities prior to implementation to ensure that: (i) reasonable attempts have been made to locate additional sources of funds (for example, issuing an open request for proposals to companies in the category); and (ii) the expected benefits of the project merit the additional risk to our AMA of accepting single-source funding. In all cases of single-source funding, our AMA will guard against conflict of interest.

(c) The relationship must preserve AMA's control over any projects and products bearing our AMA name or logo. Our AMA retains editorial control over any information produced as part of a corporate/externally funded arrangement. When an AMA program receives external financial support, our AMA must remain in control of its name, logo, and AMA content, and must approve

all marketing materials to ensure that the message is congruent with our AMA's vision and values. A statement regarding AMA editorial control as well as the name(s) of the program's supporter(s) must appear in all public materials describing the program and in all educational materials produced by the program. (This principle is intended to apply only to those situations where an outside entity requests our AMA to put its name on products produced by the outside entity, and not to those situations where our AMA only licenses its own products for use in conjunction with another entity's products.)

(d) Relationships must not permit or encourage influence by the corporate partner on our AMA. An AMA corporate relationship must not permit influence by the corporate partner on AMA policies, priorities, and actions. For example, agreements stipulating access by corporate partners to the House of Delegates or access to AMA leadership would be of concern. Additionally, relationships that appear to be acceptable when viewed alone may become unacceptable when viewed in light of other existing or proposed activities.

(e) Participation in a sponsorship program does not imply AMA's endorsement of an entity or its policies. Participation in sponsorship of an AMA program does not imply AMA approval of that corporation's general policies, nor does it imply that our AMA will exert any influence to advance the corporation's interests outside the substance of the arrangement itself. Our AMA's name and logo should not be used in a manner that would express or imply an AMA endorsement of the corporation, its policies and/or its products.

(f) To remove any appearance of undue influence on the affairs of our AMA, our AMA should not depend on funding from corporate relationships for core governance activities. Funding core governance activities from corporate sponsors, i.e., the financial support for conduct of the House of Delegates, the Board of Trustees and Council meetings could make our AMA become dependent on external funding for its existence or could allow a supporter, or group of supporters, to have undue influence on the affairs of our AMA.

(g) Funds from corporate relationships must not be used to support political advocacy activities. A full and effective separation should exist, as it currently does, between political activities and corporate funding. Our AMA should not advocate for a particular issue because it has received funding from an interested corporation. Public concern would be heightened if it appeared that our AMA's advocacy agenda was influenced by corporate funding.

(5) ORGANIZATIONAL REVIEW. Every proposal for an AMA corporate relationship must be thoroughly screened prior to staff implementation. AMA activities that meet certain criteria requiring further review are forwarded to a committee of the Board of Trustees for a heightened level of scrutiny.

(a) As part of its annual report on the AMA's performance, activities, and status, the Board of Trustees will present a summary of the AMA's corporate arrangements to the House of Delegates at each Annual Meeting.

(b) Every new AMA Corporate relationship must be approved by the Board of Trustees, or through a procedure adopted by the Board. Specific procedures and policies regarding Board review are as follows: (i) The Board routinely should be informed of all AMA corporate relationships; (ii) Upon request of two dissenting members of the CRT, any dissenting votes within the CRT, and instances when the CRT and the Board committee differ in the disposition of a proposal, are brought to the attention of the full Board; (iii) All externally supported corporate activities directed to the public should receive Board review and approval; (iv) All activities that have support from only one corporation except patient materials linked to CME, within an industry should either be in compliance with ACCME guidelines or receive Board review; and (f) All relationships where our AMA takes on a risk of substantial financial penalties for cancellation should receive Board review prior to enactment.

(c) The Executive Vice President is responsible for the review and implementation of each specific arrangement according to the previously described principles. The Executive Vice President is responsible for obtaining the Board of Trustees authorization for externally funded arrangements that have an economic and/or policy impact on our AMA.

(d) The Corporate Review Team reviews corporate arrangements to ensure consistency with the principles and guidelines. (i) The Corporate Review Team is the internal, cross-organizational group that is charged with the review of all activities that associate the AMA's name and logo with that of another entity and/or with external funding. (ii) The Review process is structured to specifically address issues pertaining to AMA's policy, ethics, business practices, corporate identity, reputation and due diligence. Written procedures formalize the committee's process for review of corporate arrangements. (iii) All activities placed on the Corporate Review Team agenda have had the senior manager's review and consent, and following CRT approval will continue to require the routine approvals of the Office of Finance and Office of the General Counsel. (iv) The Corporate Review Team reports its findings and recommendations directly to a committee of the Board.

(e) Our AMA's Office of Risk Management in consultation with the Office of the General Counsel will review and approve all marketing materials that are prepared by others for use in the U.S. and that bear our AMA's name and/or corporate identity. All marketing materials will be reviewed for appropriate use of AMA's logos and trademarks, perception of implied endorsement of the external entity's policies or products, unsubstantiated claims, misleading, exaggerated or false claims, and reference to appropriate documentation when claims are made. In the instance of international publishing of JAMA and the Archives, our AMA will require review and approval of representative marketing materials by the editor of each international edition in compliance with these principles and guidelines.

(6) ORGANIZATIONAL CULTURE AND ITS INFLUENCE ON EXTERNALLY FUNDED PROGRAMS.

(a) Organizational culture has a profound impact on whether and how AMA corporate relationships are pursued. AMA activities reflect on all physicians. Moreover, all physicians are represented to some extent by AMA actions. Thus, our AMA must act as the professional representative for all physicians, and not merely as an advocacy group or club for AMA members.

(b) As a professional organization, our AMA operates with a higher level of purpose representing the ideals of medicine. Nevertheless, non-profit associations today do require the generation of non-dues revenues. Our AMA should set goals that do not create an undue expectation to raise increasing amounts of money. Such financial pressures can provide an incentive to evade, minimize, or overlook guidelines for fundraising through external sources.

(c) Every staff member in the association must be accountable to explicit ethical standards that are derived from the vision, values, and focus areas of the Association. In turn, leaders of our AMA must recognize the critical role the organization plays as the sole nationally representative professional association for medicine in America. AMA leaders must make programmatic choices that reflect a commitment to professional values and the core organizational purpose.

Citation: BOT Rep. 20, A-99; Consolidated: CLRPD Rep. 3, I-01; Modified: CLRPD Rep. 1, A-03; Modified: CCB/CLRPD Rep 3., A-12

Corporate Practice of Medicine H-215.981

1. Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine.

2. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations.

3. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues.

Citation: Res. 247, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11; Modified: CMS Rep. 6, I-13; Reaffirmed: CMS Rep. 07, A-17; Modified: Res. 713, A-18; Reaffirmed: CMS Rep. 11, A-19

Corporate Ownership of Established Private Medical Practices H-160.960

When a private medical practice is purchased by corporate entities, patients going to that practice shall be informed of this ownership arrangement by the corporate entities and/or by the physician.

Citation: Res. 3, I-92; Modified: CMS Rep. 1, A-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed: CMS Rep. 1, A-15; Reaffirmed: CMS Rep. 11, A-19

Corporate Visitation Program H-445.994

Our AMA encourages all county and state medical associations to embark upon efforts to establish an improved and ongoing communication with the nation's business community and seek AMA's support in their implementation, which may be enhanced by enlisting the cooperation of the senior medical officer or medical consultant, if any, of the corporations contacted.

Citation: Res. 44, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CLRPD Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Informational Reports

BOT Report(s)

- 01 Racial Essentialism in Medical Education
- 03 Redefining the AMA's Position on ACA and Healthcare Reform
- 04 2021 AMA Advocacy Efforts
- 06 Mitigating the Effects of Racism in Health Care: "Best Practices"
- 07 Improving Clinical Algorithms: Moving Beyond Race and Ethnicity

CEJA Opinion(s)

- 01 Amendment to Opinion 9.3.2, "Physician Responsibilities to Impaired Colleagues"

CSAPH Report(s)

- 01 Drug Shortages: 2021 Update

* Contained in the Handbook Addendum

Contained in the Friday Tote

N-21 Resolutions (by sponsor)

Aerospace Medical Association

235# Vital Nature of Board-Certified Physician in Aerospace Medicine

American Academy of Pediatrics

703 Clear Statement Regarding the Use of CPT E/M Outpatient Visit Codes

American Association of Neurological Surgeons

236# Repeal or Modification of the Medicare Appropriate Use Criteria

American Association of Public Health Physicians

607 AMA Urges Health and Life Insurers to Divest From Investments in Fossil Fuels

American College of Cardiology

202 RESOLUTION WITHDRAWN

American College of Rheumatology

214 Stakeholder Engagement in Medicare Administrative Contractor Policy

215 Pharmacy Benefit Manager Reform as a State Legislative Priority

American Thoracic Society

112 Expanding Coverage for and Access to Pulmonary Rehabilitation

Association for Clinical Oncology

212 Sequestration

California

113 Supporting Medicare Drug Price Negotiation

609 Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Emergency

Delaware

507# Healthy Air Quality

Florida

224 Improve Physician Payments

225 End Budget Neutrality

610 Creation of Employed Physician Section

Georgia

237# Universal Good Samaritan Statute

Illinois

234* Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-dose Medications for Multiple Patients

317* Creating a More Accurate Accounting of Medical Education Financial Costs

Iowa

020* Recognizing and Remediating "Structural Urbanism" Bias as a Factor in Rural Health Disparities

Louisiana

021* Free Speech and Civil Discourse in the American Medical Association

022* Prohibition of Racist Characterization Based on Personal Attributes

617* Together We are Stronger Marketing Campaign

Maryland

123# Support for Easy Enrollment Federal Legislation

Medical Student Section

- 001 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers
- 002 Disaggregation of Race Data for Individuals of Middle Eastern and North African (MENA) Descent
- 003 Supporting the Study of Reparations as a Means to Reduce Racial Inequalities
- 004 Guidelines on Chaperones for Sensitive Exams
- 005 Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism
- 006 Evaluating Scientific Journal Articles for Racial and Ethnic Bias
- 007 Exclusion of Race and Ethnicity in the First Sentence of Case Reports
- 008 Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954
- 009 Banning the Practice of Virginity Testing
- 010 Improving the Health and Safety of Sex Workers
- 011 Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions
- 012 Increased Recognition and Treatment of Eating Disorders in Minority Populations
- 013 Equal Access to Adoption for the LGBTQ Community
- 014 Referral change - moved to Ref Comm D - now Resolution 415
- 015 Using X-Ray and Dental Records for Assessing Immigrant Age
- 016 Student-Centered Approaches for Reforming School Disciplinary Policies
- 026# Amending AMA Bylaw 2.12.2, Special Meetings of the House of Delegates
- 106 Reimbursement of School-Based Health Centers
- 107 Expanding Medicaid Transportation to Include Healthy Grocery Destinations
- 108 Medicaid and CHIP Coverage of Glucose Monitoring Devices for Patients with Diabetes
- 109 Amending D-440.985, Health Care Payment for Undocumented Persons, to Study Methods to Increase Health Care Access for Undocumented Immigrants
- 110 Caps on Insulin Co-Payments for Patients with Insurance
- 111 Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System
- 125# Medicare Coverage of Dental, Vision and Hearing Services
- 203 Poverty-Level Wages and Health
- 204 Supporting Collection of Data on Medical Repatriation
- 205 Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits
- 206 Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities to Better Address National Crises
- 207 Authority to Grant Vaccine Exemptions
- 208 Protections for Incarcerated Mothers in the Perinatal Period
- 209 Increasing Access to Hygiene and Menstrual Products
- 210 Advocating for the Amendment of Chronic Nuisance Ordinances
- 211 Support for Mental Health Courts
- 301 Equitable Reporting of USMLE Step 1 Scores
- 302 University Land Grant Status in Medical School Admissions
- 303 Decreasing Bias in Evaluations of Medical Student Performance
- 304 Reducing Complexity in the Public Service Loan Forgiveness Program
- 305 Increase Awareness Among Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status
- 306 Support for Standardized Interpreter Training
- 307 Support for Institutional Policies for Personal Days for Undergraduate Medical Students
- 308 Modifying Eligibility Criteria for Association of American Medical Colleges' Financial Assistance Program
- 309 Protecting Medical Student Access to Abortion Education and Training
- 402 Expansion on Comprehensive Sexual Health Education
- 403 Providing Reduced Parking Fees for Patients
- 404 Increase Employment Services Funding for People with Disabilities
- 405 Formal Transitional Care Program for Children and Youth with Special Health Care Needs
- 413# Universal Childcare and Preschool
- 414# Advocacy on the US Department of Education's Spring 2022 Title IX Rules on Sexual Harassment and Assault in Education Programs
- 415# Reducing Disparities in HIV Incidence Through Pre-Exposure Prophylaxis for HIV

Medical Student Section

- 505 Representation of Dermatological Pathologies in Varying Skin Tones
- 506 Enhancing Harm Reduction for People Who Use Drugs
- 510# Opposition to Sobriety Requirement for Hepatitis C Treatment
- 602 Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings
- 603 Abolishment of the Resolution Committee
- 701 Coverage of Pregnancy-Associated Healthcare for 12 Months Postpartum for Uninsured Patients who are Ineligible for Medicaid

Michigan

- 226 Addressing Adolescent Telehealth Confidentiality Concerns
- 227 Medication for Opioid Use Disorder in Physician Health Programs
- 228 Resentencing for Individuals Convicted of Marijuana-Based Offenses
- 616* Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology System

Minority Affairs Section

- 619# Continuing Equity Education

Mississippi

- 613* Due Process at our AMA

New England

- 104 Improving Access to Vaccinations for Patients
- 504 Air Pollution and COVID: A Call to Tighten Regulatory Standards

New Jersey

- 614* Insurance Industry Behaviors

New Mexico

- 114 Medicare and Private Health Insurance for Hearing Aids

New York

- 025# Opposition to Discriminatory Treatment of Haitian Asylum Seekers
- 119* Bundling Physician Fees with Hospital Fees
- 120* COBRA for College Students
- 121* Medicaid Tax Benefits
- 229* CMS Administrative Requirements
- 230* Medicare Advantage Plan Mandates
- 231* Prohibit Ghost Guns
- 232* Ban the Gay/Trans (LGBTQ+) Panic Defense
- 233* Insurers and Vertical Integration
- 316* Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic
- 408* Ensuring Affordability and Equity in COVID-19 Vaccine Boosters
- 611* September 11th as a National Holiday
- 612* UN International Radionuclide Therapy Day Recognition
- 707* Fifteen Month Lab Standing Orders
- 708* Insurance Coverage for Scalp Cooling (Cold Cap) Therapy
- 709* Prior Authorization - CPT Codes for Fair Compensation
- 710* Physician Burnout is an OSHA Issue

North Carolina

- 318# The Medical Student Match Mismatch - REVISED

Ohio

- 115 Bundled Payments and Medically Necessary Care
- 213 Eliminating Unfunded or Unproven Mandates and Regulations
- 702 System Wide Prior and Post-Authorization Delays and Effects on Patient Care Access

Oklahoma

615* Employed Physicians

Organized Medical Staff Section

240# Ransomware Prevention and Recovery

Pennsylvania

023# AMA Council on Ethical and Judicial Affairs Report on Physician Responsibilities to Impaired Colleagues: CEJA E-9.3.2

024# Organ Transplant Equity for Persons with Disabilities

238# Increasing Residency Positions for Primary Care

239# Making State Health Care Cost Containment Datasets Free of Cost and Readily Available for Academic Research

409# Screening for HPV-Related Anal Cancer

508# Personal Care Products Safety

509# Wireless Devices and Cell Tower Health and Safety

Private Practice Physician Section

241# Enforcement of Administrative Simplification Requirements - CMS

711# Hospital System Consolidation

712# Advocacy of Private Practice Options for Health Care Operations in Large Corporations

Resident and Fellow Section

018 Support for Safe and Equitable Access to Voting

019 Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent

116 Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance

117 Implant-Associated Anaplastic Large Cell Lymphoma

124# Medicare Coverage of Dental, Vision, and Hearing Services

216 Preserving Appropriate Physician Supervision of Midlevel Providers and Ensuring Patient Awareness of the Qualifications of Physicians vs. Midlevel Providers

217 Studying Physician Supervision of Allied Health Professionals Outside of their Fields of Graduate Medical Education

218 Physician Opposition to the Coordinated Effort by Corporations and Midlevel Providers to Undermine the Physician-Patient Relationship and Safe Quality Care

219 The Impact of Midlevel Providers on Medical Education

220 Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use

310 Resident and Fellow Access to Fertility Preservation

311 Improving Access to Physician Health Programs for Physician Trainees

312 Accountable Organizations to Resident and Fellow Trainees

313 Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training

314 Updating Current Wellness Policies and Improving Implementation

315 Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc. Equitable for IMGs

406 Addressing Gaps in Patient and Provider Knowledge to Increase HPV Vaccine Uptake and Prevent HPV-Associated Oropharyngeal Cancer

407 Traumatic Brain Injury and Access to Firearms

410# Affirmatively Protecting the Safety and Dignity of Physicians and Medical Students as Workers

608 Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis

618# Dissolution of the Resolution Committee

704 Expanding the AMA's Study on the Economic Impact of COVID-19

Senior Physicians Section

102 Prevention of Hearing Loss-Associated-Cognitive-Impairment Through Earlier Recognition and Remediation

103 Oral Healthcare Is Healthcare

401 Endorsement of Public Health Measures to End the COVID-19 Pandemic and Promotion of Research and Insurance Coverage to Define and Delimit the Emerging Issue of Post-Acute Covid Syndrome

601 "Virtual Water Cooler" for our AMA

Society of Critical Care Medicine

122* Increase Funding, Research and Education for Post-Intensive Care Syndrome

South Carolina

201 Protection of Peer-Review Process

Texas

118 Expanding Site-of-Service Neutrality

221 Promoting Sustainability in Medicare Physician Payments

222 Opposing Federal Preemption of State Licensing Laws and Scope-of-Practice Expansion Under the Ninth Amendment to Declaration Under the PREP Act

223 Paying Physicians for Services According to the Physician Fee Schedule

604 The Critical Role of Physicians in the COVID-19 Pandemic

605 Formalization of the Resolution Committee as a Standing Committee of the American Medical Association House of Delegates

606 Increasing the Effectiveness of Online Reference Committee Testimony

705 Advocating for Program Stability in the Merit-Based Incentive Payment System

706 Support for State Medical Record Retention Laws

Virginia

101 Standardized Coding for Telehealth Services

Washington

501 Ensuring Continued Access to Equitable Take-Home Methadone Treatment

502 Advocating for Heat Exposure Protections for Outdoor Workers

Women Physicians Section

017 Gender Equity and Female Physician Work Patterns During the Epidemic

105 Fertility Preservation Insurance Coverage for Women in Medicine

Young Physicians Section

411# Addressing Public Health Disinformation

412# Health Professional Disinformation During a Public Health Crisis

503 Marketing Guardrails for the "Over-Medicalization" of Cannabis Use

** Contained in the Handbook Addendum*

Contained in the Friday Tote

SUMMARY OF FISCAL NOTES (NOVEMBER 2021 SPECIAL MEETING)

BOT Report(s)

- 01 Racial Essentialism in Medical Education: Informational Report
- 02 Policing Reform: Modest
- 03 Redefining the AMA's Position on ACA and Healthcare Reform: Informational Report
- 04 2021 AMA Advocacy Efforts: Informational Report
- 05 Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment: Modest
- 06 Mitigating the Effects of Racism in Health Care: "Best Practices": Informational Report
- 07 Improving Clinical Algorithms: Moving Beyond Race and Ethnicity: Informational Report
- 08 Improved Access and Coverage to Non-opioid Modalities to Address Pain: Minimal
- 09 Medical Marijuana License Safety: Minimal
- 10 Physician Access to Their Medical and Billing Records: Minimal
- 11 National Guidelines for Guardianship: Minimal
- 12 Direct-to-Consumer Genetic Tests: Minimal
- 13 Study of Forced Organ Harvesting by China: Minimal
- 14 Net Neutrality and Public Health: Minimal
- 15 Opposing Attorney Presence at and/or Recording of Independent Medical Examinations: Minimal
- 16 Research Handling of De-Identified Patient Information: Minimal
- 17 Distracted Driver Education and Advocacy: Minimal
- 18 Financial Protections for Doctors in Training: Minimal
- 19 Advocacy for Physicians with Disabilities: Estimated cost of \$30,000 to convene an advisory group and develop resources.
- 20# Specialty Society Representation in the House of Delegates - Five-Year Review: Minimal

CC&B Report(s)

- 01 Further Action on Bylaw 7.5.2: Minimal
- 02 Rescission of Bylaws Related to Run-off Elections: Minimal
- 03 AMA Women Physicians Section: Clarification of Bylaw Language: Minimal

CEJA Opinion(s)

- 01 Amendment to Opinion 9.3.2, "Physician Responsibilities to Impaired Colleagues": Informational Report

CEJA Report(s)

- 01 Short-Term Medical Service Trips: Minimal
- 02 Amendment to Opinions 1.2.11, "Ethical Innovation in Medical Practice"; 11.1.2, Physician Stewardship of Health Care Resources"; 11.2.1, "Professionalism in Health Care Systems"; and 1.1.6, "Quality": Minimal

CLRPD Report(s)

- 01 Minority Affairs Section Five-Year Review: Minimal
- 02 Integrated Physician Practice Section - Five-Year Review: Minimal

CME Report(s)

- 01 Guiding Principles and Appropriate Criteria for Assessing the Competency of Late Career Physicians: Minimal
- 02 A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities: Modest

SUMMARY OF FISCAL NOTES (NOVEMBER 2021 SPECIAL MEETING)

CME Report(s)

- 03 Rural Health Physician Workforce Disparities: Minimal
- 04 Medical Student Debt and Career Choice: Minimal
- 05 Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotation: Minimal

CMS Report(s)

- 01 End-of-Life Care: Minimal
- 02 Access to Health Plan Information Regarding Lower-Cost Prescription Options: Modest
- 03 Covering the Remaining Uninsured: Minimal
- 04 Financing of Home and Community-Based Services: Minimal
- 05 Integrating Care for Individuals Dually Eligible for Medicare and Medicaid: Minimal

CSAPH Report(s)

- 01 Drug Shortages: 2021 Update: Informational Report
- 02 Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems: \$650,000
- 03 Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Surgery: Minimal
- 04 Pharmacovigilance: Minimal

HOD Comm on Compensation of the Officers

- 01 Report of the House of Delegates Committee on the Compensation of the Officers: Estimated cost for July 1, 2021 to June 30, is a max of \$37,500 if all Presidents and Officers use the allowance.

Joint Report(s)

- 01 CMS/CSAPH Joint Report - Reducing Inequities and Improving Access to Insurance for Maternal Health Care: Minimal

Report of the Speakers

- 01 Report of the Election Task Force: Minimal
- 02 Establishing an Election Committee: Minimal

Resolution(s)

- 001 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers: Minimal
- 002 Disaggregation of Race Data for Individuals of Middle Eastern and North African (MENA) Descent: Moderate
- 003 Supporting the Study of Reparations as a Means to Reduce Racial Inequalities: Estimated cost to implement this resolution is \$110,000. Estimate includes current and new staff costs.
- 004 Guidelines on Chaperones for Sensitive Exams: Minimal
- 005 Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism: Minimal
- 006 Evaluating Scientific Journal Articles for Racial and Ethnic Bias: Minimal
- 007 Exclusion of Race and Ethnicity in the First Sentence of Case Reports: Modest
- 008 Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954: Minimal
- 009 Banning the Practice of Virginity Testing: Minimal
- 010 Improving the Health and Safety of Sex Workers: Modest
- 011 Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions: Minimal
- 012 Increased Recognition and Treatment of Eating Disorders in Minority Populations: Minimal

SUMMARY OF FISCAL NOTES (NOVEMBER 2021 SPECIAL MEETING)

Resolution(s)

- 013 Equal Access to Adoption for the LGBTQ Community: Minimal
- 014 Referral change - moved to Ref Comm D - now Resolution 415:
- 015 Using X-Ray and Dental Records for Assessing Immigrant Age: Minimal
- 016 Student-Centered Approaches for Reforming School Disciplinary Policies: Minimal
- 017 Gender Equity and Female Physician Work Patterns During the Epidemic: Minimal
- 018 Support for Safe and Equitable Access to Voting: Minimal
- 019 Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent: Modest
- 020* Recognizing and Remediating "Structural Urbanism" Bias as a Factor in Rural Health Disparities: Modest
- 021* Free Speech and Civil Discourse in the American Medical Association: Minimal
- 022* Prohibition of Racist Characterization Based on Personal Attributes: Minimal
- 023# AMA Council on Ethical and Judicial Affairs Report on Physician Responsibilities to Impaired Colleagues: CEJA E-9.3.2: Minimal
- 024# Organ Transplant Equity for Persons with Disabilities: Minimal
- 025# Opposition to Discriminatory Treatment of Haitian Asylum Seekers: Minimal
- 026# Amending AMA Bylaw 2.12.2, Special Meetings of the House of Delegates: Minimal
 - 101 Standardized Coding for Telehealth Services: Minimal
 - 102 Prevention of Hearing Loss-Associated-Cognitive-Impairment Through Earlier Recognition and Remediation: Modest
 - 103 Oral Healthcare Is Healthcare: Modest
 - 104 Improving Access to Vaccinations for Patients: Modest
 - 105 Fertility Preservation Insurance Coverage for Women in Medicine: Modest
 - 106 Reimbursement of School-Based Health Centers: Minimal
 - 107 Expanding Medicaid Transportation to Include Healthy Grocery Destinations: Modest
 - 108 Medicaid and CHIP Coverage of Glucose Monitoring Devices for Patients with Diabetes: Modest
 - 109 Amending D-440.985, Health Care Payment for Undocumented Persons, to Study Methods to Increase Health Care Access for Undocumented Immigrants: Minimal
 - 110 Caps on Insulin Co-Payments for Patients with Insurance: Minimal
 - 111 Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System: Minimal
 - 112 Expanding Coverage for and Access to Pulmonary Rehabilitation: Modest
 - 113 Supporting Medicare Drug Price Negotiation: Modest
 - 114 Medicare and Private Health Insurance for Hearing Aids: Modest
 - 115 Bundled Payments and Medically Necessary Care: Modest
 - 116 Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance: Minimal
 - 117 Implant-Associated Anaplastic Large Cell Lymphoma: Minimal
 - 118 Expanding Site-of-Service Neutrality: Modest
- 119* Bundling Physician Fees with Hospital Fees: Minimum
- 120* COBRA for College Students: Modest
- 121* Medicaid Tax Benefits: Modest
- 122* Increase Funding, Research and Education for Post-Intensive Care Syndrome: Modest
- 123# Support for Easy Enrollment Federal Legislation: Minimal
- 124# Medicare Coverage of Dental, Vision, and Hearing Services: Minimal
- 125# Medicare Coverage of Dental, Vision and Hearing Services: Minimal
- 201 Protection of Peer-Review Process: Modest

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Resolution(s)

- 202 RESOLUTION WITHDRAWN: n/a
- 203 Poverty-Level Wages and Health: Minimal
- 204 Supporting Collection of Data on Medical Repatriation: Modest
- 205 Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits: Modest
- 206 Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities to Better Address National Crises: Minimal
- 207 Authority to Grant Vaccine Exemptions: Minimal
- 208 Protections for Incarcerated Mothers in the Perinatal Period: Minimal
- 209 Increasing Access to Hygiene and Menstrual Products: Modest
- 210 Advocating for the Amendment of Chronic Nuisance Ordinances: Modest
- 211 Support for Mental Health Courts: Minimal
- 212 Sequestration: Modest
- 213 Eliminating Unfunded or Unproven Mandates and Regulations: Modest
- 214 Stakeholder Engagement in Medicare Administrative Contractor Policy: Modest
- 215 Pharmacy Benefit Manager Reform as a State Legislative Priority: Modest
- 216 Preserving Appropriate Physician Supervision of Midlevel Providers and Ensuring Patient Awareness of the Qualifications of Physicians vs. Midlevel Providers: Modest
- 217 Studying Physician Supervision of Allied Health Professionals Outside of their Fields of Graduate Medical Education: Estimated cost of \$100,000 to staff and consultant expenses to conduct research, analysis and surveys and an analysis of results
- 218 Physician Opposition to the Coordinated Effort by Corporations and Midlevel Providers to Undermine the Physician-Patient Relationship and Safe Quality Care: Estimate \$250,000 includes in house research and analysis, and consultants to research, analyze, survey and analysis of results
- 219 The Impact of Midlevel Providers on Medical Education: Estimate \$52,000 includes outside consultants to conduct research and analysis.
- 220 Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use: Modest
- 221 Promoting Sustainability in Medicare Physician Payments: Modest
- 222 Opposing Federal Preemption of State Licensing Laws and Scope-of-Practice Expansion Under the Ninth Amendment to Declaration Under the PREP Act: Modest
- 223 Paying Physicians for Services According to the Physician Fee Schedule: Modest
- 224 Improve Physician Payments: Estimated cost to implement resolution is \$240,000 which includes staff time, materials and postage.
- 225 End Budget Neutrality: Modest
- 226 Addressing Adolescent Telehealth Confidentiality Concerns: Minimal
- 227 Medication for Opioid Use Disorder in Physician Health Programs: Modest
- 228 Resentencing for Individuals Convicted of Marijuana-Based Offenses: Minimum
- 229* CMS Administrative Requirements: Modest
- 230* Medicare Advantage Plan Mandates: Modest
- 231* Prohibit Ghost Guns: Minimum
- 232* Ban the Gay/Trans (LGBTQ+) Panic Defense: Modest
- 233* Insurers and Vertical Integration: Modest
- 234* Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-dose Medications for Multiple Patients: Modest
- 235# Vital Nature of Board-Certified Physician in Aerospace Medicine: Modest
- 236# Repeal or Modification of the Medicare Appropriate Use Criteria: Modest
- 237# Universal Good Samaritan Statute: Modest
- 238# Increasing Residency Positions for Primary Care: Modest
- 239# Making State Health Care Cost Containment Datasets Free of Cost and Readily Available for Academic Research: Modest

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Resolution(s)

- 240# Ransomware Prevention and Recovery: Modest
- 241# Enforcement of Administrative Simplification Requirements - CMS: Modest
- 301 Equitable Reporting of USMLE Step 1 Scores: Modest
- 302 University Land Grant Status in Medical School Admissions: Moderate
- 303 Decreasing Bias in Evaluations of Medical Student Performance: Modest
- 304 Reducing Complexity in the Public Service Loan Forgiveness Program: Modest
- 305 Increase Awareness Among Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status: Modest
- 306 Support for Standardized Interpreter Training: Moderate
- 307 Support for Institutional Policies for Personal Days for Undergraduate Medical Students: Minimal
- 308 Modifying Eligibility Criteria for Association of American Medical Colleges' Financial Assistance Program: Minimal
- 309 Protecting Medical Student Access to Abortion Education and Training: Minimal
- 310 Resident and Fellow Access to Fertility Preservation: Minimal
- 311 Improving Access to Physician Health Programs for Physician Trainees: Minimal
- 312 Accountable Organizations to Resident and Fellow Trainees: Modest
- 313 Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training: Minimal
- 314 Updating Current Wellness Policies and Improving Implementation: Modest
- 315 Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc. Equitable for IMGs: Minimal
- 316* Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic: Modest
- 317* Creating a More Accurate Accounting of Medical Education Financial Costs: Modest
- 318# The Medical Student Match Mismatch - REVISED: Estimated \$165,000 annually includes two new FTEs and existing staff costs.
- 401 Endorsement of Public Health Measures to End the COVID-19 Pandemic and Promotion of Research and Insurance Coverage to Define and Delimit the Emerging Issue of Post-Acute Covid Syndrome: Modest
- 402 Expansion on Comprehensive Sexual Health Education: Minimal
- 403 Providing Reduced Parking Fees for Patients: Modest
- 404 Increase Employment Services Funding for People with Disabilities: Minimal
- 405 Formal Transitional Care Program for Children and Youth with Special Health Care Needs: Minimal
- 406 Addressing Gaps in Patient and Provider Knowledge to Increase HPV Vaccine Uptake and Prevent HPV-Associated Oropharyngeal Cancer: Minimal
- 407 Traumatic Brain Injury and Access to Firearms: Minimal
- 408* Ensuring Affordability and Equity in COVID-19 Vaccine Boosters: Minimum
- 409# Screening for HPV-Related Anal Cancer: Minimal
- 410# Affirmatively Protecting the Safety and Dignity of Physicians and Medical Students as Workers: Estimated cost to implement resolution is \$28K for legal support/guidance and development and staffing costs.
- 411# Addressing Public Health Disinformation: Modest
- 412# Health Professional Disinformation During a Public Health Crisis: Modest
- 413# Universal Childcare and Preschool: Moderate
- 414# Advocacy on the US Department of Education's Spring 2022 Title IX Rules on Sexual Harassment and Assault in Education Programs: Moderate
- 415# Reducing Disparities in HIV Incidence Through Pre-Exposure Prophylaxis for HIV: Minimal
- 501 Ensuring Continued Access to Equitable Take-Home Methadone Treatment: Minimal
- 502 Advocating for Heat Exposure Protections for Outdoor Workers: Minimal
- 503 Marketing Guardrails for the "Over-Medicalization" of Cannabis Use: Minimal

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Resolution(s)

- 504 Air Pollution and COVID: A Call to Tighten Regulatory Standards: Minimal
- 505 Representation of Dermatological Pathologies in Varying Skin Tones: Minimal
- 506 Enhancing Harm Reduction for People Who Use Drugs: Minimal
- 507# Healthy Air Quality: Minimal
- 508# Personal Care Products Safety: Modest
- 509# Wireless Devices and Cell Tower Health and Safety: Minimal
- 510# Opposition to Sobriety Requirement for Hepatitis C Treatment: Minimal
- 601 "Virtual Water Cooler" for our AMA: Minimal
- 602 Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings: Multi-million dollar undertaking: consults to develop plan, project mgmt, purchase of carbon credits to offset areas where AMA may not be able to reduce emissions. Measuring and reporting on compliance will add to significant annual costs thereafter.
- 603 Abolishment of the Resolution Committee: Minimal
- 604 The Critical Role of Physicians in the COVID-19 Pandemic: Projects underway and included in current budgets. Throughout the COVID-19 pandemic our AMA has been implementing the directives outlined by this resolution and continued efforts to communicate the role of physicians and medical students as we emerge from the pandemic are embedded in our AMA operating budget.
- 605 Formalization of the Resolution Committee as a Standing Committee of the American Medical Association House of Delegates: Minimal
- 606 Increasing the Effectiveness of Online Reference Committee Testimony: Minimal
- 607 AMA Urges Health and Life Insurers to Divest From Investments in Fossil Fuels: Modest
- 608 Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis: \$2M to est a crisis campaign to dist evidence based info on the relationship btwn climate change and human health, determine high yield adv and leadership opps for physicians, centralize effort towards environ justice and an equitable transition to net zero carbon society by 2050
- 609 Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Emergency: Moderate
- 610 Creation of Employed Physician Section: Modest
- 611* September 11th as a National Holiday: Minimal
- 612* UN International Radionuclide Therapy Day Recognition: Minimal
- 613* Due Process at our AMA: Minimal
- 614* Insurance Industry Behaviors: Estimated to cost approximately \$300,000 annually derived from outsourcing to local counsels around the country.
- 615* Employed Physicians: Implementing components of this resolution are estimated to begin at approximately \$720,000 annually. Further costs will be impacted by a myriad of variables, such as granting proportional representation to the Organized Medical Staff Section given the current ambiguity of defining an employed physician.
- 616* Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology System: Modest
- 617* Together We are Stronger Marketing Campaign: Minimal
- 618# Dissolution of the Resolution Committee: Minimal
- 619# Continuing Equity Education: Approximately \$50,000 annually
- 701 Coverage of Pregnancy-Associated Healthcare for 12 Months Postpartum for Uninsured Patients who are Ineligible for Medicaid: Minimal
- 702 System Wide Prior and Post-Authorization Delays and Effects on Patient Care Access: Modest
- 703 Clear Statement Regarding the Use of CPT E/M Outpatient Visit Codes: Modest
- 704 Expanding the AMA's Study on the Economic Impact of COVID-19: Modest
- 705 Advocating for Program Stability in the Merit-Based Incentive Payment System: Modest
- 706 Support for State Medical Record Retention Laws: Modest
- 707* Fifteen Month Lab Standing Orders: Modest
- 708* Insurance Coverage for Scalp Cooling (Cold Cap) Therapy: Modest
- 709* Prior Authorization - CPT Codes for Fair Compensation: Minimal

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Resolution(s)

710* Physician Burnout is an OSHA Issue: Modest

711# Hospital System Consolidation: Modest

712# Advocacy of Private Practice Options for Health Care Operations in Large Corporations: Modest

Minimal - less than \$1,000

Modest - between \$1,000 - \$5,000

Moderate - between \$5,000 - \$10,000

*** Contained in Handbook Addendum**