

## 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

REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-N-21

Subject: Financial Protections for Doctors in Training

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee F

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

4  
5 That our American Medical Association (AMA) support retirement plans for all residents and  
6 fellows, which includes retirement plan matching in order to further secure the financial  
7 stability of physicians and increase financial literacy during training; and

8  
9 That our AMA support that all programs provide financial advising to residents and fellows.

10  
11 The reference committee heard testimony acknowledging the significance of medical student debt  
12 and the need for robust financial counseling. It also heard limited testimony in support of  
13 retirement plans and matching, noting concern about the restricted amount of GME funding  
14 available to institutions.

15  
16 **BACKGROUND**

17  
18 Training institutions generally offer residents and fellows medical, dental, vision and disability  
19 benefits that are comparable to those offered to other employees of an institution. Some also offer  
20 retirement plan options including matching contributions, but anecdotal reports indicate that this  
21 benefit is inconsistent, which results in inequitable and unreliable financial protections for trainees.  
22 Similarly, while some training institutions provide education on financial management and  
23 planning, anecdotal reports indicate that this benefit is also inconsistent and results in large  
24 variation in trainees’ proficiency in and confidence on the subject.

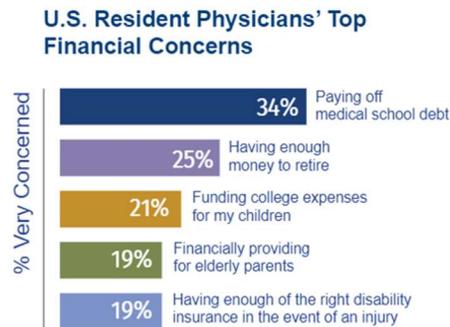
25  
26 Medicare is the single largest funding source for graduate medical education (GME)<sup>1</sup> with the  
27 federal government matching a portion of what state Medicaid programs pay teaching  
28 institutions.<sup>2,3</sup> Funding is limited, and Congress repeatedly considers cuts to GME. As a result,  
29 training institutions that do not currently offer retirement-related benefits could be hard-pressed to  
30 begin doing so.

31  
32 **DISCUSSION**

33  
34 *Retirement savings*

35  
36 The depth and breadth of institutional benefits afforded to physicians in training varies widely and  
37 can lead to anxiety over financial stability and preparedness for the future, especially retirement. In  
38 fact, resident and fellow respondents to a 2017 study conducted by AMA Insurance (AMAI)

1 reported their two highest concerns as “having enough money to retire” and “paying off medical  
2 school debt.”<sup>4</sup>



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

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

11  
12 *Education and advising*

13  
14 Sound financial education and advising are critical for residents and fellows, who face a unique and  
15 challenging financial situation relative to their non-physician peers. Nevertheless, the  
16 aforementioned AMAI study indicated that 88% of residents and fellows do not use a financial  
17 advisor, with the primary reasons being (1) lack of time, (2) cost, and (3) lack of trustworthiness.  
18 These barriers are a strong indication that busy trainees need easy-to-digest, affordable information  
19 from credible sources. While our AMA offers some resources, gaps still exist. Therefore, it stands  
20 to reason that our AMA should encourage teaching institutions to offer financial education and  
21 advising to residents and fellows.

22  
23 *Existing AMA resources*

24  
25 The AMA’s Career Planning Resource ([https://www.ama-assn.org/amaone/career-planning-  
26 resource](https://www.ama-assn.org/amaone/career-planning-resource)) helps residents and fellows plan and achieve their career goals, and includes basic  
27 guidance on topics such as loan repayment options, creating a budget and financial plan, choosing  
28 the best insurance policies, and planning for retirement. Additionally, AMAI operates the

29  
30 Physicians Financial Partners program ([https://www.amainsure.com/physicians-financial-  
31 partners/about-us.html](https://www.amainsure.com/physicians-financial-partners/about-us.html)), which provides medical students and physicians with a single source to  
32 find experienced and fully vetted financial professionals. Finally, the AMA offers member benefits  
33 to help medical students and physicians organize personal finances and manage debt, most notably  
34 through a partnership with Laurel Road offering discounted rates and other benefits on student loan  
35 refinancing, mortgages, and personal loans ([https://www.ama-assn.org/member-benefits/personal-  
36 member-benefits-discounts/loans-financial-services](https://www.ama-assn.org/member-benefits/personal-member-benefits-discounts/loans-financial-services)).

1 *Current AMA policy*

2  
3 The AMA has long-standing policy encouraging teaching institutions to offer benefits to residents  
4 and fellows that will reduce personal cost of living expenditures, such as allowances for housing,  
5 childcare, and transportation, as well as supporting quality and affordable comprehensive medical,  
6 mental health, dental, and vision care, including professional liability and disability insurance (see  
7 for example Policies H-310.912, H-295.942, H-295.873, and H-305.988, which are reproduced in  
8 full in the Appendix). Existing AMA policy does not address retirement planning or financial  
9 advising for residents and fellows.

10  
11 CONCLUSION

12  
13 Residents and fellows often are burdened with significant debt coming out of medical school. As  
14 they progress through training, aside from attaining clinical competency, it is of utmost importance  
15 that they become financially prepared for the future—whether that entails paying down debt,  
16 saving for retirement, or otherwise making sound financial decisions. While some teaching  
17 institutions offer benefit packages including retirement plans with matching contributions, many do  
18 not, and funds are limited. Similarly, while some institutions provide financial education and  
19 advising, many do not, and many trainees are left feeling ill-prepared and unsettled when it comes  
20 to their financial security.

21  
22 RECOMMENDATIONS

23  
24 The Board of Trustees recommends that the following be adopted in lieu of Resolution 608-A-19  
25 and the remainder of the report be filed:

- 26  
27 1. That our American Medical Association (AMA) support the availability of retirement plans  
28 for residents and fellows at all teaching institutions that are no less favorable than those  
29 offered to other institution employees. (New HOD Policy)  
30  
31 2. That AMA Policy H-310.912, “Residents and Fellows’ Bill of Rights,” be amended by  
32 addition and deletion to read as follows:  
33  
34 1. Our AMA continues to advocate for improvements in the ACGME Institutional and  
35 Common Program Requirements that support AMA policies as follows: a) adequate  
36 financial support for and guaranteed leave to attend professional meetings; b) submission  
37 of training verification information to requesting agencies within 30 days of the request;  
38 c) adequate compensation with consideration to local cost-of-living factors and years of  
39 training, and to include the orientation period; d) health insurance benefits to include dental  
40 and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be  
41 no less than six weeks per year; and f) stronger due process guidelines.  
42  
43 2. Our AMA encourages the ACGME to ensure access to educational programs and  
44 curricula as necessary to facilitate a deeper understanding by resident physicians of the US  
45 health care system and to increase their communication skills.  
46  
47 3. Our AMA regularly communicates to residency and fellowship programs and other  
48 GME stakeholders this Resident/Fellows Physicians’ Bill of Rights.  
49  
50 4. Our AMA: a) will promote residency and fellowship training programs to evaluate their  
51 own institution’s process for repayment and develop a leaner approach. This includes

1 disbursement of funds by direct deposit as opposed to a paper check and an online system  
2 of applying for funds; b) encourages a system of expedited repayment for purchases of  
3 \$200 or less (or an equivalent institutional threshold), for example through payment  
4 directly from their residency and fellowship programs (in contrast to following traditional  
5 workflow for reimbursement); and c) encourages training programs to develop a budget  
6 and strategy for planned expenses versus unplanned expenses, where planned expenses  
7 should be estimated using historical data, and should include trainee reimbursements for  
8 items such as educational materials, attendance at conferences, and entertaining applicants.  
9 Payment in advance or within one month of document submission is strongly  
10 recommended.

11  
12 5. Our AMA will partner with ACGME and other relevant stakeholders to encourage  
13 training programs to reduce financial burdens on residents and fellows by providing  
14 employee benefits including, but not limited to, on-call meal allowances, transportation  
15 support, relocation stipends, and childcare services.

16  
17 6. Our AMA will work with the Accreditation Council for Graduate Medical Education  
18 (ACGME) and other relevant stakeholders to amend the ACGME Common Program  
19 Requirements to allow flexibility in the specialty-specific ACGME program requirements  
20 enabling specialties to require salary reimbursement or “protected time” for resident and  
21 fellow education by “core faculty,” program directors, and assistant/associate program  
22 directors.

23  
24 7. Our AMA encourages teaching institutions to offer retirement plan options, retirement  
25 plan matching, financial advising and personal finance education.

26  
27 8. 7 Our AMA adopts the following “Residents and Fellows’ Bill of Rights” as applicable  
28 to all resident and fellow physicians in ACGME-accredited training programs:

29  
30 RESIDENT/FELLOW PHYSICIANS’ BILL OF RIGHTS

31 Residents and fellows have a right to:

32  
33 [...]

34  
35 E. Adequate compensation and benefits that provide for resident well-being and health.

36  
37 [...]

38  
39 (3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should  
40 Receive: a. Quality and affordable comprehensive medical, mental health, dental, and  
41 vision care for residents and their families, as well as retirement plan options, professional  
42 liability insurance and disability insurance to all residents for disabilities resulting from  
43 activities that are part of the educational program; b. An institutional written policy on and  
44 education in the signs of excessive fatigue, clinical depression, substance abuse and  
45 dependence, and other physician impairment issues; c. Confidential access to mental health  
46 and substance abuse services; d. A guaranteed, predetermined amount of paid vacation  
47 leave, sick leave, family and medical leave and educational/professional leave during each  
48 year in their training program, the total amount of which should not be less than six weeks;  
49 e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions  
50 under which sleeping quarters, meals and laundry or their equivalent are to be provided.  
51 (Modify Current HOD Policy)

Fiscal Note: Less than \$500

#### REFERENCES

1. Direct Graduate Medical Education (DGME). <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME>
2. Indirect Graduate Medical Education (IGME). <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Indirect-Medical-Education-IME>
3. Medicaid Graduate Medical Education Payments: Results From the 2018 50-State Survey. [https://store.aamc.org/downloadable/download/sample/sample\\_id/284/](https://store.aamc.org/downloadable/download/sample/sample_id/284/)
4. 2017 Report on U.S. Physicians' Financial Preparedness. American Medical Association Insurance. <https://www.amainsure.com/research-reports/2017-financial-preparedness-resident-physicians/index.html?page=1>

## APPENDIX: RELEVANT AMA POLICY

### **Policy H-310.912, “Residents and Fellows’ Bill of Rights”**

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines. 2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills. 3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians’ Bill of Rights. 4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution’s process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended. 5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation. 6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or “protected time” for resident and fellow education by “core faculty,” program directors, and assistant/associate program directors. 7. Our AMA adopts the following ‘Residents and Fellows’ Bill of Rights’ as applicable to all resident and fellow physicians in ACGME-accredited training programs:

#### RESIDENT/FELLOW PHYSICIANS’ BILL OF RIGHTS

Residents and fellows have a right to:

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

With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance. With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

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

E. Adequate compensation and benefits that provide for resident well-being and health. (1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal. (2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages) and include appropriate adjustments for changes in the cost of living. (3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education. With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

G. Due process in cases of allegations of misconduct or poor performance. With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient,

health professional, or training program in accordance with the due process guidelines established by the AMA. H. Access to and protection by institutional and accreditation authorities when reporting violations. With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey. Citation: CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19

**Policy H-295.942 “Insurance Coverage for Medical Students and Resident Physicians”**

The AMA urges (1) all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. (5) Our AMA: (a) actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians; (b) will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance. Citation: BOT Rep. W, I-91 Reaffirmed: BOT Rep. 14, I-93 Appended: Res. 311, I-98 Modified: Res. 306, A-04 Modified: CME Rep. 2, A-14

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

Our AMA: (1) supports the elimination of benefits waiting periods imposed by employers of resident and fellow physicians-in-training; (2) will strongly encourage the Accreditation Council for Graduate Medical Education (ACGME) to require programs to make insurance for health care, dental care, vision care, life, and disability available to their resident and fellow physicians on the trainees' first date of employment and to aggressively enforce this requirement; and (3) will work with the ACGME and with the Liaison Committee on Medical Education (LCME) to develop policies that provide continuous hospital, health, and disability insurance coverage during a traditional transition from medical school into graduate medical education. (4) encourages the Accreditation Council for Graduate Medical Education to request that sponsoring institutions offer

to residents and fellows a range of comparable medical insurance plans no less favorable than those offered to other institution employees. Citation: BOT Action in response to referred for decision Res. 318, A-06 Appended: CME Rep. 5, A-10

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

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

# REPORT OF THE BOARD OF TRUSTEES

B of T Report 19-N-21

Subject: Advocacy for Physicians with Disabilities

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee F

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

3  
4 study and report back on eliminating stigmatization and enhancing inclusion of physicians with  
5 disabilities including, but not limited to:

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

9  
10 This report addresses and makes recommendations related to strategies to help reduce  
11 stigmatization for physicians with a disability and promote remedies that enhance supportive  
12 techniques for these physicians. For the purposes of this report, “disability” is defined as it is under  
13 the federal Americans with Disabilities Act (ADA) as “a physical or mental impairment that  
14 substantially limits one or more major life activity,” though the report recognizes that this is a legal  
15 definition rather than a medical one, and that other valid definitions exist.

## 16 17 DISCUSSION

### 18 19 *Eliminating stigmatization*

20  
21 A key component of the stigmatization recognized by Policy D-90.991 is language, including  
22 spoken and written words. How physicians refer to each other, patients, and other actors in the  
23 healthcare sector can go a long way to lessening unintended emotional or professional burdens.  
24 Careful consideration of the proper use of “person first” and “identify first” language when  
25 engaging with individuals with disabilities can lead to a greater sense of belonging in the  
26 organization and at AMA-sponsored events.

27  
28 Person-first language can be thought of as language that centers the personhood of someone, while  
29 identity-first language centers the community that person feels a sense of belonging to. While  
30 person-first language is taught in academic programs and frequently required for publication in  
31 scholarly journals, its use in clinical practice can lag. Whether through habit or a return to the  
32 jargon acquired during medical training, physicians can find themselves falling back into saying  
33 “diabetic” instead of “person with diabetes,” for example.

34  
35 Adding to the complexity and applicability of its use is the acknowledgement that not all people  
36 prefer person-first language, opting for language that centers their identity instead. Prominent  
37 examples of this identity-first approach can include members of the deaf community who  
38 understand deafness to be a formative factor in a set of cultural beliefs, behaviors, and perspectives

1 central to who they are as people. Likewise, members of the autistic community may prefer  
2 “autistic” over “person with autism” because they understand autism as a component of identity.

3  
4 Additionally, not all disabilities are readily apparent to the outside observer. So-called “invisible  
5 disabilities” can be challenging to address because of their less overt nature. An invisible disability  
6 can be thought of as any invisible condition that limits a person’s movement or activities and is  
7 often misunderstood by others. Examples can include mental health conditions (for example,  
8 depression, anxiety, substance use disorders, etc.), learning impairments (dyslexia, attention deficit  
9 hyperactivity disorder), or biological medical conditions that aren’t externally apparent, such as  
10 diabetes or gastrointestinal diseases. While any disability if serious enough could manifest external  
11 signs, the absence of those signs should not be construed to assume a person is free from them.

12  
13 Cultivating an awareness and sensitivity to how people understand their own abilities, as well as a  
14 recognition that not all people feel the same way, is critical to eliminating stigmatization. The  
15 AMA should work with its internal resource teams to develop an action plan for properly and  
16 effectively addressing language, terms, and vocabulary in use at internal and public AMA events  
17 and invest in opportunities to afford a richer understanding of how disability can manifest itself  
18 among employees and members.

19  
20 *Enhancing inclusion*

21  
22 Resources for physicians with disabilities are scarce. While professional organizations, such as the  
23 Association of Medical Professionals with Hearing Loss, the Society of Healthcare Professionals  
24 with Disabilities, exist, their reach tends to be limited and information and resources for physicians  
25 may be hard to come by, particularly in times of crisis or emergency. Greater resources exist  
26 through organizations designed to help medical students, such as the Association of American  
27 Medical Colleges or the Coalition for Disability Access in Health Science and Medical Education,  
28 however more work is needed not only to bring together resources for physicians but to create them  
29 in the first place.

30  
31 In 2020, the AMA launched the Access internal employee resource group intended to support and  
32 empower individuals with disabilities at the AMA and to expand the relationship of the AMA with  
33 people with disabilities. The group seeks to better identify existing access needs within the AMA  
34 and support efforts to meet those needs. Going forward, the AMA should support and work with  
35 the resource group to promote and foster educational and training opportunities for AMA members  
36 and the larger medical community to better understand the role that disabilities can play in the  
37 healthcare work environment.

38  
39 *Securing legal protections*

40  
41 Under criteria established by the U.S. Equal Employment Opportunity Commission (EEOC), a  
42 healthcare worker must meet one of three criteria to be considered an individual with a disability:  
43 the worker has a physical or mental impairment that “substantially limits one or more major life  
44 activities;” has a record of impairment that is substantially limiting; or is treated by an employer as  
45 having substantially limited impairment. Examples of “major life activities” include things that can  
46 be done with little or no difficulty, such as sitting, walking, seeing, hearing, speaking, learning,  
47 concentrating, or any other basic task.

48  
49 The EEOC also recognizes people with substance use disorders as potentially qualifying for the  
50 definition of disability. Physicians with alcohol use disorder are considered to have a qualifying  
51 disability under the ADA. Likewise, physicians who have previously had a substance use disorder

1 diagnosis but are not currently engaging in drug use may also be considered to have a disability  
2 under the law if that disorder is substantially limiting a major life activity.

3  
4 In order for physicians with a disability to be protected under the ADA, they must be qualified to  
5 perform the essential functions of a job, with or without a reasonable accommodation. This means  
6 physicians must be able to meet an employer's requirements for the job and be able to perform the  
7 fundamental job duties on their own or with reasonable assistance. These protections extend only to  
8 applicants and employees of a business. Independent contractors of a business, notably, are not  
9 covered, meaning that medical staff with a disability, separate from the non-medical employees of  
10 a healthcare facility, can find themselves with less protection than the employees. Physicians,  
11 particularly medical staff physicians, can thusly benefit from efforts to help them maximize their  
12 rights and privileges under the law.

### 13 14 CONCLUSION

15  
16 According to the U.S. Census Bureau, approximately 85 million people in the United States have a  
17 disability, roughly 27 percent of the total population. Studies have shown that many medical  
18 treatment facilities may lack the resources necessary to adequately treat patients with disabilities  
19 simply for want of accommodations such as a ramp, or adequately sized hallways. It should be  
20 understood that if these facilities want for the ability to treat patients, they are likely also  
21 inadequate as places of employment for physicians with disabilities. And while federal and state  
22 laws have led to improvements for people with disabilities, both as patients and providers who are  
23 employees, greater action is required to create a truly equitable work and treatment environment.  
24 The reduction of stigma and the promotion of inclusion for physicians with disabilities is a  
25 daunting task requiring a variety of approaches and measures in order to achieve success. While the  
26 AMA cannot expect to single-handedly make these achievements, it can serve in good faith as a  
27 shepherd of them with relatively little disruption or financial cost.

### 28 29 RECOMMENDATIONS

30  
31 The Board of Trustees recommends that the following be adopted and the remainder of the report  
32 be filed:

- 33
- 34 1. That our American Medical Association (AMA) establish an advisory group composed of  
35 AMA members who themselves have a disability to work toward inclusion for physicians with  
36 disabilities in all AMA activities. (Directive to Take Action)  
37
  - 38 2. That our AMA promote and foster educational and training opportunities for AMA members  
39 and the medical community at large to better understand the role disabilities can play in the  
40 healthcare work environment, including cultivating a rich understanding of so-called invisible  
41 disabilities for which accommodations may not be immediately apparent. (Directive to Take  
42 Action)  
43
  - 44 3. That our AMA develop and promote tools for physicians with disabilities to advocate for  
45 themselves in their own workplaces, including a deeper understanding of the legal options  
46 available to physicians to manage their own disability-related needs in the workplace.  
47 (Directive to Take Action)  
48
  - 49 4. That our AMA communicate to employers and medical staff leaders the importance of  
50 including within personnel policies and medical staff bylaws protections and reasonable

- 1 accommodations for physicians with visible and invisible disabilities. (Directive to Take  
2 Action)  
3  
4 5. That part 1 of Policy D-90.991, Advocacy for Physicians with Disabilities, be rescinded as  
5 having been accomplished by this report. (Modify Current HOD Policy)

Fiscal Note: Convene advisory group and develop resources as directed at an estimated cost of \$30,500.

# REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-N-21

Subject: Minority Affairs Section Five-Year Review

Presented by: Clarence Chou, MD, Chair

Referred to: Reference Committee F

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1 AMA Bylaw 7.0.9 states, “A delineated section must reconfirm its qualifications for continued  
2 delineated section status and associated representation in the House of Delegates by demonstrating  
3 at least every 5 years that it continues to meet the criteria adopted by the House of Delegates.”  
4 AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and  
5 Development (CLRPD) is “to evaluate and make recommendations to the House of Delegates,  
6 through the Board of Trustees, with respect to the formation and/or change in status of any section.  
7 The Council will apply criteria adopted by the House of Delegates.”

8  
9 The Council assessed information from the letter of application submitted by the Minority Affairs  
10 Section (MAS) for renewal of delineated section status.

## 11 APPLICATION OF CRITERIA TO THE MINORITY AFFAIRS SECTION

12  
13  
14 Criterion 1: Issue of Concern – Focus will relate to concerns that are distinctive to the subset within  
15 the broader, general issues that face medicine. A demonstrated need exists to deal with these  
16 matters, as they are not currently being addressed through an existing AMA group.

17  
18 The MAS provides a nationwide forum to advocate for health issues of minoritized communities  
19 and professional concerns of underrepresented and minoritized physicians, residents/fellows and  
20 medical students. African American/Black, Hispanic/Latino and American Indian/Alaska Native  
21 individuals comprise one-third of the U.S. population yet represent only 11% of the total physician  
22 workforce, according to a 2019 report by the Association of American Medical Colleges;  
23 representation among these racial and ethnic groups in the physician workforce lags significantly  
24 behind their numbers in the general population. In addition, these three populations faced historical  
25 discrimination, which prevented them from entering the profession.

26  
27 During the last five years the following priority issues have been the focus of the MAS:

- 28  
29
- 30 • Diversity in medicine and minoritized physician advocacy: The MAS Doctors Back to  
31 School™ (DBTS) program aims to encourage interest in careers in medicine among  
32 elementary, middle and high school students through visits from physicians and medical  
33 students in the hope of increasing diversity within the medical profession. Over 100,000  
34 minoritized youth have been engaged through the program by volunteer physicians and  
35 medical students nationwide. Additionally, MAS partners with the AMA Foundation to  
36 promote scholarship programs among minoritized medical students. Each year, two  
37 scholarships are awarded and over \$1,000,000 in scholarships have been awarded to  
hundreds of minoritized medical students. Studies have demonstrated that physicians from

1 diverse backgrounds increase patient satisfaction, provide culturally competent care and  
2 decrease racial and ethnic health care disparities.

- 3  
4 • Enhancing AMA policy and advocacy on behalf of minoritized patients and physicians:  
5 The MAS has sponsored or cosponsored more than 30 resolutions that have modified  
6 AMA policy since 2015 on topics relevant to minoritized patients and physicians. These  
7 topics have included racial essentialism in medicine, primary care physicians in  
8 underserved areas, language proficiency data of physicians in the AMA Masterfile, terms  
9 and language in policies adopted to protect populations from discrimination and  
10 harassment, preventing anti-transgender violence and strategies for enhancing diversity in  
11 the physician workforce.
- 12  
13 • Enhancing AMA partnerships with external stakeholders to improve and strengthen  
14 AMA's impact on health education for minoritized communities, programmatic initiatives,  
15 and awareness of AMA's ongoing work to achieve health equity and eliminate health  
16 disparities: The MAS has long-standing relationships with the Association of American  
17 Indian Physicians (AAIP), National Hispanic Medical Association (NHMA), National  
18 Medical Association (NMA), National Minority Quality Forum and the Medical  
19 Organization for Latino Advancement. Strategic partnerships with these organizations  
20 include collaborative efforts through representation, policy, programs, and education. Key  
21 outcomes have included remarks and presentations at annual conferences by AMA  
22 presidents and MAS leaders, designated seats on the MAS governing council (GC), and  
23 AMA sponsorships and cross-promotional activities (e.g., CME sessions, speaking  
24 engagements, exhibit booths, AMA member engagement initiatives, participation in AMA  
25 marketing campaigns, research, physician advocacy and AMA policy development.)  
26

27 *CLRPD assessment: The MAS focuses on the concerns of underrepresented and minoritized*  
28 *physicians and medical students and issues related to the health of minoritized communities. As the*  
29 *only formalized structure to facilitate and encourage the participation of minoritized physicians in*  
30 *the deliberations of the AMA HOD and other AMA activities, the MAS fills a demonstrated need, as*  
31 *within the physician community and organized medicine, African American/Black,*  
32 *Hispanic/Latino, and American Indian/Alaska Native physicians and medical students face both*  
33 *current and historical underrepresentation.*  
34

35 Criterion 2: Consistency – Objectives and activities of the group are consistent with those of the  
36 AMA. Activities make good use of available resources and are not duplicative.  
37

38 In August 2020, MAS collaborated with AMA staff to identify section-specific objectives to build  
39 upon the established foundational objectives that guide all AMA sections. Those MAS-specific  
40 objectives are to improve communications with strategic partners, improve representation in  
41 medicine among minoritized populations and enhance health policy related to minoritized  
42 communities. To accomplish these objectives, the MAS developed specific key goals related to  
43 each objective using the S.M.A.R.T tool, which is used to set goals that are specific, measurable,  
44 achievable, relevant and time-bound:  
45

- 46 • Improve communication with strategic partners: 1) fully inform GC members, MAS  
47 members and external partners of MAS activities, policy efforts and other issues of  
48 importance to the health of minoritized communities; and 2) increase engagement of MAS  
49 members.

- 1 • Improve diversity in medicine among minoritized populations: 1) increase representation  
2 of minoritized physicians and medical students in ambassador and other AMA leadership  
3 roles such as HOD delegates by 2025; and 2) contribute expertise annually to improve two  
4 pathway programs.
- 5
- 6 • Improve health policy related to minoritized populations at the AMA: contribute annually  
7 to the development and/or initiation of at least three policies.
- 8

9 To achieve these goals, MAS has employed the following tactics:

- 10
- 11 • Launching a member engagement survey
- 12 • Developing a leadership academy for MAS members interested in AMA leadership roles
- 13 • Collaborating with pathway programs for minoritized populations
- 14 • Continuing the DBTS program
- 15 • Strategically partnering with AMA business units including the AMA Foundation, other  
16 AMA sections, Advocacy, the Center for Health Equity, and the Board of Trustees as well  
17 as other HOD delegations
- 18 • Holding a MAS Caucus at each HOD meeting
- 19 • Developing educational programming
- 20

21 *CLRPD Assessment: The activities of the MAS focus on bringing forward issues that are important*  
22 *and unique to its constituents. The section has worked to develop appropriate and measurable*  
23 *objectives in alignment with the AMA and has implemented tactics to achieve those goals within*  
24 *specified time periods. Its strategic foci on improving communications with strategic partners,*  
25 *improving representation in medicine among underrepresented and minoritized physicians and*  
26 *medical students, and improving health policy related to minoritized communities at the AMA are*  
27 *appropriate, and the methodologies employed toward achieving those goals demonstrate a*  
28 *commitment to doing so effectively and efficiently.*

29

30 Criterion 3: Appropriateness - The structure of the group will be consistent with its objectives and  
31 activities.

32

33 Individual physicians or medical students initiate membership in the MAS upon request.  
34 Membership is open to any AMA member physician or medical student who expresses an interest  
35 in issues related to racially and ethnically minoritized physicians or health issues related to  
36 minoritized populations. Eligible voters with full rights and privileges are referred to as MAS  
37 members. To facilitate section business and policy development, the section's ten GC members  
38 meet in-person three times each year and hold monthly virtual meetings. Current MAS members  
39 with an active AMA membership are eligible to be nominated to the designated positions on the  
40 GC. Three physician organizations (NMA, AAIP, and NHMA) and the three AMA fixed sections  
41 nominate representatives to be elected to their designated positions on the MAS GC.

42

43 The MAS holds business meetings in conjunction with AMA HOD meetings. MAS represents the  
44 interests of its members in the HOD through the actions of its elected delegate, and the Chair of the  
45 MAS GC serves as the alternate delegate to the HOD. As part of the section business meetings,  
46 informational panels are convened to inform section members about wide-ranging critical issues  
47 that align with the section's priorities. Topics have included pathway programs for minoritized  
48 populations, gun violence, priorities of medical societies representing minoritized physicians and  
49 health equity in medicine. The MAS also conducts a DBTS program with local schools in  
50 conjunction with HOD meetings.

1 *CLRPD Assessment: MAS membership is open to any AMA member with an interest in racially and*  
2 *ethnically minoritized physicians or health issues of minoritized populations. The section's*  
3 *business meetings provide opportunities for its members to participate in the deliberations of the*  
4 *section, as well as providing educational opportunities to increase members' knowledge of issues*  
5 *related to the priorities of the section.*

6  
7 Criterion 4: Representation Threshold - Members of the formal group would be based on  
8 identifiable segments of the physician population and AMA membership. The formal group would  
9 be a clearly identifiable segment of AMA membership and the general physician population. A  
10 substantial number of members would be represented by this formal group. At minimum, this  
11 group would be able to represent 1,000 AMA members.

12  
13 The AMA has nearly 31,000 members self-identified as African American/Black, Hispanic/Latino  
14 and American Indian/Alaska Native (an increase of approximately 7,000 since the previous review  
15 of the MAS delineated section status in 2016), and all these physicians and medical students are  
16 eligible members of the MAS. In addition, membership to the MAS is available to any AMA  
17 member physician or medical student who expresses an interest in issues related to racially and  
18 ethnically minoritized physicians or health issues related to minoritized communities. Recent  
19 actions by the AMA and the HOD have demonstrated a recognized urgency for the Association to  
20 address current and historical inequities in medicine.

21  
22 *CLRPD Assessment: The MAS is comprised of members from an identifiable segment of AMA*  
23 *membership and the general physician population. This group represents more than 1,000 AMA*  
24 *members.*

25  
26 Criterion 5: Stability - The group has a demonstrated history of continuity. This segment can  
27 demonstrate an ongoing and viable group of physicians, who will be represented by this section.  
28 Both the segment and the AMA will benefit from an increased voice within the policymaking  
29 body.

30  
31 The AMA Minority Affairs Consortium became the MAS in 2011. Approximately 100 members  
32 attend each of the two MAS business meetings held in conjunction with HOD meetings. To  
33 determine policy priorities on issues of concern, MAS members submit draft resolutions to the  
34 MAS GC for its consideration in advance of each meeting of the HOD. The GC determines priority  
35 status and approves resolutions that will advance to the HOD for further consideration. To develop  
36 a consensus opinion on MAS resolutions, MAS members participate in an online member forum  
37 and vote to support or oppose draft resolutions. In addition, MAS solicits input from all AMA  
38 meeting attendees during MAS business meetings. As noted previously, since 2015, the MAS has  
39 sponsored or cosponsored more than 30 resolutions that have been adopted, reaffirmed or amended  
40 AMA policy by the HOD on a variety of topics relevant to minoritized patients and physicians.  
41 More than 2,800 AMA members have opted in to subscribe to the MAS listserv.

42  
43 *CLRPD Assessment: The MAS has an established history at the AMA and actively participates in*  
44 *the policymaking process of the HOD, which benefits from the distinct voice of the MAS in its*  
45 *deliberations. Since its inception, the MAS has taken numerous steps to align its structure with the*  
46 *policymaking activities of the AMA.*

47  
48 Criterion 6: Accessibility - Provides opportunity for members of the constituency who are  
49 otherwise underrepresented to introduce issues of concern and to be able to participate in the  
50 policymaking process within the AMA HOD.

1 During MAS business meetings, leadership requests policy ideas from section members to submit  
2 at future HOD meetings and works to identify gaps in current policy. Attendance at in-person  
3 meetings averages approximately 100 attendees. The GC approves resolutions for adoption and  
4 works with the author(s) to refine wording and research citations. To develop a consensus opinion  
5 on draft resolutions, MAS members meet via an online forum prior to the HOD handbook  
6 deadlines and vote in support or opposition of a resolution. Members also may submit comments or  
7 testimony that offer revisions to the original resolution. Approximately 100 MAS members provide  
8 votes and testimony prior to each policymaking meeting. Over 1,500 MAS members receive the  
9 resolution information electronically. The MAS GC, in cooperation with the Committee on  
10 Advocacy, considers comments, votes and testimony before editing resolutions for a final  
11 ratification vote. A majority vote of those present directs the action of the MAS GC and MAS  
12 Delegate to submit or not submit MAS resolutions to the HOD.

13

14 *CLRPD Assessment: The MAS provides opportunities for members of its constituency who are*  
15 *otherwise underrepresented to introduce issues of concern and participate in the HOD*  
16 *policymaking process. Through a variety of forums and outreach efforts, MAS members are*  
17 *afforded the opportunity to comment on draft resolutions, and MAS leadership considers the*  
18 *feedback of its members before finalizing those resolutions.*

19

## 20 CONCLUSION

21

22 The CLRPD has determined that the MAS meets all criteria; therefore, it is appropriate to renew  
23 the delineated section status of the section.

24

## 25 RECOMMENDATION

26

27 The Council on Long Range Planning and Development recommends that our American Medical  
28 Association renew delineated section status for the Minority Affairs Section through 2026 with the  
29 next review no later than the 2026 Interim Meeting and that the remainder of this report be filed.  
30 (Directive to Take Action)

Fiscal Note: Less than \$500 to update policy database.

# REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 2-N-21

Subject: Integrated Physician Practice Section Five-Year Review

Presented by: Clarence Chou, MD, Chair

Referred to: Reference Committee F

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1 AMA Bylaw 7.0.9 states, “A delineated section must reconfirm its qualifications for continued  
2 delineated section status and associated representation in the House of Delegates by demonstrating  
3 at least every 5 years that it continues to meet the criteria adopted by the House of Delegates.”  
4 AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and  
5 Development (CLRPD) is “to evaluate and make recommendations to the House of Delegates,  
6 through the Board of Trustees, with respect to the formation and/or change in status of any section.  
7 The Council will apply criteria adopted by the House of Delegates.”

8  
9 The Council accessed information from a letter of application submitted by the Integrated  
10 Physician Practice Section (IPPS) for renewal of delineated section status.

## 11 APPLICATION OF CRITERIA TO THE INTEGRATED PHYSICIAN PRACTICE SECTION

12  
13  
14 Criterion 1: Issue of Concern - Focus will relate to concerns that are distinctive to the subset within  
15 the broader, general issues that face medicine. A demonstrated need exists to deal with these  
16 matters, as they are not currently being addressed through an existing AMA group.

17  
18 The House of Delegates (HOD) adopted the Integrated Physician Practice Section (IPPS) as a  
19 delineated section in 2011. The precursor to the IPPS was the Advisory Committee on Group  
20 Practice Physicians, a Board-appointed committee founded in the early 1990s. The characteristic  
21 that distinguishes IPPS from other AMA component groups is that the section focuses on the  
22 continuum of care through an integrated delivery system. The IPPS works to advance the interests  
23 of multi-specialty, physician-led, integrated health care delivery systems, and medical groups  
24 actively working toward systems of coordinated care. The IPPS provides a nationwide forum to  
25 give voice to and advocate for issues that impact physicians in practice settings who advance  
26 physician-led integrated care.

27  
28 In 2019, AMA sections implemented a strategic planning framework that is uniform across the  
29 sections. All sections have the three common foundational objectives as follows: develop and  
30 activate impactful policy on issues of relevance to section constituencies; cultivate the next  
31 generation of physician leaders and hone the leadership skills of established leaders; and equip  
32 section leaders with resources and opportunities to tell the section story and recruit peers to AMA  
33 sections. In support of these foundational objectives, IPPS adopted the following objectives that are  
34 unique to the section: 1) strengthen awareness of the IPPS (to constituents both internal and  
35 external to the AMA) as the expert on physician-led integrated care; and 2) advance collective  
36 expertise to promote physician-led coordinated care and how it is operationalized.

1 In order to maintain its role as the voice for physician-led integrated health care whose members  
2 have experience leading such health care systems, the section seeks to constitute the IPPS  
3 Governing Council (GC) mostly with executive-level physicians and also sustain diversity among  
4 its leadership including gender, ethnic, geographic and practice setting diversity. The IPPS aspires  
5 to continue growing its membership and sustain a majority of new members who are executive-  
6 level or high-ranking physicians in their organizations; works to continually advance the  
7 effectiveness of its members within the AMA’s policymaking process; seeks to advance the  
8 delivery model of physician-led integrated care by showcasing IPPS members at AMA live or  
9 virtual programs, and other AMA media; proactively seeks ways to advance IPPS members for  
10 placement in advisory roles or committees; and promotes the delivery model of physician-led  
11 integrated care.

12  
13 Priority issues/concerns currently being addressed by IPPS include employer-driven innovations in  
14 health care; new payment models around value-based care, risk contracts, and Medicare payment  
15 policies; health system consolidation and the impact on physician-led integrated systems; and  
16 social determinants of health and quality measurement.

17  
18 *CLRPD Assessment: The IPPS is the sole component group that focuses on issues concerning*  
19 *integrated physician practices and physician-led coordinated health care. The section provides a*  
20 *direct and ongoing relationship between the AMA and this cohort of physicians.*

21  
22 Criterion 2: Consistency - Objectives and activities of the group are consistent with those of the  
23 AMA. Activities make good use of available resources and are not duplicative.

24  
25 The IPPS works closely with the AMA membership team to feature the section as an important part  
26 of the benefits package for large health systems and to help achieve the AMA’s strategic  
27 membership objectives. An example of this approach is the leadership of IPPS in the development  
28 of the AMA’s Integrated Care Consortium (ICC), which allows participation of physician  
29 executives from AMA member groups and focuses on recruiting large health systems into the  
30 [AMA Health System Program](#) that offers partners unique resources to improve outcomes, elevate  
31 recognition and drive value. The IPPS GC meets in conjunction with the ICC during the Annual  
32 Meeting of the HOD to help ICC members understand the opportunities for amplifying their voice  
33 and advancing their interests through the IPPS and HOD. In 2019, 100% of ICC attendees attended  
34 the IPPS meeting.

35  
36 The IPPS works closely with the AMA’s Professional Satisfaction and Practice Sustainability  
37 (PS2) unit. Some of those efforts include frequent partnering in the development of IPPS  
38 educational programs and featuring PS2 staff as speakers or leaders of IPPS roundtable  
39 discussions. The efforts have proved symbiotic in helping PS2 gain important insights from the  
40 IPPS as well as helping the IPPS understand and offer input into the AMA’s work in the quality  
41 arena. Additionally, the IPPS has assisted the AMA’s Improving Health Outcomes (IHO) efforts by  
42 inviting staff from that area to meet with IPPS GC members to obtain updates on IHO initiatives.  
43 As a result, several IPPS member organizations have rolled out IHO programs on hypertension and  
44 diabetes within their systems.

45  
46 The IPPS has worked to develop policy in the HOD including advancing resolutions and offering  
47 input on council and board reports while they are still in development. At the November 2020  
48 Special Meeting, the HOD adopted recommendations in BOT Report 6, “Covenants Not to  
49 Compete,” which relates to restrictive covenants that the IPPS has particular interest in. The IPPS  
50 GC had reviewed the draft report, shared its position on the issue and found the report to be fair

1 and balanced. The IPPS has reached out to staff and members of councils on other occasions to  
2 discuss upcoming various issues.

3  
4 *CLRPD Assessment: The IPPS works with a variety of groups to help support the work of the AMA*  
5 *related to health system reform and physician-led integrated care. Participation in the IPPS serves*  
6 *as a key member benefit for physician groups considering AMA group membership. Additionally,*  
7 *the section has selected areas of focus that align closely with the AMA's strategic direction and has*  
8 *sought opportunities for collaboration on cross-cutting issues and programs. IPPS has been*  
9 *doubling its efforts to ensure that the section's activities and foci aptly address the criteria.*

10  
11 Criterion 3: Appropriateness - The structure of the group will be consistent with its objectives and  
12 activities.

13  
14 The IPPS includes two levels of membership as defined in the AMA Bylaws: Associate with full  
15 privileges, and Affiliate with limited privileges. The IPPS Credentials Committee reviews all  
16 applications for Associate and Affiliate membership and makes a recommendation as to whether an  
17 applicant's organization meets the criteria established by the section for Associate or Affiliate  
18 membership.

19  
20 The IPPS GC found that some existing members of the section whose systems had merged or been  
21 acquired no longer met the IPPS criteria, even though their organizations remained committed to  
22 physician leadership, and had physicians in high executive positions. Therefore, in 2018, the IPPS  
23 GC sought to strike a balance between establishing a high threshold for physician leadership while  
24 at the same time not excluding organizations that were committed to physician leadership.

25  
26 The new membership criteria ultimately approved by the AMA Board of Trustees are as follows:

27  
28 **Associate Members.** Associate Members are members of the AMA who are in physician-led,  
29 integrated health care organizations, which coordinate patient care across specialties and among  
30 physicians who share common records and clinical care processes. An organization must meet 7  
31 characteristics of physician-led, integrated health care organizations in order to qualify its  
32 physician members as Associate Members. Associate Members must demonstrate that their  
33 organizations have physicians in defined leadership roles at high levels in the organization, with  
34 meaningful decision authority and/or input regarding strategic, quality and operational issues, as  
35 well as a defined communication channel to the organization's governing body.

36  
37 **Affiliate Members.** Affiliate Members are members of the AMA who practice in organizations  
38 moving toward physician-led integrated health care that do not yet satisfy the characteristics of  
39 organizations eligible to qualify their physicians as Associate Members, but that meet at least one  
40 of the required characteristics for Associate Members. Affiliate Members shall be non-voting  
41 members of the Section.

42  
43 The new criteria around physician leadership have made it possible for more health systems to  
44 qualify for membership and contribute to IPPS. Section members can serve on the IPPS GC; attend  
45 and be a featured speaker at Assembly Meetings; lead a roundtable discussion at live meetings;  
46 share their expertise and network with peers during IPPS meetings; submit a resolution to the  
47 section and participate in select advocacy efforts; and serve on a variety of IPPS committees  
48 including Policy Development Committee, Tellers Committee, and Credentials Committee.

49  
50 *CLRPD Assessment: The structure of the IPPS allows members to participate in the deliberations*  
51 *and pursue the objectives of the section, including opportunities for between-meeting engagement.*

1 *The IPPS GC developed a strategic framework to enhance the section's focus and impact of future*  
2 *efforts. In its 2020 letter of application, the IPPS noted that the section will endeavor to increase*  
3 *efforts of diversity among its leadership. CLRPD members will evaluate any progress on this goal*  
4 *with its next evaluation in five years.*

5  
6 Criterion 4: Representation Threshold - Members of the formal group would be based on  
7 identifiable segments of the physician population and AMA membership. A substantial number of  
8 members would be represented by this formal group. At minimum, this group would be able to  
9 represent 1,000 AMA members. It is important to note this threshold will not be used to determine  
10 representation, as each new section will be allocated only one delegate and one alternate delegate in  
11 the AMA HOD.

12  
13 The IPPS has approximately 40 active health care systems whose representatives reliably attend the  
14 IPPS meetings. There are physicians of 20 additional health care systems who have completed  
15 certification forms and attended an IPPS meeting but are not active members of the section.

16  
17 The IPPS has current data on the number of physicians in the organizations that partner with the  
18 AMA Health System Program. Those health systems alone represent 21,263 physician members.  
19 Outside of the Health System Partners, it has not been feasible to track data on the number of  
20 physicians in health systems in IPPS. The biggest barrier to that data collection has been the steady  
21 pace of health system mergers/acquisitions. Regarding potential IPPS membership among the  
22 general population, it is challenging to identify the universe of physician-led integrated systems. In  
23 the absence of hard data that identify how many organizations are physician-led and how many  
24 physicians are in those organizations, the number of AMA members eligible for representation in  
25 IPPS is unknown; however, that number exceeds 1,000 physician members.

26  
27 During the November 2020 Special Meeting of the HOD, IPPS welcomed new members from:  
28 multiple Permanente systems across the country; Atlantic Health, New Jersey; Hattiesburg Clinic,  
29 Mississippi; Ochsner Health, Louisiana; University of Iowa Hospitals and Clinics, Iowa; and Henry  
30 Ford Health System, Michigan.

31  
32 *CLRPD Assessment: The IPPS estimates that 21,263 physician members are represented through*  
33 *their health systems, which exceeds the minimum threshold of 1,000 AMA members. Further, the*  
34 *total potential representation in the IPPS encompasses a significant number of AMA members.*

35  
36 Criterion 5: Stability - The group has a demonstrated history of continuity. This segment can  
37 demonstrate an ongoing and viable group of physicians, who will be represented by this section.  
38 Both the segment and the AMA will benefit from an increased voice within the policymaking  
39 body.

40  
41 Attendance at IPPS meetings is typically higher at the Annual Meetings, which holds true across  
42 the sections. At the IPPS Annual Meetings, 50-75 people attend and 40-50 physicians attend the  
43 Interim Meetings. The primary section communication vehicle is a monthly newsletter that keeps  
44 members updated on all IPPS activities. That communication is sent primarily to IPPS members  
45 and boasts an open rate of 30% (AMA email benchmark is approximately 20%).

46  
47 Outreach to potential members who have not signed up to receive the newsletter has been more  
48 challenging. To build membership, the IPPS seeks to reach out to physician executives in  
49 physician-led integrated systems. However, a list of those physicians and their contact information  
50 does not exist. In the absence of a targeted email list, the two most effective methods of growing  
51 the section have been peer-to-peer outreach and recruitment of members of the ICC. Since its

1 formation in 2018, the ICC has been the most successful method of attracting physician executives  
2 to IPPS meetings and activities. At the last meeting of the ICC in 2019, all ICC attendees attended  
3 the IPPS meeting on the following day.

4  
5 *CLRPD Assessment: Since its inception, the IPPS has taken numerous steps to align its structure*  
6 *with the policymaking activities of the AMA and increase its membership. The AMA and physicians*  
7 *from physician-led integrated practices benefit from having a distinct voice of the IPPS in the*  
8 *HOD.*

9  
10 Criterion 6: Accessibility - Provides opportunity for members of the constituency, who are  
11 otherwise underrepresented, to introduce issues of concern and to be able to participate in the  
12 policymaking process within the HOD.

13  
14 The IPPS Policy Development Committee meets periodically to discuss issues relevant to the  
15 section and consider drafting specific resolutions. Any interested member can serve on the  
16 committee. Any items of interest are included in an IPPS GC Report, which is considered by the  
17 Assembly at the meeting.

18  
19 Prior to every IPPS meeting, the IPPS newsletter includes a link to the IPPS website that hosts a  
20 policy primer video and information on how to submit a resolution. Once resolutions are submitted,  
21 the IPPS online forum is open for section members and nonmembers to comment on IPPS  
22 resolutions and to highlight issues of interest included in the HOD handbook.

23  
24 The IPPS GC takes an active role in the process of reviewing HOD business. With each passing  
25 meeting, the IPPS GC and Assembly become more skilled in their understanding of the HOD and  
26 how to advance policies of interest.

27  
28 At section meetings, attendees are invited to comment on any of the items in the IPPS GC Report,  
29 as well as raise items of interest from the HOD not included in the report. During the discussion, if  
30 it is unclear where the attendees stand on an issue, the Chair calls for a vote. The IPPS develops  
31 consensus on HOD business through the IPPS online forum, the IPPS GC's initial review of the  
32 HOD handbook, development of an IPPS Report, and discussions and voting at IPPS meetings.

33  
34 *CLRPD Assessment: The IPPS provides numerous opportunities for members of the constituency*  
35 *who are otherwise underrepresented to introduce issues of concern and to be able to participate in*  
36 *the HOD policymaking process.*

37  
38 CONCLUSION

39  
40 The CLRPD has determined that the IPPS meets all required criteria; therefore, it is appropriate to  
41 renew the delineated section status of the IPPS.

42  
43 RECOMMENDATION

44  
45 The Council on Long Range Planning and Development recommends that our American Medical  
46 Association renew delineated section status for the Integrated Physician Practice Section through  
47 2026 with the next review no later than the 2026 Interim Meeting and that the remainder of this  
48 report be filed. (Directive to Take Action)

Fiscal Note: Less than \$500 to update policy database.

REPORT OF THE HOUSE OF DELEGATES COMMITTEE  
ON THE COMPENSATION OF THE OFFICERS

Compensation Committee Report, N-21

Subject: Report of the House of Delegates Committee on the Compensation of the Officers  
Presented by: Steven Tolber, MD, Chair  
Referred to: Reference Committee F

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1 This report by the committee at the November 2021 Special Meeting of the House of Delegates  
2 presents two recommendations. It also documents the compensation paid to Officers for the period  
3 July 1, 2020 thru June 30, 2021 and includes the 2020 calendar year IRS reported taxable value of  
4 benefits, perquisites, services, and in-kind payments for all Officers.

5  
6 BACKGROUND

7  
8 At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on  
9 Trustee Compensation, currently named the Committee on Compensation of the Officers, (the  
10 “Committee”). The Officers are defined in the American Medical Association’s (AMA)  
11 Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the  
12 HOD, Article V refers simply to “Officer,” which includes all 21 members of the Board among  
13 whom are the President, President-Elect, Immediate Past President, Secretary, Speaker of the HOD  
14 and Vice Speaker of the HOD, collectively referred to in this report as Officers.) The composition,  
15 appointment, tenure, vacancy process and reporting requirements for the Committee are covered  
16 under the AMA Bylaws. Bylaws 2.13.4.5 provides:

17  
18 The Committee shall present an annual report to the House of Delegates recommending the  
19 level of total compensation for the Officers for the following year. The recommendations of the  
20 report may be adopted, not adopted, or referred back to the Committee, and may be amended  
21 for clarification only with the concurrence of the Committee.

22  
23 At A-00, the Committee and the Board jointly adopted the American Compensation Association’s  
24 definition of total compensation which was added to the Glossary of the AMA Constitution and  
25 Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an  
26 individual for work performance, including: (a) all forms of money or cash compensation; (b)  
27 benefits; (c) perquisites; (d) services; and (e) in-kind payments.

28  
29 Since the inception of this Committee, its reports document the process the Committee follows to  
30 ensure that current or recommended Officer compensation is based on sound, fair, cost-effective  
31 compensation practices as derived from research and use of independent external consultants,  
32 expert in Board compensation. Reports beginning in December 2002 documented the principles the  
33 Committee followed in creating its recommendations for Officer compensation.

34  
35 At A-08, the HOD approved changes that simplified compensation practices with increased  
36 transparency and consistency. At A-10, Reference Committee F requested that this Committee  
37 recommend that the HOD affirm a codification of the current compensation principle, which

1 occurred at I-10. At that time, the HOD affirmed that this Committee has and will continue to base  
2 its recommendations for Officer compensation on the principle of the value of work performed,  
3 consistent with IRS guidelines and best practices recommended by the Committee's external  
4 independent consultant, who is expert in Board compensation.

5  
6 At A-11, the HOD approved the alignment of Medical Student and Resident Officer compensation  
7 with that of all other Officers (excluding Presidents and Chair) because these positions perform  
8 comparable work.

9  
10 Immediately following A-11, the Committee retained Mr. Don Delves, founder of the Delves  
11 Group, to update his 2007 research by providing the Committee with comprehensive advice and  
12 counsel on Officer compensation. The updated compensation structure was presented and approved  
13 by the HOD at I-11 with an effective date of July 1, 2012.

14  
15 The Committee's I-13 report recommended and the HOD approved the Committee's  
16 recommendation to provide a travel allowance for each President to be used for upgrades because  
17 of the significant volume of travel representing our AMA.

18  
19 At I-16, based on results of a comprehensive compensation review conducted by Ms. Becky Glantz  
20 Huddleston, an expert in Board Compensation with Willis Towers Watson, the HOD approved the  
21 Committee's recommendation of modest increases to the Governance Honorarium and Per Diems  
22 for Officer Compensation, excluding the Presidents and Chair, effective July 1, 2017. At A-17 the  
23 HOD approved modifying the Governance Honorarium and Per Diem definition so that Internal  
24 Representation, greater than eleven days, receives a per diem.

25  
26 At A-18, based on comprehensive review of Board leadership compensation, the HOD approved  
27 the Committee's recommendation to increase the President, President-elect, Immediate Past-  
28 President, Chair, and Chair-elect honoraria by 4% effective July 1, 2018.

29  
30 At A-18 and A-19, the House approved the Committee's recommendation to provide a Health  
31 Insurance Stipend to President(s) who are under Medicare eligible age when the President(s) and  
32 his/her covered dependents, not Medicare eligible, lose the President's employer provided health  
33 insurance during his/her term as President. Should the President(s) become Medicare eligible while  
34 in office, he/she received an adjusted Stipend to provide insurance coverage to his/her dependents  
35 not Medicare eligible.

36  
37 The Committee's I-19 report recommended and the HOD approved the Committee's  
38 recommendation to increase the Governance Honorarium and Per Diem for Officers, excluding  
39 Presidents and Chair, by approximately 3% each effective July 1, 2020.

#### 40 41 CASH COMPENSATION SUMMARY

42  
43 The cash compensation of the Officers shown in the following table will not be the same as  
44 compensation reported annually on the AMA's IRS Form 990s because Form 990s are based on a  
45 calendar year. The total cash compensation in the summary is compensation for the days these  
46 officers spent away from home on AMA business approved by the Board Chair. The total cash  
47 compensation in the summary includes work as defined by the Governance Honorarium, Per Diem  
48 for Representation and Telephone Per Diem for External Representation. Detailed definitions are in  
49 the Appendix.

1 The summary covers July 1, 2020 to June 30, 2021.

AMA Officers	Position	Total Compensation	Total Days
David H Aizuss, MD	Officer	\$ 67,700	39
Grayson W Armstrong, MD, MPH	Resident/Fellow Physician Officer	\$ 67,000	36.5
Susan R Bailey, MD	President	\$ 290,160	72
Madelyn E. Butler, MD	Officer	-	2
Willarda V Edwards, MD, MBA	Officer	\$ 71,200	38
Lisa Bohman Egbert, MD	Vice Speaker, House of Delegates	\$ 142,600	97.5
Jesse M Ehrenfeld, MD, MPH	Immediate Past Chair	\$ 101,300	67
Scott Ferguson, MD	Officer	\$ 71,200	43.5
Sandra Adamson Fryhofer, MD	Secretary	\$ 112,500	72
Gerald E Harmon, MD	President-Elect	\$ 284,960	54
Patrice A Harris, MD, MA	Immediate Past President	\$ 284,960	74
Drayton Charles Harvey	Officer	-	2
Pratistha Koirala, MD	Officer	-	2
Russ Kridel, MD	Chair	\$ 280,280	44.5
Ilse R Levin, DO, MPH & TM	Officer	\$ 67,000	36
Thomas J Madejski, MD	Officer	\$ 74,000	42
Mario E Motta, MD	Officer	\$ 74,000	35.5
Bobby Mukkamala, MD	Chair-Elect	\$ 207,480	42
Blake Elizabeth Murphy	Medical Student Officer	\$ 67,000	37.5
Harris Pastides, PhD, MPH	Public Member Officer	\$ 67,000	36
Jack Resneck, Jr, MD	Officer	\$ 77,500	49.5
Bruce A Scott, MD	Speaker, House of Delegates	\$ 126,450	91.5
Michael Suk, MD, JD, MPH, MBA	Officer	\$ 78,200	42.5
Willie Underwood, III, MD, MSc, MPH	Officer	\$ 71,200	37.5

2 President, President-Elect, Immediate Past President, and Chair  
 3 In 2020 – 2021, each of these positions received an annual Governance Honorarium which was  
 4 paid in monthly increments. These four positions spent a total of 244.5 days on approved  
 5 Assignment and Travel, or 61.1 days each on average.

6  
 7 Chair-Elect  
 8 This position received a Governance Honorarium of approximately 75% of the Governance  
 9 Honorarium provided to the Chair.

10  
 11 All other Officers  
 12 All other Officers received cash compensation, which included a Governance Honorarium of  
 13 \$67,000 paid in monthly installments. The remaining cash compensation is for Assignment and  
 14 Travel Days that are approved by the Board Chair to externally represent the AMA and for Internal  
 15 Representation days above 11. These days were compensated at a per diem rate of \$1,400. *Note:*  
 16 The Speaker and Vice Speaker had higher compensation than normal given how much extra time  
 17 they devoted to planning the virtual special meetings of the House.

1 Assignment and Travel Days

2 The total Assignment and Travel Days for all Officers (excluding the President, President-Elect,  
3 Immediate Past President and Chair) were 849.5.

4  
5 EXPENSES

6  
7 Total expenses paid for period, July 1, 2020 – June 30, 2021, \$45,390, without use of upgrades for  
8 Presidents' travel per the approved Presidential Upgrade Allowance of \$2,500 per position per  
9 term.

10  
11 BENEFITS, PERQUISITES, SERVICES, AND IN-KIND PAYMENTS

12  
13 Officers are able to request benefits, perquisites, services, and in-kind payments, as defined in the  
14 "AMA Board of Trustees Standing Rules on Travel Expenses." These non-taxable business  
15 expense items are provided to assist the Officers in performing their duties.

- 16  
17
  - AMA standard laptop computer or iPad
  - 18 • iPhone
  - 19 • American Express card (for AMA business use)
  - 20 • Combination fax/printer/scanner
  - 21 • An annual membership to the airline club of choice offered each year during the Board
  - 22 member's tenure
  - 23 • Personalized AMA stationary, business cards, and biographical data for official use

24

25 Additionally, all Officers are eligible for \$305,000 term life insurance and are covered under the  
26 AMA's \$500,000 travel accident policy and \$10,000 individual policy for medical costs arising out  
27 of any accident while traveling on official business for the AMA. Life insurance premiums paid by  
28 the AMA are reported as taxable income. Also, travel assistance is available to all Officers when  
29 traveling more than 100 miles from home or internationally.

30  
31 Secretarial support, other than that provided by the AMA's Board office, is available up to defined  
32 annual limits as follows: President, during the Presidential year, \$15,000, and \$5,000 each for the  
33 President-Elect, Chair, Chair-Elect, and Immediate Past President per year. Secretarial expenses  
34 incurred by other Officers in conjunction with their official duties are paid up to \$750 per year per  
35 Officer. This is reported as taxable income.

36  
37 As our Officers begin to travel more on behalf of our AMA, back-up care for child(ren) or adult  
38 family member(s) could be a concern. To alleviate that concern, Officers will be eligible to  
39 participate in a service provided to AMA employees by Care@Work through Care.com. This  
40 service offers referral services at no cost and back-up care for children and adults up to 10 days a  
41 calendar year at a subsidized rate. If a Board member uses back-up care, it will be reported to the  
42 IRS as taxable income.

43  
44 Calendar year taxable life insurance and taxable secretarial fee reported to the IRS totaled \$43,068  
45 and \$38,500 respectively for 2020. An additional \$15,125 was paid to third parties for secretarial  
46 services during 2020.

1 FINDINGS

2  
3 The Cash Compensation Summary, travel expenses, and the suspension of tracking telephonic  
4 representation since all meetings were conducted virtually reflect the impact of the Coronavirus on  
5 the Officers in representing our AMA. Effective March 17, 2020 all travel ceased, and all in-person  
6 meetings were canceled or moved to a virtual format. Our AMA leadership quickly pivoted to  
7 continue representing the AMA, both internally and externally, in a completely virtual  
8 environment. This pivot, while appearing seamless, required significant flexibility and behind-the-  
9 scenes planning of our Officers. As you know, both our Annual and Interim Meetings were  
10 suspended.

11  
12 The President, President-Elect, and Immediate Past President, along with all other Officers, have  
13 traveled to represent the AMA while continuing to represent the AMA in podcasts, on Facebook,  
14 Zoom, Microsoft Teams and other media to advocate on behalf of physicians and patients. Travel is  
15 not without risks and to minimize the risk during this health emergency, this Committee  
16 recommends an increase from \$2500 to \$5000 to the travel upgrade allowance for President,  
17 President-Elect, and Immediate Past-President. The Committee also recommends that to minimize  
18 the risk to all other Officers, an upgrade allowance of \$1250 be piloted between November 17,  
19 2021 thru April 17, 2022. Use of the upgrade allowance for Officers will comport with the current  
20 definition in the travel policy and the Board travel and expense standing rules. At A-22 the  
21 Committee will report on the use of the upgrade allowance during the pilot.

22  
23 This Committee commends and thanks our Officers for their representation of the AMA.

24  
25 RECOMMENDATIONS

- 26  
27 1. That there be no changes to the Officers' compensation for the period beginning July 1, 2021  
28 through June 30, 2022. (Directive to Take Action)  
29  
30 2. That the travel policy and the Board travel and expense standing rules be amended by addition,  
31 shown with underscores as follows:

32  
33 Transportation

- 34 a. Air: AMA policy on reimbursement for domestic air travel for members of the Board is that the  
35 AMA will reimburse for coach fare only. The Presidents (President, Immediate Past President  
36 and President Elect) will each have access to an individual \$5,000 term allowance (July 1 to  
37 June 30) and during the pilot, all other Officers will each have access to \$1,250 (pilot extends  
38 from November 15, 2021 to April 15, 2022) to use for upgrades as each deems appropriate,  
39 typically when traveling on an airline with non-preferred status. The unused portion of the  
40 allowance is not subject to carry forward or use by any other Officer and remains the property  
41 of the AMA. In rare instances it is recognized that short notice assignments may require up to  
42 first class travel because of the lack of availability of coach seating, and this will be authorized  
43 when necessary by the Board Chair, prior to travel. Business Class airfare is authorized for  
44 foreign travel on AMA business. (Also see Rule IV--Invitations, B—Foreign, for policy on  
45 foreign travel). (Directive to Take Action)

- 46  
47 3. That the remainder of the report be filed.

Fiscal Note: Estimated cost for July 1, 2021 – June 30, is a maximum of \$37,500 if all Presidents  
and Officers use the allowance.

APPENDIX

POSITION	GOVERNANCE HONORARIUM
President	\$290,160
Immediate Past President	\$284,960
President-Elect	\$284,960
Chair	\$280,280
Chair-Elect	\$207,480
Officers	\$67,000

Definition of Governance Honorarium Effective July 1, 2017:

The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board Committee meetings, task forces, subcommittees, Board orientation, development and media training, Board calls, sections, councils, or other internal representation meetings or calls, and any associated review or preparatory work, and all travel days related to all meetings as noted up to eleven (11) Internal Representation days.

Definition of Per Diem for Representation effective July 1, 2017:

The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating, achievement of the respective organization goals such as the AMA Foundation, PCPI, etc. or for Internal Representation days above eleven (11). The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather-related travel delays. Per Diem for Chair-assigned representation and related travel is \$1,400 per day.

Definition of Telephone Per Diem for External Representation effective July 1, 2017:

Officers, excluding the Board Chair and the President(s) who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation days above eleven (11), receive a per diem for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for those meetings would require approval of the Chair of the Board. The amount of the Telephonic Per Diem will be ½ of the full Per Diem which is \$700.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601  
(N-21)

Introduced by: Senior Physicians Section

Subject: "Virtual Water Cooler" for our AMA

Referred to: Reference Committee F

---

- 1 Whereas, 42% of physicians in all specialties report experiencing burnout, and 71% of  
2 physicians experiencing burnout report that it is having a strong or moderately negative impact  
3 on their lives. (Medscape 2021 survey of 12K physicians); and  
4
- 5 Whereas, All physicians have experienced increasing isolation during the Covid-19 pandemic,  
6 and professional isolation is associated with increased levels of burnout; and  
7
- 8 Whereas, Professional burnout is often associated with thoughts of leaving the profession, and  
9 when unmitigated can predispose to errors, anxiety, and other negative consequences; and  
10
- 11 Whereas, Most physicians do not readily share feelings or professional concerns with others;  
12 nonetheless, women physicians prefer to share such sensitive issues with colleagues, and  
13 younger male physicians may likewise be willing to do so; and  
14
- 15 Whereas, The majority of women physicians report having no mentor, and the same is likely  
16 true for young men, and possibly especially for physicians and trainees who are members of  
17 minoritized or marginalized groups; and  
18
- 19 Whereas, Social supports are critically important to increasing survival from many serious  
20 illnesses, and to developing a more objective outlook on most aspects of life for many people;  
21 and  
22
- 23 Whereas, Collegial advice and mentoring are associated with enhanced productivity, career  
24 satisfaction, longevity and success in every field in which it has been studied; and  
25
- 26 Whereas, An invaluable benefit to members in a professional association is the potential ability  
27 to contact other members for advice upon occasion; and  
28
- 29 Whereas, There is no ready mechanism for AMA members who are not active at a leadership  
30 level to identify or contact electronically or even to know which members might be willing to  
31 provide collegial advice or support from time to time; and  
32
- 33 Whereas, Telephonic and (especially) asynchronous electronic communications have removed  
34 barriers to communication across geographic regions; and  
35
- 36 Whereas, The AMA-SPS has over 60,000 members, all of whom have lived professional and  
37 lifetime experience, and some percentage of whom might be willing to mentor other members if  
38 asked, and if a mutually convenient mechanism exists, and

1 Whereas, Many sections and ambassadors have already voiced an interest in pursuing some  
2 type of mentoring program for our AMA; therefore be it

3  
4 RESOLVED, That our American Medical Association explore options facilitating the ability of  
5 members to identify and directly contact other members who are interested in participating in  
6 informal inter-member mentoring, in order that self-selected members may readily enter into  
7 collegial communications with one another; and shall report back such options to the House of  
8 Delegates within 12 months. (Directive to Take Action)

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

Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The lack of mentoring affects many physicians, and has a disproportionate impact on younger physicians who are most likely to be suffering as a result of interference by Covid-19 with acquisition of training, or assimilation of acquired skills into practice. Physicians and trainees from underrepresented and disadvantaged backgrounds are even more impacted, and therefore most likely to need/benefit from mentoring. Losses in physician satisfaction, workforce productivity or continuing participation in the profession has a major adverse effect upon all physicians, and ultimately, all patients.

AMA and especially SPS has a wealth of members who are willing and able to provide mentoring or advice to younger members if approached, and many senior members have expressed dismay at not being able to more directly assist younger members to navigate their healthful and joyous pursuit of our calling. There may be mentoring proposals in the pipeline. Prior proposals may have been too complex to be successful. AMA has as yet no mechanism whereby members can identify and informally contact other members who are available and willing to advise, or self-identify their availability and interest in helping other members to deal with common concerns. The proposed action is likely to have meaningful impact, but may require new policy or modification of existing policy to implement. An AMA resolution is an appropriate avenue to address this issue.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602  
(N-21)

Introduced by: Medical Student Section

Subject: Mitigating Environmental Contributors to Disease and Sustainability of AMA  
National Meetings

Referred to: Reference Committee F

---

1 Whereas, Environmental health is defined as the science and practice of preventing the direct  
2 and indirect adverse effects of hazardous agents on health and wellbeing<sup>1,2</sup>; and  
3

4 Whereas, A 2018 report by the World Health Organization (WHO) on the burden of disease  
5 from environmental risks estimated that approximately thirteen million deaths worldwide could  
6 be attributed to preventable environmental factors and 24% of global deaths were due to  
7 modifiable environmental factors<sup>3</sup>; and  
8

9 Whereas, Environmental justice is defined as the principle that all people and communities  
10 regardless of race, color, national origin, or income, are entitled to equal protection by  
11 environmental and public health laws and regulations, while environmental injustice describes  
12 environmental laws, regulations and policies that overly affect a group of people resulting in  
13 greater exposure to environmental hazards<sup>4</sup>; and  
14

15 Whereas, Environmental racism refers to a type of environmental injustice in which the racial  
16 and ethnic contexts of environmental regulations and policies, exposures, support structures,  
17 and health outcomes cause inequitable environmental hazards for some racial groups<sup>5,6</sup>; and  
18

19 Whereas, Low-income and minoritized communities are burdened by environmental injustice in  
20 that they reside in areas with higher environmental exposures, reduced preventive measures,  
21 and limited medical intervention, further exacerbating health outcome disparities<sup>7-11</sup>; and  
22

23 Whereas, The enactment of exclusionary housing policies, including zoning ordinances,  
24 restrictive covenants, blockbusting, steering, and redlining, purposefully created racial  
25 segregation, exposed Black communities to environmental pollutants and targeting for  
26 construction of toxin-releasing facilities, isolated them from essential health resources such as  
27 healthy food options, hospitals, and green spaces, and permitted health inequities to  
28 concentrate in disadvantaged low-income neighborhoods<sup>12-16</sup>; and  
29

30 Whereas, The environmental justice and fair housing collaboration between the Environmental  
31 Protection Agency (EPA) and U.S. Department of Housing and Urban Development (HUD)  
32 remains inadequate due to insufficient action to provide non-discriminatory and affordable  
33 housing units in locations without risk of environmental health exposures<sup>17</sup>; and  
34

35 Whereas, A combination of inequitable land-use policies, lack of environmental regulation and  
36 enforcement, and market forces in petrochemical and heavy metal industries have contributed  
37 to the perpetuation of poverty and worse health outcomes in minoritized populations<sup>18</sup>; and

1 Whereas, Proximity to and exposure to hazards from the oil and gas, plastics, animal  
2 production, chemical manufacturing, endocrine-disrupting chemicals, and metal industries have  
3 been strongly linked to at least one of the following: neural tube defects, preterm birth, low-birth  
4 weight, diffuse interstitial lung fibrosis, chronic bronchitis, asthma exacerbation, diabetes,  
5 hypertension secondary to chronic inflammation, pneumonia, reduced child cognition from  
6 heavy metal exposure, neurologic diseases, cancers, hyperlipidemia, and thyroid disease<sup>19-28</sup>;  
7 and

8  
9 Whereas, Closures of industrial sites and reductions in pollution have been linked to improved  
10 fertility and reduced preterm births and respiratory hospitalizations<sup>29-31</sup>; and

11  
12 Whereas, Recent natural disasters such as hurricanes, the over 1,500 oil spills from the Dakota  
13 Access Pipeline and the Keystone Pipeline in the last decade alone, the Texas freeze, and  
14 states' responses to these natural disasters perpetuate environmental injustice by  
15 disproportionately affecting predominantly minoritized and low-income communities<sup>32-37</sup>; and

16  
17 Whereas, The health of American Indian tribes depends on essential natural resources that  
18 have either been depleted and/or contaminated by mining and oil corporations, leading to  
19 adverse health outcomes<sup>38-41</sup>; and

20  
21 Whereas, Government agencies have failed to act on current policy and integrate current  
22 environmental science research or expertise into ongoing environmental regulations and public  
23 health initiatives, resulting in continued and amplified environmental hazards and failing to  
24 protect people, especially in Black and American Indian communities, from known and  
25 predictable environmental health dangers<sup>42-49</sup>; and

26  
27 Whereas, Climate change represents an important tenet of environmental health that can  
28 significantly impact public and community health<sup>50</sup>; and

29  
30 Whereas, The United States healthcare system alone is responsible for 10% of national  
31 greenhouse gas emissions and, if it were its own country, it would be the 13th largest producer  
32 of greenhouse gas emissions in the world<sup>50,51</sup>; and

33  
34 Whereas, Extreme weather and climate events have significantly increased healthcare spending  
35 in the United States, with \$14 billion in additional spending through 760,000 additional patient  
36 encounters and 1,689 premature deaths between 2000 and 2009<sup>52-53</sup>; and

37  
38 Whereas, The Intergovernmental Panel on Climate Change (IPCC) has determined it is possible  
39 to avoid warming past 1.5°C above pre-industrial levels by 2100 if extreme measures are taken  
40 to curtail anthropogenic emissions<sup>54</sup>; and

41  
42 Whereas, If global warming exceeds 1.5°C, the estimated global effects include 92,207  
43 additional heat-related deaths per year by 2030, 350 million more humans exposed to severe  
44 heat by 2050, and 31 to 69 million humans exposed to flooding from sea level rise by 2100<sup>54</sup>;  
45 and

46  
47 Whereas, Compared to no action, limiting global warming to less than 1.5°C would result in  
48 ~50% lower annual health-related costs and prevention of ~50% of infectious disease cases in  
49 the United States by 2100<sup>52,53</sup>; and

1 Whereas, The IPCC has estimated that limiting global warming to 1.5°C would require “global  
2 net human-caused emissions of carbon dioxide to fall by about 45 percent from 2010 levels by  
3 2030, and reach net zero by approximately 2050”<sup>54</sup>; and  
4

5 Whereas, IPCC defines net zero emissions as a state where anthropogenic emissions of  
6 greenhouse gasses (GHG) are balanced by anthropogenic removals of GHG over a specific  
7 time period<sup>52</sup>; and  
8

9 Whereas, Setting emissions targets is an essential part of carbon abatement, and many non-  
10 profit organizations, large corporations, and countries have committed to carbon neutrality for  
11 their business operations by a date certain in order to improve their business efficiencies and to  
12 foster the development of carbon neutral practices<sup>55-57</sup>; and  
13

14 Whereas, Multiple organizations in the healthcare industry have committed to becoming carbon  
15 neutral on or before 2030, including Harvard Medical School and its affiliated hospitals, all  
16 University of California campus and medical centers, the Cleveland Clinic, and Kaiser-  
17 Permanente<sup>58-61</sup>; and  
18

19 Whereas, Other professional organizations, including the Association of Energy Services  
20 Professionals, and International Federation of Medical Students’ Associations have committed  
21 to making their conferences carbon neutral<sup>62,63</sup>; and  
22

23 Whereas, Our AMA has set discrete benchmark dates for achieving goals in other settings,  
24 including child blood lead levels (H-60.924), accreditation of health care service providers in jails  
25 (D-430.997), and disaggregation of demographic data (H-350.954); and  
26

27 Whereas, Our AMA recognizes that racism, in all its forms, is an urgent public health threat, and  
28 has pledged to work to combat the adverse health effects of racism (H-65.952); and  
29

30 Whereas, Our AMA has substantial policy recognizing the impacts of climate change,  
31 committing to sustainable business operations, emphasizing the importance of physician  
32 leadership regarding climate change, encouraging the study of environmental causes of  
33 disease, and encouraging other stakeholders in healthcare to practice environmental  
34 responsibility, but has no explicit emissions goal and no way to account for progress towards  
35 environmental sustainability (H-135.938, H-135.923, G-630.100, D-135.997, H-135.973);  
36 therefore be it

1 RESOLVED, That our American Medical Association amend Policy D-135.997, "Research into  
2 the Environmental Contributors to Disease," by addition and deletion to read as follows:

3  
4 ~~Research into the Environmental Contributors to Disease~~ and Advocating for  
5 Environmental Justice D-135.997

6 Our AMA will (1) advocate for greater public and private funding for research into the  
7 environmental causes of disease, and urge the National Academy of Sciences to  
8 undertake an authoritative analysis of environmental causes of disease; (2) ask the  
9 steering committee of the Medicine and Public Health Initiative Coalition to consider  
10 environmental contributors to disease and environmental racism as a priority public  
11 health issues; (3) encourage federal, state, and local agencies to address and  
12 remediate environmental injustice, environmental racism, and all other environmental  
13 conditions that are adversely impacting health, especially in marginalized communities;  
14 and (4) lobby Congress to support ongoing initiatives that include reproductive health  
15 outcomes and development particularly in minority populations in Environmental  
16 Protection Agency Environmental Justice policies (Modify Current HOD Policy); and be  
17 it further

18  
19 RESOLVED, That our AMA commit to reaching net zero emissions for its business operations  
20 by 2030, and remain net zero or net negative, as defined by a carbon neutral certifying  
21 organization (Directive to Take Action); and be it further

22  
23 RESOLVED, That our AMA create educational programs for and encourage the United States  
24 healthcare system, including but not limited to hospitals, clinics, ambulatory care centers, and  
25 healthcare professionals, to decrease emissions to half of 2010 levels by 2030 and become net  
26 zero by 2050, and remain net zero or negative, as defined by a carbon neutral certifying  
27 organization (Directive to Take Action); and be it further

28  
29 RESOLVED, That our AMA report the progress on implementing this resolution at each annual  
30 meeting hereafter. (Directive to Take Action)

Fiscal Note: Implementation of this resolution would be a multi-million dollar undertaking.

Date Received: 09/30/21

## AUTHORS STATEMENT OF PRIORITY

The damaging effects of climate change are clear and urgent. Life-threatening natural disasters continue to displace people, limit access to resources, and cause devastating loss of life are increasing in frequency. Further, these effects are felt most profoundly by marginalized communities, especially communities of color. These populations are much more likely to live near power plants, uranium mines, concrete plants, and many other dangerous industrial sources of emissions, which lead to high rates of exposures to heavy metals, particulate matter, endocrine-disrupting chemicals, and radiation, which have all been strongly linked to lung diseases, neurological disorders, cancers, and numerous other pathologies. This is not by choice, but due to environmental racism, as companies and governments have deliberately targeted marginalized communities for construction of these industrial sites, knowing these communities do not have the resources or political power to fight back. Our AMA has an obligation to take a strong stance against this discrimination and to protect these vulnerable communities. Further, we as an organization have a strong obligation to halt our own contributions to the harms of environmental injustice. The AMA should join other large professional and healthcare institutions in committing to reducing the emissions of its business meetings to net zero by 2030, so that our meetings are no longer contributing to environmental harm to vulnerable communities and to all. This resolution is vital and time-sensitive, and it gives the AMA concrete actions to take to address the urgent crisis of climate change and environmental racism.

### References:

1. Steward JA. Definitions of Environmental Health. NEHA. <https://www.neha.org/about-neha/definitions-environmental-health>. Accessed March 14, 2021.
2. Novice, R. Overview of the environment and health in Europe in the 1990s. World Health Organization. Published Mar. 29th, 1999.
3. Prüss-Ustün, A., J. Wolf and C. Corvalan. Preventing disease through healthy environments: a global assessment of the burden of disease from environmental risks. World Health Organization. Published 2016.
4. Brulle RJ, Pellow DN. Environmental justice: human health and environmental inequalities. *Annual Review of Public Health*. 2006;27:103-24.
5. The Lancet Planetary Health. Environmental racism: time to tackle social injustice. *Lancet Planet Health*. 2018;2(11):e462. doi:10.1016/S2542-5196(18)30219-5
6. Nigra AE. Environmental racism and the need for private well protections. *Proc Natl Acad Sci U S A*. 2020;117(30):17476-17478. doi:10.1073/pnas.2011547117
7. Neuwirth LS. Resurgent lead poisoning and renewed public attention towards environmental social justice issues: A review of current efforts and call to revitalize primary and secondary lead poisoning prevention for pregnant women, lactating mothers, and children within the U.S. *Int J Occup Environ Health*. 2018;24(3-4):86-100. doi:10.1080/10773525.2018.1507291
8. Smith GS, Thorpe RJ Jr. Gentrification: A Priority for Environmental Justice and Health Equity Research. *Ethn Dis*. 2020;30(3):509-512. Published 2020 Jul 9. doi:10.18865/ed.30.3.509
9. Smith GS, Breakstone H, Dean LT, Thorpe RJ Jr. Impacts of Gentrification on Health in the US: a Systematic Review of the Literature. *J Urban Health*. 2020;97(6):845-856. doi:10.1007/s11524-020-00448-4
10. Adler NE, Newman K. Socioeconomic disparities in health: pathways and policies. *Health Aff (Millwood)*. 2002;21(2):60-76. doi:10.1377/hlthaff.21.2.60
11. Schaidler LA, Swetschinski L, Campbell C, Rudel RA. Environmental justice and drinking water quality: are there socioeconomic disparities in nitrate levels in U.S. drinking water?. *Environ Health*. 2019;18(1):3. Published 2019 Jan 17. doi:10.1186/s12940-018-0442-6
12. Mikati I, Benson AF, Luben TJ, Sacks JD, Richmond-Bryant J. Disparities in Distribution of Particulate Matter Emission Sources by Race and Poverty Status. *Am J Public Health*. 2018;108(4):480-5.
13. Cushing L, Faust J, August LM, Cendak R, Wieland W, Alexeeff G. Racial/Ethnic Disparities in Cumulative Environmental Health Impacts in California: Evidence From a Statewide Environmental Justice Screening Tool (CalEnviroScreen 1.1). *Am J Public Health*. 2015;105(11):2341-8.
14. Mohai P, Saha R. Which came first, people or pollution? A review of theory and evidence from longitudinal environmental justice studies. *Environ Res Lett*. 2015;10:125011.
15. Dimick, J., Ruhter, J., Sarrazin, M. V., & Birkmeyer, J. D. (2013). Black Patients More Likely Than Whites To Undergo Surgery At Low-Quality Hospitals In Segregated Regions. *Health Affairs*, 32(6), 1046-1053. <https://doi.org/10.1377/hlthaff.2011.1365>.
16. Henderson S, Wells R. Environmental Racism and the Contamination of Black Lives: A Literature Review. *J Afr Am St*. 2021. <https://doi.org/10.1007/s12111-020-09511-5>
17. Haberle, M. Fair Housing and Environmental Justice: New Strategies and Challenges. *Journal of Affordable Housing and Community Development*. 2018. <https://prprac.org/fair-housing-and-environmental-justice-new-strategies-and-challenges/>
18. Banzhaf S, Ma L, Timmins C. Environmental Justice: the Economics of Race, Place, and Pollution. *J Econ Perspect*. 2019;33(1):185-208.

19. Johnston J, Cushing L. Chemical Exposures, Health, and Environmental Justice in Communities Living on the Fenceline of Industry. *Curr Envir Health Rpt* 7. 2020; 48–57.
20. Campanale C, Massarelli C, Savino I, Locaputo V, Uricchio VF. A Detailed Review Study on Potential Effects of Microplastics and Additives of Concern on Human Health. *Int J Environ Res Public Health*. 2020;17(4): 1212.
21. Arnetz BB, Arnetz J, Harkema JR, et al. Neighborhood air pollution and household environmental health as it relates to respiratory health and healthcare utilization among elderly persons with asthma. *J Asthma*. 2020;57(1):28-39. doi:10.1080/02770903.2018.1545856
22. Johnston J, Cushing L. Chemical exposures, health, and environmental justice in communities living on the Fenceline of industry. *Current Environmental Health Reports*. 2020;7(1):48-57. doi:10.1007/s40572-020-00263-8.
23. Schultz AA, Peppard P, Gangnon RE, Malecki KMC. Residential proximity to concentrated animal feeding operations and allergic and respiratory disease. *Environment International*. 2019;130:104911. doi:10.1016/j.envint.2019.104911.
24. Rojas-Rueda D, Morales-Zamora E, Alsufyani WA, et al. Environmental Risk Factors and Health: An Umbrella Review of Meta-Analyses. *International Journal of Environmental Research and Public Health*. 2021;18(2):704. doi:10.3390/ijerph18020704.
25. Kihal-Talantikite W, Zmirou-Navier D, Padilla C, Deguen S. Systematic literature review of reproductive outcome associated with residential proximity to polluted sites. *International Journal of Health Geographics*. 2017;16(1). doi:10.1186/s12942-017-0091-y.
26. Gong X, Lin Y, Bell ML, Zhan FB. Associations between maternal residential proximity to air emissions from industrial facilities and low birth weight in Texas, USA. *Environment International*. 2018;120:181-198. doi:10.1016/j.envint.2018.07.045.
27. Ruiz D, Becerra M, Jagai JS, Ard K, Sargis RM. Disparities in Environmental Exposures to Endocrine-Disrupting Chemicals and Diabetes Risk in Vulnerable Populations. *Diabetes Care*. 2018;41(1):193-205. doi:10.2337/dc16-2765
28. Breathett K, Sims M, Gross M, et al. Cardiovascular Health in American Indians and Alaska Natives: A Scientific Statement From the American Heart Association. *Circulation*. 2020;141(25):e948-e959. doi:10.1161/CIR.0000000000000773
29. Casey JA, Gemmill A, Karasek D, Ogburn EL, Goin DE, Morello-Frosch R. Increase in fertility following coal and oil power plant retirements in California. *Environ Health*. 2018;17(1):44. Published 2018 May 2. doi:10.1186/s12940-018-0388-8
30. Casey JA, Karasek D, Ogburn EL, et al. Retirements of Coal and Oil Power Plants in California: Association With Reduced Preterm Birth Among Populations Nearby. *Am J Epidemiol*. 2018;187(8):1586-1594. doi:10.1093/aje/kwy110
31. Burr WS, Dales R, Liu L, et al. The Oakville Oil Refinery Closure and Its Influence on Local Hospitalizations: A Natural Experiment on Sulfur Dioxide. *Int J Environ Res Public Health*. 2018;15(9):2029. Published 2018 Sep 17. doi:10.3390/ijerph15092029
32. Earthjustice. Oil, Water, and Steel: The Dakota Access Pipeline. Earthjustice. <https://earthjustice.org/features/oil-water-and-steel-the-dakota-access-pipeline>. Published June 27, 2019. Accessed April 8, 2021.
33. Belvederesi C, Thompson MS, Komers PE. Statistical analysis of environmental consequences of hazardous liquid pipeline accidents. *Heliyon*. 2018;4(11):e00901. Published 2018 Nov 7. doi:10.1016/j.heliyon.2018.e00901
34. Allen B. Environmental justice, local knowledge, and after-disaster planning in New Orleans. *Tech in Soc*. 2007;29(2):153-9.
35. Grineski SE, et al. Hazard characteristics and patterns of environmental injustice: household-level determinants of environmental risk in Miami, Florida. *Risk Anal*. 2017;37(7):1419-34.
36. D'Andrea MA, Reddy GK. Adverse Health Complaints of Adults Exposed to Benzene After a Flaring Disaster at the BP Refinery Facility in Texas City, Texas. *Disaster Med Public Health Prep*. 2018;12(2):232-240. doi:10.1017/dmp.2017.59
37. D'Andrea MA, Reddy GK. Detrimental Health Effects of Benzene Exposure in Adults After a Flaring Disaster at the BP Refinery Plant in Texas City. *Disaster Med Public Health Prep*. 2016;10(2):233-239. doi:10.1017/dmp.2015.160
38. Lewis J, Hoover J, MacKenzie D. Mining and Environmental Health Disparities in Native American Communities. *Curr Environ Health Rep*. 2017;4(2):130-141. doi:10.1007/s40572-017-0140-5
39. Barros N, Tulve NS, Heggem DT, Bailey K. Review of built and natural environment stressors impacting American-Indian/Alaska-Native children. *Rev Environ Health*. 2018;33(4):349-381. doi:10.1515/reveh-2018-0034
40. Meltzer GY, Watkins BX, Vieira D, Zelikoff JT, Boden-Albala B. A Systematic Review of Environmental Health Outcomes in Selected American Indian and Alaska Native Populations. *J Racial Ethn Health Disparities*. 2020;7(4):698-739. doi:10.1007/s40615-020-00700-2
41. Glick AA. The Wild West Re-Lived: Oil Pipelines Threaten Native American Tribal Lands. *Villanova Law Environmental Law Journal*. 2019;30(1):105. doi:<https://digitalcommons.law.villanova.edu/cgi/viewcontent.cgi?article=1419&context=elj>
42. Woodruff TJ, Sutton P. The Navigation Guide Systematic Review Methodology: A Rigorous and Transparent Method for Translating Environmental Health Science into Better Health Outcomes. *Environmental Health Perspectives*. 2014;122(10):1007-1014. doi:10.1289/ehp.1307175.
43. Correction: Regulating toxic chemicals for public and environmental health. *PLOS Biology*. 2018;16(1). doi:10.1371/journal.pbio.1002619.
44. Pulido L, Kohl E, Cotton N-M. State Regulation and Environmental Justice: The Need for Strategy Reassessment. *Capitalism Nature Socialism*. 2016;27(2):12-31. doi:10.1080/10455752.2016.1146782.
45. Goldstein BD, Kriesky J, Pavliakova B. Missing from the Table: Role of the Environmental Public Health Community in Governmental Advisory Commissions Related to Marcellus Shale Drilling. *Environmental Health Perspectives*. 2012;120(4):483-486. doi:10.1289/ehp.1104594.
46. Larson LR, Lauber TB, Kay DL, Cutts BB. Local Government Capacity to Respond to Environmental Change: Insights from Towns in New York State. *Environmental Management*. 2017;60(1):118-135. doi:10.1007/s00267-017-0860-1.
47. Campbell C, Greenberg R, Mankikar D, Ross R. A Case Study of Environmental Injustice: The Failure in Flint. *International Journal of Environmental Research and Public Health*. 2016;13(10):951. doi:10.3390/ijerph13100951.
48. Bullard RD, Wright B. *The Wrong Complexion for Protection: How the Government Response to Natural and Unnatural Disasters Endangers African American Communities*. New York: New York Univ. Press; 2012.
49. Beidinger-Burnett H, Ahern L, Ngai M, Filippelli G, Sisk M. Inconsistent screening for lead endangers vulnerable children: policy lessons from South Bend and Saint Joseph County, Indiana, USA. *J Public Health Policy*. 2019;40(1):103-113. doi:10.1057/s41271-018-0155-7
50. Eckelman, M.J., Sherman, J.D. Environmental impacts of the U.S. healthcare system and effects on public health. *PLoS ONE*. 2016;11(6): e0157014. <https://doi.org/10.1371/journal.pone.0157014>
51. Blumenthal, D., Seervai, S. To be high performing, the U.S. health system will need to adapt to climate change. *To the Point: The Commonwealth Fund*. Apr. 18, 2018.

52. United States Environmental Protection Agency Office of Atmospheric Programs. Climate change in the United States: benefits of global action. EPA 430-R-15-001. <https://www.epa.gov/sites/production/files/2015-06/documents/cirareport.pdf>. Published 2015. Accessed March 28, 2019.
53. Knowlton, K., et al. Six climate change-related events in the United States accounted for about \$14 billion in lost lives and health costs. *Health Aff (Millwood)*. Nov. 2011;30(11):2167-76.
54. Intergovernmental Panel on Climate Change. Special Report: Global Warming of 1.5°C. <https://www.ipcc.ch/sr15/>. Published 2018. Accessed March 29, 2019.
55. Climate Neutral Now. UNFCCC.int. <https://unfccc.int/climate-action/climate-neutral-now>. Published 2020. Accessed 9 April, 2020.
56. Managing Air Quality - Emissions Inventories. EPA.gov. <https://www.epa.gov/air-quality-management-process/managing-air-quality-emissions-inventories#contrib>. Published 2018. Accessed 25 Aug. 2019.
57. Wang, R. Adopting local climate policies: what have California cities done and why?. *SAGE Journals*. 2012;49(4), pp.593-613.
58. Decarbonizing healthcare. Harvard.edu. <https://hms.harvard.edu/news/decarbonizing-health-care>. Published Dec. 2019. Accessed 8 April, 2020.
59. Reducing our carbon footprint: carbon neutral by 2027. ClevelandClinic.org. <https://my.clevelandclinic.org/about/community/healthy-environment/sustainability-global-citizenship/environment/climate-resilience#reducing-carbon-footprint-tab>. Published 2019. Accessed April 9, 2020.
60. Carbon neutrality: our commitment. UniversityOfCalifornia.edu. <https://www.universityofcalifornia.edu/initiative/carbon-neutrality-initiative/our-commitment>. Published 2013. Accessed April 9, 2020.
61. Johnson, S. Kaiser Permanente to go carbon-neutral in 2020. *ModernHealthcare.com*. <https://www.modernhealthcare.com/article/20180910/NEWS/180919992/kaiser-permanente-to-go-carbon-neutral-in-2020>. Published September 10, 2018. Accessed April 9, 2020.
62. AESP and ICF commit to carbon neutral conference. *PRNewsire.com*. <https://www.prnewswire.com/news-releases/aesp-and-icf-commit-to-carbon-neutral-conference-300774945.html>. Published January 8, 2019. Accessed April 9, 2019.
63. Zotova, O., et. al. Carbon neutral medical conferences should be the norm. *TheLancet.com*. [https://www.thelancet.com/journals/lanph/article/PIIS2542-5196\(20\)30003-6/fulltext](https://www.thelancet.com/journals/lanph/article/PIIS2542-5196(20)30003-6/fulltext). Published February 2020. Accessed April 9, 2020.

## RELEVANT AMA POLICY

### 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. CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19

### 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. 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

### **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. Res. 924, I-16; Reaffirmation: I-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.

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

**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.  
BOT Rep. 34, A-18

**Support of Clean Air and Reduction in Power Plant Emissions H-135.949**

Our AMA supports:

(1) Federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and

(2) Efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels

Res. 429, A-03; Reaffirmation I-07; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Modified: Res. 506, A-15; Modified: Res. 908, I-17

**EPA and Greenhouse Gas Regulation H-135.934**

(1) Our AMA supports the Environmental Protection Agency's authority to promulgate rules to regulate and control greenhouse 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.

Res. 925, I-10; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Appended: Res. 523, A-17

**Conservation, Recycling, and Other "Green" Initiatives G-630.100**

AMA policy on conservation and recycling include the following:

(1) Our AMA directs its offices to implement conservation-minded practices whenever feasible and to continue to participate in "green" initiatives.

(2) It is the policy of our AMA to use recycled paper whenever reasonable for its in-house printed matter and publications, including JAMA, and materials used by the House of Delegates, and that AMA printed material using recycled paper should be labeled as such.

(3) During meetings of the American Medical Association House of Delegates, our AMA Sections, and all other AMA meetings, recycling bins, where and when feasible, for white (and where possible colored) paper will be made prominently available to participants.

CCB/CLRPD Rep. 3, A-12; Modified: Speakers Rep., A-15

**Disaggregation of Demographic Data Within Ethnic Groups H-350.954**

(1) Our AMA supports the disaggregation of demographic data regarding: (a) Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and (b) ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine.

(2) Our AMA: (a) will advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; (b) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (c) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (d) will report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine.

Res. 001, I-17; Appended: Res. 403, A-19

### **Reducing Lead Poisoning H-60.924**

(1) Our AMA: (a) supports regulations and policies designed to protect young children from exposure to lead; (b) urges the Centers for Disease Control and Prevention to give priority to examining the current weight of scientific evidence regarding the range of adverse health effects associated with blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure; (c) encourages physicians and public health departments to screen children based on current recommendations and guidelines and to report all children with elevated blood levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children. In some cases this will be done by the physician, and in other communities by the laboratories; (d) promotes community awareness of the hazard of lead-based paints; and (e) urges paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.

(2) Our AMA will call on the United States government to establish national goals to: (a) ensure that no child has a blood lead level  $>5 \mu\text{g/dL}$  ( $>50 \text{ ppb}$ ) by 2021, and (b) eliminate lead exposures to pregnant women and children, so that by 2030, no child would have a blood lead level  $>1 \mu\text{g/dL}$  ( $10 \text{ ppb}$ ).

(3) Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals: (a) adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant women and children from lead toxicity and neurodevelopmental impairment; (b) identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer products) to protect children before they are exposed; (c) continue targeted screening of children to identify those who already have elevated blood lead levels for case management, as well as educational and other services; (d) eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out all remaining uses of lead in products (aviation gas, cosmetics, wheel weights, industrial paints, batteries, lubricants, and other sources), and the export of products containing lead, and setting more protective limits on emissions from battery recyclers and other sources of lead emissions; (e) provide a dedicated funding stream to enhance the resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical services to mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities that are disproportionately exposed to lead; and (f) establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant women and children, defined as blood lead levels above  $1 \mu\text{g/dL}$  ( $10 \text{ ppb}$ ).

(4) Our AMA supports requiring an environmental assessment of dwellings, residential buildings, or child care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level, to determine the potential source of lead poisoning, including testing the water supply.

CCB/CLRPD Rep. 3, A-14; Appended: Res. 926, I-16; Appended: Res. 412, A-17

#### **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.

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

#### **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.

Res. 402, A-03 Appended: Res. 927, I-11 Reaffirmed in lieu of: Res. 505, A-19

#### **Environmental Health Programs H-135.969**

Our AMA (1) urges the physicians of the United States to respond to the challenge for a clean environment individually and through professional groups by becoming the spokespersons for environmental stewardship; and (2) encourages state and county medical societies to establish active environmental health committees.

Res. 124, A-90 Reaffirmed: Sunset Report, I-00 Reaffirmed: CSAPH Rep. 1, A-10 Reaffirmed: CSAPH Rep. 01, A-20

#### **Federal Programs H-135.999**

The AMA believes that the problem of air pollution is best minimized through the cooperative and coordinated efforts of government, industry and the public. Current progress in the control of air pollution can be attributed primarily to such cooperative undertakings. The Association further believes that the federal government should play a significant role in these continuing efforts. This may be done by federal grants for (1) the development of research activity and (2) the encouragement of local programs for the prevention and control of air pollutants.

BOT Rep. M, A-63 Reaffirmed: CLRPD Rep. C, A-88, Reaffirmed: Sunset Report, I-98 Reaffirmation, I-06 Reaffirmation, I-07 Reaffirmed: CSAPH Rep. 01, A-17

#### **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.
- Res. 5, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603  
(N-21)

Introduced by: Medical Student Section

Subject: Abolishment of the Resolution Committee

Referred to: Reference Committee F

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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 viewpoints<sup>1</sup>;  
4 and

5  
6 Whereas, Robust, “actualized” democracies, defined as “the ideal in which all citizens share  
7 full, 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 governance<sup>2-6</sup>; 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 (eg, cardiovascular diseases and transport injuries) that have not been heavily  
14 targeted by foreign aid and require health-care delivery”<sup>7</sup>; 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”<sup>8</sup>; 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”<sup>9</sup>; 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 Resolution Committee in the AMA Bylaws  
26 “to formally reflect the defined scope of the Interim Meeting”, as currently reflected in B-2.13.3<sup>10</sup>;  
27 and

28  
29 Whereas, The number of resolutions not considered based on Resolutions Committee  
30 recommendations for the past eight Interim Meetings has never exceeded ten- 2 at the Interim  
31 2019 House of Delegates, 8 at the Interim 2018 House of Delegates, 4 at the Interim 2017  
32 House of Delegates, 3 at the Interim 2016 House of Delegates, 9 at the Interim 2015 House of  
33 Delegates, 8 at the Interim 2014 House of Delegates, 10 at the Interim 2013 House of  
34 Delegates, and 9 at the Interim 2012 House of Delegates<sup>11</sup>, indicating that it has not been  
35 substantively constraining the business of the House of Delegates; and

1 Whereas, In reflecting upon the formation of the Resolution Committee, the Report of the  
2 Executive Vice President at the Interim 2002 House of Delegates noted that “while I appreciate  
3 the need to streamline, I strongly believe that everything the AMA does is advocacy,” and  
4 elaborated that “this includes activities you might not initially view as advocacy, like the public  
5 stands we take on issues of public health and science”<sup>12</sup>; and  
6

7 Whereas, At the Annual 2011 AMA Medical Student Section Assembly, in recognition of the  
8 advocacy-only criterion in place for Interim Houses of Delegates and in an attempt to limit the  
9 number of resolutions adopted by the MSS that would not be considered by the House of  
10 Delegates at the subsequent Interim Meeting, the MSS IOPs were amended by Governing  
11 Council Report A such that “Resolutions will be considered at the AMA-MSS Annual Meeting  
12 only if they pertain to AMA advocacy efforts or address issues of an urgent nature that  
13 must be addressed before the following Interim Meeting”<sup>13-14</sup>; and  
14

15 Whereas, At the Annual 2011 Medical Student Section Assembly, the MSS IOPs were amended  
16 to establish a Resolution Committee mirroring that of the AMA House of Delegates, with the  
17 delineated purpose of “determin[ing] fairly if resolutions meet the definition of advocacy and  
18 urgency set forth by the AMA HOD”<sup>13-14</sup>; and  
19

20 Whereas, At the Annual 2013 Medical Student Section Assembly, just two years after the  
21 institution of the MSS Resolution Committee, Governing Council Report A recommended the  
22 abolition of the “advocacy-only rule” and hence the MSS Resolution Committee, recognizing the  
23 “unintended consequences” of the rule, and this report was adopted<sup>14-15</sup>; and  
24

25 Whereas, At the Annual 2013 Medical Student Section Assembly, Governing Council Report A  
26 observed that “the HOD criteria used for qualifying resolutions as advocacy vs. non-advocacy  
27 proved difficult to clearly quantify, causing the MSS Assembly to disagree with the  
28 recommendations of the resolution committee regarding multiple resolutions at the 2012 Annual  
29 Meeting” in justifying the elimination of the MSS Resolution Committee<sup>14-15</sup>; and  
30

31 Whereas, AMA policy G-600.060, “Introducing Business to the AMA House,” reaffirms the  
32 AMA’s commitment to democracy and directs the AMA to “continue to safeguard the democratic  
33 process in our AMA House of Delegates and ensure that individual delegates are not barred  
34 from submitting a resolution directly to the House of Delegates”; and  
35

36 Whereas, AMA policy G-640.020, “Political Action Committees and Contributions,” “opposes  
37 legislative initiatives that improperly limit individual and collective participation in the democratic  
38 process”; and  
39

40 Whereas, The AMA Bylaws dictate that “Reports, recommendations, resolutions or other new  
41 business presented prior to the recess of the opening session of the House of Delegates shall  
42 be referred to an appropriate reference committee for hearings and report, subject to  
43 acceptance as business of the House of Delegates” (B-2.11.4), to allow for full consideration of  
44 each item; therefore be it

1 RESOLVED, That our American Medical Association abolish the Resolution Committee by  
2 amending the AMA Bylaws B-2.13.3, "Resolution Committee," as follows by deletion:  
3

4 **Resolution Committee. B-2.13.3**

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

8 ~~2.13.3.1 Appointment. The Speaker shall appoint the members of the committee.~~  
9 ~~Membership on this committee is restricted to delegates.~~

10 ~~2.13.3.2 Size. The committee shall consist of a maximum of 31 members.~~

11 ~~2.13.3.3 Term. The committee shall serve only during the meeting at which it is~~  
12 ~~appointed, unless otherwise directed by the House of Delegates.~~

13 ~~2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum.~~

14 ~~2.13.3.5 Meetings. The committee shall not be required to hold meetings. Action may be~~  
15 ~~taken by written or electronic communications.~~

16 ~~2.13.3.6 Procedure. A resolution shall be accepted for consideration at an Interim~~  
17 ~~Meeting upon majority vote of committee members voting. The Speaker shall only vote~~  
18 ~~in the case of a tie. If a resolution is not accepted, it may be submitted for consideration~~  
19 ~~at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1.~~

20 ~~2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee~~  
21 ~~shall be presented to the House of Delegates at the call of the Speaker. (Modify Bylaws)~~

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

Date Received: 09/30/21

**AUTHORS STATEMENT OF PRIORITY**

Our AMA's governance affects the enactment of every policy we have. One of the central tenets of parliamentary procedure, including the parliamentary authority of the AMA, The American Institute of Parliamentarians Standard Code of Parliamentary Procedure (B-11.1, G-600.054), is to protect the rights of minority viewpoints. Democratic governance has been associated with freedom of expression and action, protection of human rights, transparent and responsive governance, and even health gains. At the Annual 2002 House of Delegates, Board of Trustees Report 23 was adopted, which included a recommendation establishing a Resolution Committee "to ensure that the emphasis of the Interim Meeting is placed on advocacy and legislation," although leadership at the time expressed misgivings, stating that "everything the AMA does is advocacy." The number of resolutions not considered based on Resolutions Committee recommendations, prior to the first Special Meetings Resolution Committee of the November 2020 meeting, for the past eight Interim Meetings has never exceeded ten. 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." With many changes occurring throughout the pandemic, we believe it is vital to improve and safeguard democracy within our AMA. We consider this issue of highest import and priority.

**References:**

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
4. Dalton RJ, Jou W, Shin DC. Understanding Democracy: Data from Unlikely Places. *Journal of Democracy*. 2007;18(4):142-156. <https://www.journalofdemocracy.org/articles/understanding-democracy-data-from-unlikely-places/>. Accessed March 18, 2021.
5. Galston WA. The Enduring Vulnerability of Liberal Democracy. *Journal of Democracy*. 2020;31(3):8-24. doi:10.1353/jod.2020.0042
6. Inglehart R, Foa R, Peterson C, Welzel C. Development, Freedom, and Rising Happiness: A Global Perspective (1981–2007). *Perspectives on Psychological Science*. 2008;3(4):264-285. doi:10.1111/j.1745-6924.2008.00078.x
7. Bollyky TJ, Templin T, Cohen M, Schoder D, Dieleman JL, Wigley S. The relationships between democratic experience, adult health, and cause-specific mortality in 170 countries between 1980 and 2016: an observational analysis. *The Lancet*. 2019;393(10181):1628-1640. doi:10.1016/s0140-6736(19)30235-1
8. Democracy. United Nations. <https://www.un.org/en/global-issues/democracy>. Accessed March 18, 2021.
9. Board of Trustees Report 23, American Medical Association Annual 2002 House of Delegates. <https://ama.nmtvault.com/jsp/browse.jsp>. Accessed March 18, 2021.
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.
13. Governing Council Report A, American Medical Association Medical Student Section Annual 2011 Assembly.
14. American Medical Association Medical Student Section. Summary of Actions: Medical Student Section Items of Business, 1999-2020. <https://www.ama-assn.org/system/files/2020-11/mss-summary-of-actions-archive.pdf>. Published November 2020. Accessed March 18, 2021.
15. Governing Council Report A, American Medical Association Medical Student Section Annual 2013 Assembly.

## RELEVANT AMA POLICY

### 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.

#### **Policy Timeline**

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; Reaffirmed: Joint CCB/CLRPD Rep. 1, A-21

### **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; Modified: Speakers Rep, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604  
(N-21)

Introduced by: Texas, Florida, New Jersey, California, Washington

Subject: The Critical Role of Physicians in the COVID-19 Pandemic

Referred to: Reference Committee F

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1 Whereas, Globally there have been more than 4.7 million deaths due to COVID -19; and

2  
3 Whereas, The U.S. has experienced more than 700,000 of these deaths, 3,600 of which are  
4 health care worker deaths; and

5  
6 Whereas, Studies show health care workers were more than three times as likely as the general  
7 public to become infected with the coronavirus; and

8  
9 Whereas, Physicians perform unique and critical roles in taking care of patients with COVID- 19;  
10 and

11  
12 Whereas, Physicians remain on the front lines, often risking their own physical and emotional  
13 health, to care for so many critically ill patients in hospitals throughout the country; and

14  
15 Whereas, The median age of death due to COVID-19 for health care workers is only 57,  
16 compared with the median age of 78 in the general population; and

17  
18 Whereas, COVID-19 infections can cause long-term health conditions not yet fully understood;  
19 and

20  
21 Whereas, Principle seven of the American Medical Association’s Principles of Medical Ethics  
22 states, “A physician shall recognize a responsibility to participate in activities contributing to the  
23 improvement of the community and the betterment of public health”; and

24  
25 Whereas, Principle nine of AMA’s Principles of Medical Ethics states, “A physician shall, while  
26 caring for a patient, regard responsibility to the patient as paramount”; therefore be it

27  
28 RESOLVED, That our American Medical Association create and fund a public awareness  
29 campaign recognizing the vital role physicians have played in the COVID-19 pandemic and  
30 highlighting:

- 31
- 32 • Physician leadership in public health messaging, raising awareness of vital prevention and
  - 33 treatment recommendations;
  - 34 • Medical treatment of patients during this time of great crisis;
  - 35 • Remembrance of physicians who died of COVID-19 while rendering care during the
  - 36 pandemic;
  - 37 • The personal sacrifices borne by physicians related to the pandemic; and
  - 38 • The emotional stress from the long hours spent taking care of patients (Directive to Take
  - 39 Action); and be it further

1 RESOLVED, That the target audience for this campaign be physicians, legislators, and the  
2 public (Directive to Take Action); and be it further

3

4 RESOLVED, That the purpose of this campaign is to thank our physician colleagues and make  
5 government officials and the public aware of the personal costs physicians have shouldered  
6 during this crisis. (Directive to Take Action)

Fiscal Note: Projects underway and included in current budget.

Received: 10/13/21

**AUTHORS STATEMENT OF PRIORITY**

Perhaps there is no greater priority at this meeting than to recognize the work of physicians who have responded so admirably during the COVID-19 pandemic. This top priority resolution affects every physician today given the devastating consequences of COVID-19 for patients in not only for critical care but virtually every other practice setting, specialty, and location throughout the U.S. Our AMA is the best organization to lead this important campaign recognizing the hard work of physicians and this effort would have an immediate and positive impact for physicians who are treating the masses of patients, saving lives, and being leaders on the front lines against this public health crisis. Physicians responded, despite risking their own illness and at a cost that left little time for family support and self-care. Physicians also suffered their own economic losses during the crisis which have yet to be recovered. For being the heroes of COVID-19, but also recognizing the long-term consequences of bearing this burden during this crisis, this resolution asks the AMA to create a recognition campaign for recognizing physicians in their incredible work over these past 20 difficult months.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 605  
(N-21)

Introduced by: Texas

Subject: Formalization of the Resolution Committee as a Standing Committee of the American Medical Association House of Delegates

Referred to: Reference Committee F

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- 1 Whereas, The speakers of the American Medical Association House of Delegates appointed a  
2 Resolution Committee for the 2020 and 2021 Special Meetings of AMA with the purpose of  
3 prioritizing proposed resolutions to the House based on certain criteria to determine each  
4 resolution's urgency and appropriateness as business of the AMA House, recognizing the  
5 limitations of conducting House business in a virtual format during the COVID-19 pandemic; and  
6  
7 Whereas, The Resolution Committee is expected to streamline and increase the efficiency of  
8 the business of the House; and  
9  
10 Whereas, The Resolutions Committee should reflect the priorities of the House of Delegates,  
11 and the appointment of its membership should be diverse and represent the broad base of the  
12 House; therefore be it  
13  
14 RESOLVED, That the Bylaws of the American Medical Association be amended to provide that  
15 the Resolution Committee be responsible for reviewing resolutions submitted for consideration  
16 at all meetings of the American Medical Association House of Delegates and determining  
17 compliance of the resolutions with the purpose of any such meeting (Modify Bylaws); and be it  
18 further  
19  
20 RESOLVED, That the membership of the Resolution Committee reflect the diversity of the  
21 House of Delegates (New HOD Policy); and be it further  
22  
23 RESOLVED, That the Resolution Committee rules be written to produce impartial results and  
24 appropriate changes be made to the AMA Bylaws as necessary to empower the committee.  
25 (Modify Bylaws)

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

Received: 10/13/21

**AUTHORS STATEMENT OF PRIORITY**

The volume of business of the AMA House of Delegates has grown to the level that many reference committees have gone way over their timelines. During Special Meetings of the House, the concept of the Resolution Committee to prioritize business has been done for 3 meetings and has worked well. In order to continue this practice at the annual and interim meetings, a change in the bylaws and rules is necessary.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 606  
(N-21)

Introduced by: Texas

Subject: Increasing the Effectiveness of Online Reference Committee Testimony

Referred to: Reference Committee F

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- 1 Whereas, Written online testimony has been used by the American Medical Association for  
2 many years; and  
3  
4 Whereas, Recently some in-person reference committees meetings have lasted considerably  
5 longer than their allotted time; and  
6  
7 Whereas, Shifting the majority of the testimony to the online written form would provide the  
8 reference committee members with more verifiable testimony and shorten the length of the  
9 in-person reference committee while allowing all opinions to be heard; and  
10  
11 Whereas, There is a perception that online testimony is not as effective as in-person testimony;  
12 and  
13  
14 Whereas, Having a good discussion in the online testimony with the development of a  
15 preliminary reference committee report would give greater credence to that testimony and may  
16 serve to reduce the amount of in-person testimony; therefore be it  
17  
18 RESOLVED, That our American Medical Association conduct a trial of no less than two-years  
19 during which all reference committees, prior to the in-person reference committee hearing,  
20 produce a preliminary reference committee report based on the written online testimony  
21 (Directive to Take Action); and be it further  
22  
23 RESOLVED, That the preliminary reference committee document become the agenda for  
24 discussion at the in-person reference committee (Directive to Take Action); and be it further  
25  
26 RESOLVED, That after the trial period there be an evaluation to determine if this procedure  
27 should continue (Directive to Take Action); and be it further  
28  
29 RESOLVED, That AMA pursue any bylaw changes that might be necessary to allow this trial  
30 (Modify Bylaws); and be it further  
31  
32 RESOLVED, That the period for online testimony be no longer than 10 days.) (Directive to Take  
33 Action)

Fiscal Note: Minimal

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

The volume of business of the AMA House of Delegates has grown to the level that many reference committees have gone way over their timelines. AMA has allowed on-line testimony for several years but frequently there is very limited testimony provided even on the most controversial topics. Many perceive that on-line testimony is not considered as effective as in-person testimony. The TMA used the changes outlined in this resolution in our virtual house of delegates and found it to be very effective in stimulating on-line discussion and shortening the time of the in-person reference committees.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 607  
(N-21)

Introduced by: American Association of Public Health Physicians

Subject: AMA Urges Health and Life Insurers to Divest From Investments in Fossil Fuels

Referred to: Reference Committee F

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1 Whereas, Our AMA recognizes the urgent, ongoing health threats posed to our patients by  
2 global climate change,<sup>1,5</sup> which on its current trajectory is likely to far exceed the health impacts  
3 of COVID19 and HIV combined; and  
4

5 Whereas, Our AMA has declared “the importance of physician involvement in policymaking at  
6 the state, national, and global level and supports efforts to search for novel, comprehensive,  
7 and economically sensitive approaches to mitigating climate change to protect the health of the  
8 public; and recognizes that whatever the etiology of global climate change, policymakers should  
9 work to reduce human contributions to such changes”<sup>1</sup>; and  
10

11 Whereas, In 2018, our AMA adopted policy that “AMA, AMA Foundation, and any affiliated  
12 corporations will work in a timely, incremental, and fiscally responsible manner, to the extent  
13 allowed by their legal and fiduciary duties, to end all financial investments or relationships  
14 (divestment) with companies that generate the majority of their income from the exploration for,  
15 production of, transportation of, or sale of fossil fuels”<sup>2</sup>; and  
16

17 Whereas, Many health and life insurance companies followed the example of the AMA by  
18 divesting from tobacco companies because the tobacco industry’s products and marketing  
19 strategies so clearly threaten human health; and  
20

21 Whereas, Moody’s Investors Service warned investors in 2017 that the oil and gas industry  
22 faces significant credit risks due to the world’s ongoing transition away from fossil fuel<sup>3</sup>; and  
23

24 Whereas, The oil and gas industry stock prices have been the poorest performing sector of  
25 world stock markets since 2008, a period during which the prices of most other sectors have  
26 risen dramatically; and  
27

28 Whereas, The top 10 U.S. health insurers, ranked by U.S. market share and for whom there are  
29 publicly disclosed fossil fuel investment data, have invested nearly \$24 billion dollars in fossil  
30 fuels companies;<sup>4</sup> and  
31

32 Whereas, Collectively, the largest nineteen health or life insurance companies have declared  
33 investments of more than over \$183 billion in the fossil fuel industry<sup>4</sup>; therefore be it  
34

35 RESOLVED, That our American Medical Association declare that climate change is an urgent  
36 public health emergency, and calls upon all governments, organizations, and individuals to work  
37 to avert catastrophe (New HOD Policy); and be it further

- 1 RESOLVED, That our AMA urge all health and life insurance companies, including those that  
2 provide insurance for medical, dental, and long-term care, to work in a timely, incremental, and  
3 fiscally responsible manner to end all financial investments or relationships (divestment) with  
4 companies that generate the majority of their income from the exploration for, production of,  
5 transportation of, or sale of fossil fuels (Directive to Take Action); and be it further  
6  
7 RESOLVED, That our AMA send letters to the nineteen largest health or life insurance  
8 companies in the United States to inform them of AMA policies concerned with climate change  
9 and with fossil fuel divestments, and urging these companies to divest (Directive to Take  
10 Action); and be it further  
11  
12 RESOLVED, That our AMA report the status of AMA's implementation of our 2018 fossil fuels  
13 divestment policies (D-135.969 and H-135.921), and of this resolution, at the 2022 Interim  
14 Meeting of the House of Delegates. (Directive to Take Action)

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

Received: 10/13/21

#### AUTHORS STATEMENT OF PRIORITY

1. Climate change is the most important public health issue facing the world in 21<sup>st</sup> Century. Given its current trajectory, the cumulative impacts of climate change are likely to exceed those of COVID-19 and HIV combined. Climate change already impacts most physicians and many patients. Since then, overwhelming evidence shows the certainty of escalating damage to the world's health, safety, and peace.
2. Each year that the world fails to take meaningful action is aggravating the health impacts of climate change. We respectfully ask that this resolution not be delayed further.
3. This resolution builds upon and references key existing AMA policies.
4. AMA's voice on climate change and health is necessary and meaningful. The resolution calls for actions that will be of negligible financial cost to the AMA.
5. Our AMA's own policies on fossil fuels divestment has set an industry standard and, as with tobacco and other public health challenges, it is proper and necessary for AMA to communicate its concerns with the insurance industry. AMA can capitalize on this proposal to make a significant, positive impact at this pivotal time
6. AMA's existing policies are referenced in the resolution. This fills a significant gap.
7. It is appropriate and necessary for AMA to ask the insurance industry to follow the lead of major health professional societies by pledging to divest of fossil fuels and to instead invest in energy efficiency and renewable energy.

#### References:

1. AMA Policy H-135.938 Global Climate Change and Human Health
2. AMA Policies D-135.969 & H-135.921 AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies
3. [https://www.moodys.com/research/Moodys-Significant-credit-risks-arise-for-oil-and-gas-industry--PR\\_365728](https://www.moodys.com/research/Moodys-Significant-credit-risks-arise-for-oil-and-gas-industry--PR_365728) Accessed 4.30.2021
4. <https://www.psr.org/wp-content/uploads/2020/10/running-out-of-time.pdf> Accessed 4.30.2021

## **RELEVANT AMA POLICY**

### **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

### **AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies D-135.969**

Our AMA, AMA Foundation, and any affiliated corporations will work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels.

Citation: BOT Rep. 34, A-18

### **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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 608  
(N-21)

Introduced by: Resident and Fellow Section

Subject: Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis

Referred to: Reference Committee F

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1 Whereas, The Lancet Countdown on health and climate change has warned that “a rapidly  
2 changing climate has dire implications for every aspect of human life, exposing vulnerable  
3 populations to extremes of weather, altering patterns of infectious disease, and compromising  
4 food security, safe drinking water, and clean air”<sup>1</sup> earning it the title of the “greatest public health  
5 challenge of the 21st century”<sup>2</sup>; and  
6

7 Whereas, Human activities since the Industrial Revolution resulting in burning fossil fuels like  
8 coal and oil have increased the concentration of atmospheric carbon dioxide levels<sup>3</sup> higher than  
9 ever before since the evolution of homo sapiens<sup>4</sup>; and  
10

11 Whereas, At least 250,000 additional deaths are anticipated annually between 2030 and 2050  
12 from heat exposure in the elderly, diarrhea, malaria, and childhood malnutrition alone<sup>5</sup>, without  
13 factoring in the myriad of other ways that climate change acts as a health risk multiplier; and  
14

15 Whereas, Despite the landmark Paris Agreement in 2016, when countries committed to limit  
16 global warming to “well below 2°C,” global carbon dioxide (CO<sub>2</sub>) emissions continue to rise  
17 steadily<sup>6</sup>, with no convincing or sustained abatement; and  
18

19 Whereas, Humans have already caused a rise in the global average temperature of 1.2°C and  
20 our changing climate is already producing considerable shifts in the underlying social and  
21 environmental determinants of health at the global level<sup>7</sup>; and  
22

23 Whereas, People and communities are differentially exposed to hazards and disproportionately  
24 affected by climate-related health risks; for example, some populations might experience  
25 increased climate risks due to a combination of exposure and sensitivity, such as outdoor  
26 workers<sup>8</sup>, communities disproportionately burdened by poor environmental quality<sup>9</sup>, and some  
27 communities in the rural Southeastern United States<sup>10</sup>; and  
28

29 Whereas, Across all climate risks, children, older adults, low-income communities, some  
30 communities of color, and those experiencing discrimination are disproportionately affected by  
31 extreme weather and climate events, partially because they are often excluded in planning  
32 processes<sup>11</sup>; and  
33

34 Whereas, According to the latest available science, in order to limit warming to 1.5°C and  
35 achieve the Paris Agreement goals would require global greenhouse gas (GHG) emissions to  
36 have peaked by 2020 and be reduced to zero by around 2050<sup>12</sup>; thus we have a vanishing  
37 window of opportunity for meaningful action; and

1 Whereas, Many climate change mitigation interventions have immediate local air quality  
2 benefits, among others, and thus immediate health co-benefits<sup>13</sup>; and  
3

4 Whereas, Cutting GHG emissions “may appear to be difficult and costly, but its near-term  
5 benefits outweigh its costs in many areas<sup>14</sup>; and  
6

7 Whereas, It is estimated that worldwide 10.2 million premature deaths annually are attributable  
8 to the fossil-fuel component of PM2.5, constituting nearly 18% of premature deaths<sup>15</sup>; and  
9

10 Whereas, Worldwide, tobacco use causes more than seven million deaths per year<sup>16</sup>; and  
11

12 Whereas, Our AMA has extensive policy to organize physician leadership vis a vis tobacco’s  
13 public health harms<sup>17</sup>; and  
14

15 Whereas, The Tobacco Industry and Fossil Fuel Industry business models are similar in that  
16 their products are incongruous with the interests of public health and their profit interests  
17 motivate well-funded misinformation campaigns<sup>18</sup>; and  
18

19 Whereas, “The strategy, tactics, infrastructure, and rhetorical arguments and techniques used  
20 by fossil fuel interests to challenge the scientific evidence of climate change—including cherry  
21 picking, fake experts, and conspiracy theories—come straight out of the Tobacco Industry’s  
22 playbook for delaying tobacco control”<sup>19</sup>; and  
23

24 Whereas, Physicians are uniquely trusted messengers, with a unique responsibility to advocate  
25 politically for policies to safeguard health in the face of any public health crisis, whether the  
26 COVID-19 pandemic or the climate crisis, in order to build social will for science-based policy  
27 action; and  
28

29 Whereas, Our AMA has adopted multiple policies addressing climate change (H-135.919, H-  
30 135.938, H-135.977, H-135.923, D-135.968, D-135.969, H-135.973), but these policies fall short  
31 of coordinating strategic physician advocacy leadership on the scale necessary for such a  
32 health crisis; and  
33

34 Whereas, In the face of the existential threat that the climate crisis poses, the aforementioned  
35 policies have not been leveraged to fulfill our AMA’s Declaration of Professional Responsibility  
36 (H-140.900) which states, “We, the members of the world community of physicians, solemnly  
37 commit ourselves to ‘Medicine’s Social Contract with Humanity’ in order to continue to earn  
38 society’s trust in the healing profession, by, among other oaths, promising that we will ‘Educate  
39 the public and polity about present and future threats to the health of humanity’”; and  
40

41 Whereas, Our AMA has no identified longitudinal body or Center for coordinating and  
42 centralizing the Association’s efforts to address climate change which the WHO calls “...the  
43 greatest threat to global health in the 21st century”<sup>20</sup>; and  
44

45 Whereas, Our AMA Corporate Policies on Tobacco H-500.975: resolved that (1) Our AMA: (a)  
46 continues to urge the federal government to reduce and control the use of tobacco and tobacco  
47 products; (b) supports developing an appropriate body for coordinating and centralizing the  
48 Association’s efforts toward a tobacco-free society; and (c) will defend vigorously all attacks by  
49 the tobacco industry on the scientific integrity of AMA publications; therefore be it

- 1 RESOLVED, That our American Medical Association reaffirm Policy H-135.949, “Support of  
2 Clean Air and Reduction in Power Plant Emissions,” (Reaffirm HOD Policy); and be it further  
3  
4 RESOLVED, That our AMA establish a climate crisis campaign that will distribute evidence-  
5 based information on the relationship between climate change and human health, determine  
6 high-yield advocacy and leadership opportunities for physicians, and centralize our  
7 AMA’s efforts towards environmental justice and an equitable transition to a net-zero  
8 carbon society by 2050. (Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is \$2M.

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

Our AMA has adopted policy previously regarding climate change and its effects on human health, but has not developed a comprehensive advocacy plan or center regarding climate change. With the worsening of climate change, increased action is needed by our AMA in order to remain a leader in providing evidence-based solutions, advocacy and help to the nation’s physicians and our patients.

References:

1. Watts N. et al. (2018). *The 2018 report of the lancet countdown on health and climate change: shaping the health of nations for centuries to come (executive summary)*. Lancet 392, 2479–2514. 10.1016/S0140-6736(18)32594-7
2. Lancet Countdown 2020 <https://www.thelancet.com/countdown-health-climate#:~:text=Climate%20change%20is%20the%20greatest,of%20the%20landmark%20Paris%20Agreement>.
3. <https://climate.nasa.gov/causes/>
4. Da, J., Zhang, Y.G., Li, G. *et al.* Low CO<sub>2</sub> levels of the entire Pleistocene epoch. Nat Commun 10, 4342 (2019). <https://doi.org/10.1038/s41467-019-12357-5>
5. [https://www.who.int/health-topics/climate-change#tab=tab\\_1](https://www.who.int/health-topics/climate-change#tab=tab_1)
6. <https://www.epa.gov/ghgemissions/global-greenhouse-gas-emissions-data#:~:text=Global%20carbon%20emissions%20from%20fossil,increase%20from%201970%20to%202011>.
7. The 2020 report of the Lancet Countdown on health and climate change: responding to converging crises. Watts, N et al Lancet 2021; 397: 129–70 Published Online December 2, 2020 [https://doi.org/10.1016/S0140-6736\(20\)32290-X](https://doi.org/10.1016/S0140-6736(20)32290-X)
8. Kiefer, M., J. Rodríguez-Guzmán, J. Watson, B. van Wendel de Joode, D. Mergler, and A. S. da Silva, 2016: Worker health and safety and climate change in the Americas: Issues and research needs. *Revista panamericana de salud publica = Pan American Journal of Public Health*, **40** (3), 192–197.
9. Vickery, J., and L. M. Hunter, 2016: Native Americans: Where in environmental justice research? *Society & Natural Resources*, **29** (1), 36–52.
10. Gutierrez, K., and C. LePrevost, 2016: Climate justice in rural southeastern United States: A review of climate change impacts and effects on human health. *International Journal of Environmental Research and Public Health*, **13** (2), 189.
11. Roth, M., 2018: A resilient community is one that includes and protects everyone. *Bulletin of the Atomic Scientists*, **74** (2), 91–94.
12. <https://unfccc.int/process-and-meetings/the-paris-agreement/the-paris-agreement>
13. Baines, A. Health co-benefits of climate action. [www.thelancet.com/planetary-health](http://www.thelancet.com/planetary-health) Vol 1 April 2017
14. Haines A, Ebi K. The imperative for climate action to protect health. N Engl J Med 2019;380:263-73.
15. <https://www.sciencedirect.com/science/article/abs/pii/S0013935121000487>
16. World Health Organization. [WHO Report on the Global Tobacco Epidemic, 2017external icon](https://www.who.int/news-room/fact-sheets/detail/tobacco). Geneva: World Health Organization, 2017 [accessed 2019 Jan 31]
17. <https://policysearch.ama-assn.org/policyfinder/search/tobacco/relevant/1/>
18. Andy S. L. Tan, Cabral A. Bigman, “Misinformation About Commercial Tobacco Products on Social Media—Implications and Research Opportunities for Reducing Tobacco-Related Health Disparities”, *American Journal of Public Health* 110, no. S3 (October 1, 2020): pp. S281-S283.
19. Cook, J., et al. (2019). America Misled: How the fossil fuel industry deliberately misled Americans about climate change. Fairfax, VA: George Mason University Center for Climate Change Communication. Available at <https://www.climatechangecommunication.org/america-misled/>
20. <https://www.who.int/globalchange/global-campaign/cop21/en#:~:text=Climate%20change%20is%20the%20greatest,to%20current%20and%20future%20generations>.

## **RELEVANT AMA POLICY**

### **Support of Clean Air and Reduction in Power Plant Emissions H-135.949**

Our AMA supports (1) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (2) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels.

Citation: Res. 429, A-03; Reaffirmation I-07; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Modified: Res. 506, A-15; Modified: Res. 908, I-17

### **Climate Change Education Across the Medical Education Continuum H-135.919**

Our AMA: (1) supports teaching on climate change in undergraduate, graduate, and continuing medical education such that trainees and practicing physicians acquire a basic knowledge of the science of climate change, can describe the risks that climate change poses to human health, and counsel patients on how to protect themselves from the health risks posed by climate change; (2) will make available a prototype presentation and lecture notes on the intersection of climate change and health for use in undergraduate, graduate, and continuing medical education; and (3) will communicate this policy to the appropriate accrediting organizations such as the Commission on Osteopathic College Accreditation and the Liaison Committee on Medical Education.

Citation: Res. 302, A-19

### **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

### **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

### **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

### **Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Health Care Leadership D-135.968**

Our AMA will continue to explore environmentally sustainable practices for *JAMA* distribution.

Citation: BOT Rep. 8, I-19

### **AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies D-135.969**

Our AMA, AMA Foundation, and any affiliated corporations will work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels.

Citation: BOT Rep. 34, A-18

### **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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 609  
(N-21)

Introduced by: California

Subject: Fulfilling Medicine’s Social Contract with Humanity in the Face of the Climate Health Emergency

Referred to: Reference Committee F

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1 Whereas, Ahead of the November 2021 UN Climate Summit known as the Conference of the  
2 Parties (COP26) where governments will further the Paris Agreement commitments, over 200  
3 international health journal editors have made an unprecedented joint statement that “*the*  
4 *greatest threat to global public health is the continued failure of world leaders to keep the*  
5 *global temperature rise below 1.5°C*”<sup>1</sup> to prevent catastrophic harm to health that will be  
6 impossible to reverse; and  
7

8 Whereas, The Lancet Countdown on health and climate change has warned that “A rapidly  
9 changing climate has dire implications for every aspect of human life, exposing vulnerable  
10 populations to extremes of weather, altering patterns of infectious disease, and compromising  
11 food security, safe drinking water, and clean air”<sup>2,3</sup> earning it the title of the “greatest public  
12 health challenge of the 21st century”;<sup>4</sup> and  
13

14 Whereas, At least 250,000 additional deaths are anticipated annually between 2030 and 2050  
15 from heat exposure in the elderly, diarrhea, malaria, and childhood malnutrition *alone*<sup>5</sup>, without  
16 factoring in the myriad other ways that climate change acts as a health risk multiplier; and  
17

18 Whereas, It is estimated that worldwide 10.2 million premature deaths annually are attributable  
19 to the particulate matter (PM) 2.5 of planet-warming fossil-fuels, constituting nearly 18% of  
20 premature deaths<sup>6</sup>; and  
21

22 Whereas, Burning fossil fuels and other greenhouse gas (GHG) emissions have already  
23 caused a rise in the global average temperature of 1.2°C and our changing climate is already  
24 producing considerable shifts in the underlying social and environmental determinants of health  
25 at the global level<sup>7</sup>; and  
26

27 Whereas, Across all climate risks, children, older adults, low-income communities, outdoor  
28 workers<sup>8</sup> some communities of color, communities disproportionately burdened by poor  
29 environmental quality<sup>9,10</sup> and those experiencing discrimination are disproportionately affected  
30 by extreme weather and climate events, partially because they are often excluded in planning  
31 processes<sup>11</sup>; and  
32

33 Whereas, Many climate change mitigation interventions have immediate local air  
34 quality benefits-- among others-- and thus immediate health co-benefits<sup>12</sup> which is part  
35 of why near-term benefits outweigh climate solution costs in many areas<sup>13</sup>; and  
36

37 Whereas, According to the latest available science, to limit warming to 1.5°C and achieve the  
38 Paris Agreement goals would require global greenhouse gas (GHG) emissions to have peaked  
39 by 2020 net zero carbon emissions by 2050 at the latest<sup>14</sup>, UN Secretary General António

1 Guterres on the August 2021 IPCC report<sup>15</sup> said: "The report '*is a code red for humanity*' but  
2 scientists say a catastrophe can be avoided if the world acts fast, thus we are in a vanishing  
3 window of opportunity for meaningful action"; and  
4

5 Whereas, Physicians are uniquely trusted messengers<sup>16</sup>, with a unique responsibility to  
6 advocate politically for policies to safeguard health in the face of any public health crisis--  
7 whether the COVID-19 pandemic or the need for tobacco regulation-- in order to build social  
8 will for science-based policy action, and  
9

10 Whereas, Our AMA House of Delegates has adopted multiple policies addressing climate  
11 change (*H-135.919*, [H-135.938](#), *H-135.977*, *H-135.923*, *D-135.968*, *D-135.969*, *H-135.973*),  
12 but these policies fall short of coordinating strategic physician advocacy leadership on the  
13 scale necessary for such a health crisis; and  
14

15 Whereas, In the face of the existential threat that the climate crisis poses, these policies have  
16 not been leveraged to fulfill our AMA's *Declaration of Professional Responsibility* ([H-140.900](#)) in  
17 which '*We, the members of the world community of physicians, solemnly commit ourselves to*  
18 '*Medicine's Social Contract with Humanity*' in order to continue to earn society's trust in the  
19 healing profession, by, among other oaths, promising that we will '*Educate the public and polity*  
20 '*about present and future threats to the health of humanity*', and '*Advocate for social, economic,*  
21 '*educational, and political changes that ameliorate suffering and contribute to human well-*  
22 '*being*;' therefore be it  
23

24 RESOLVED, That our American Medical Association declare climate change is an urgent public  
25 health emergency that threatens the health and well-being of all individuals (New HOD Policy);  
26 and be it further  
27

28 RESOLVED, That our AMA support equitable policies to achieve global peaking of greenhouse  
29 gas emissions as soon as possible and to achieve a climate neutral world by mid-century in  
30 alignment with Paris Agreements (New HOD Policy); and be it further  
31

32 RESOLVED, That our AMA, study our existing climate change policies and report back to the  
33 House of Delegates at the 2022 Interim Meeting with specific recommendations on how AMA  
34 will enact these policies, particularly advocacy priorities, in order to fulfill our commitments as  
35 stated in the AMA's *Declaration of Professional Responsibility* ([H-140.900](#)) in the face of the  
36 climate crisis. (Directive to Take Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 10/13/21

## AUTHORS STATEMENT OF PRIORITY

Climate change is an existential health care crisis that must be addressed by the AMA immediately. It impacts all physician and patients. A recent Health Affairs article states, “In a warming, unequal world, it is impossible to tend to patients’ health without addressing the larger environmental and social context—just as it would be absurd to ignore a raging pandemic. Doctors are essential to reframing the climate crisis to focus on people’s health.” The UN Secretary General called the last climate report “*A code red for humanity.*” Climate change is exposing people to extremes of weather, infectious disease, and compromising food security, safe drinking water, and clean air. It is perhaps the greatest public health challenge of the century. President Biden has listed climate change as a top priority and established the new HHS Office of Climate Change and Health Equity. The National Academy of Medicine just named the climate crisis one of their “Grand Challenges” and our AMA CEO is serving on a NAM climate task force. AMA needs additional policy to respond immediately to these government efforts and the overall climate crisis. Estimated health costs of climate change already exceed \$800 billion per year with additional costs for Medicare and Medicaid. Public health, health care capacity, and funding for Medicaid and Medicare physician payments are all at-risk given our current climate trajectory. As the nation’s leading physician organization, it is critical that AMA speak-out on the climate crisis and its impact on public health now. The COVID-19 pandemic demonstrated the importance of AMA’s early and active leadership on the science of public health.

### References:

1. Call for Emergency Action to Limit Global Temperature Increases, Restore Biodiversity and Protect Health. *N Engl J Med*. September 16, 2021; 385:1134-1137. [https://www.nejm.org/doi/full/10.1056/NEJMe2113200?query=featured\\_home](https://www.nejm.org/doi/full/10.1056/NEJMe2113200?query=featured_home) DOI: 10.1056/NEJMe2113200
2. Intergovernmental Panel on Climate Change. Summary for policymakers. In: *Global warming of 1.5°C*. 2018 (<https://www.ipcc.ch/sr15/>)
3. Watts N, Amann M, Arnell N, et al. The 2018 report of the Lancet countdown on health and climate change: Shaping the health of nations for centuries to come. *The Lancet*. 2018;392(10163):2479-2514. doi:10.1016/s0140-6736(18)32594-7.
4. Watts N, Amann M, Arnell N, et al. The 2019 report of The Lancet Countdown on health and climate change: ensuring that the health of a child born today is not defined by a changing climate. *The Lancet*. 2019;394(10211):1836-1878. doi:10.1016/s0140-6736(19)32596-6
5. Climate change. World Health Organization. [https://www.who.int/health-topics/climate-change#tab=tab\\_1](https://www.who.int/health-topics/climate-change#tab=tab_1). Accessed May 5, 2021.
6. Vohra K, Vodonos A, Schwartz J, Marais EA, Sulprizio MP, Mickley LJ. Global mortality from outdoor fine particle pollution generated by fossil fuel combustion: Results from GEOS-Chem. *Environmental Research*. 2021;195:110754. doi:10.1016/j.envres.2021.110754
7. Watts N, Amann M, Arnell N, et al. The 2020 report of The Lancet Countdown on health and climate change: responding to converging crises. *The Lancet*. 2021;397(10269):129-170. doi:10.1016/s0140-6736(20)32290-x
8. Kiefer M, Rodríguez-Guzmán J, Watson J, van Wendel de Joode B, Mergler D, da Silva AS. Worker health and safety and climate change in the Americas: issues and research needs. *Rev Panam Salud Publica*. 2016;40(3):192-197.
9. Vickery J, Hunter LM. Native Americans: Where in Environmental Justice Research?. *Soc Nat Resour*. 2016;29(1):36-52. doi:10.1080/08941920.2015.1045644
10. Gutierrez KS, LePrevost CE. Climate Justice in Rural Southeastern United States: A Review of Climate Change Impacts and Effects on Human Health. *Int J Environ Res Public Health*. 2016;13(2):189. Published 2016 Feb 3. doi:10.3390/ijerph13020189
11. Roth M. A resilient community is one that includes and protects everyone. *Bulletin of the Atomic Scientists*. 2018;74(2):91-94. doi:10.1080/00963402.2018.1436808
12. Haines A. Health co-benefits of climate action. *The Lancet Planetary Health*. 2017;1(1).doi:10.1016/s2542-5196(17)30003-7
13. Haines A, Ebi K. The Imperative for Climate Action to Protect Health. *New England Journal of Medicine*. 2019;380(3):263-273. doi:10.1056/nejmra1807873
14. IPCC, 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.
15. The Paris Agreement. United Nations Climate Change. <https://unfccc.int/process-and-meetings/the-paris-agreement/the-paris-agreement>. Accessed May 5, 2021.

16. Saad L. U.S. Ethics Ratings Rise for Medical Workers and Teachers. Gallup.com. <https://news.gallup.com/poll/328136/ethics-ratings-rise-medical-workers-teachers.aspx>. Published March 23, 2021. Accessed May 5, 2021.

## **RELEVANT AMA POLICY**

### **Climate Change Education Across the Medical Education Continuum H-135.919**

Our AMA: (1) supports teaching on climate change in undergraduate, graduate, and continuing medical education such that trainees and practicing physicians acquire a basic knowledge of the science of climate change, can describe the risks that climate change poses to human health, and counsel patients on how to protect themselves from the health risks posed by climate change; (2) will make available a prototype presentation and lecture notes on the intersection of climate change and health for use in undergraduate, graduate, and continuing medical education; and (3) will communicate this policy to the appropriate accrediting organizations such as the Commission on Osteopathic College Accreditation and the Liaison Committee on Medical Education.

Citation: Res. 302, A-19

### **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

### **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)

### **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

### **Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Health Care Leadership D-135.968**

Our AMA will continue to explore environmentally sustainable practices for *JAMA* distribution.

Citation: BOT Rep. 8, I-19

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Citation: BOT Rep. 34, A-18

### **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

### **A Declaration of Professional Responsibility H-140.900**

Our AMA adopts the Declaration of Professional Responsibility

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

##### **Preamble**

Never in the history of human civilization has the well being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising to do great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all. As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

##### **Declaration**

We, the members of the world community of physicians, solemnly commit ourselves to: (1)

Respect human life and the dignity of every individual.

- (2) Refrain from supporting or committing crimes against humanity and condemn any such acts.
- (3) Treat the sick and injured with competence and compassion and without prejudice.
- (4) Apply our knowledge and skills when needed, though doing so may put us at risk.
- (5) Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.
- (6) Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.
- (7) Educate the public and polity about present and future threats to the health of humanity.
- (8) Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.
- (9) Teach and mentor those who follow us for they are the future of our caring profession.

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

Citation: CEJA Rep. 5, I-01; Reaffirmation A-07; Reaffirmed: CEJA Rep. 04, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 610  
(N-21)

Introduced by: Florida

Subject: Creation of Employed Physician Section

Referred to: Reference Committee F

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- 1 Whereas, The rate of employed physicians climbed steadily from January 2019 to January 2020  
2 from 62.5% to 64.5% and that number continues to rise; and  
3  
4 Whereas, Up to 70% of physicians are employed by hospitals or corporations; and  
5  
6 Whereas, 48,000 physicians left independent practice for employment by hospitals, health  
7 systems or corporate entities; and  
8  
9 Whereas, Hospital medical staffs struggle with challenges associated with employed physicians,  
10 and have yet to resolve numerous challenges and conflicts that arise between the demands of  
11 hospital administrators and physician patient-care responsibilities; and  
12  
13 Whereas, There are numerous conflicts of interest for employed medical staff leaders; and  
14  
15 Whereas, Many employed physicians have low trust and confidence as well as sense a lack of  
16 accountability that hospital administrator's goal is to provide excellence in patient care; and  
17  
18 Whereas, Employed physicians are in a disadvantaged position when negotiating and re-  
19 negotiating contracts; and  
20  
21 Whereas, Less than 150,000 practicing physicians are members of the American Medical  
22 Association while employed physicians currently do not appreciate any tangible benefit from  
23 joining the American Medical Association; and  
24  
25 Whereas, Offering a section, specifically dedicated to the challenges faced by employed  
26 physicians would attract new members; therefore be it  
27  
28 RESOLVED, That our American Medical Association study the necessity and feasibility to  
29 create a Section for Employed Physicians (Directive to Take Action); and be it further  
30  
31 RESOLVED, That the section would work toward determining problems associated with  
32 employment; recommend solutions; and utilize necessary resources when resolving conflicts  
33 and challenges between employed physicians and their employers. (Directive to Take Action)

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

Received: 10/13/21

**AUTHORS STATEMENT OF PRIORITY**

This is a high priority resolution as it affects the majority of physicians and is consistent with our mission. Modification of current policy and creation of new policy will have a positive impact for employed physicians and the patients they care for. The majority of physicians in the US are now employed and they are at a significant disadvantage when negotiating and renegotiating contracts and have unique challenges. In order to understand the depth and breadth of the problem the AMA should study the necessity and feasibility of a Employed physicians section which could work toward determining the problems associated with employment and recommend solutions. This new section could also drive membership with this vital segment of the physician workforce.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 611  
(N-21)

Introduced by: New York  
Subject: September 11<sup>th</sup> as a National Holiday  
Referred to: Reference Committee F

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1 Whereas, September 11, 2001 took over 3,000 lives in an act of terrorism against the United  
2 States of America; and  
3  
4 Whereas, September 11, 2021 marked the twentieth anniversary of that horrific day; and  
5  
6 Whereas, Thousands of responders, uniformed and civilian, employed and volunteers, served at  
7 Ground Zero, the Pentagon and Shanksville, PA, risking their lives, being exposed to debris,  
8 powdered cement, fumes, vapors, dust, and a variety of other irritants, including exposure to  
9 human remains, as well as many severe psychological stressors, and the devastation to the  
10 World Trade Center site itself; and  
11  
12 Whereas, There are many Americans who now live with September 11 related medical and  
13 mental health conditions as well as those whose lives were prematurely shortened because of  
14 the impact of these toxic exposures; and  
15  
16 Whereas, The effects of the 9/11 attack have forever altered the world in every aspect of life  
17 from mental, emotional, medical, business, security, education, etc.; and  
18  
19 Whereas, Every American and every individual has felt the impact from lost loved ones who  
20 were taken away too early, or from the increased security and vigilance needed to protect this  
21 country; and  
22  
23 Whereas, Every life lost on that day represents the freedoms for which we were attacked; and  
24  
25 Whereas, *Patriot Day, 9/11*, is already recognized as a day of remembrance; and  
26  
27 Whereas, The terror attack on US soil on September 11, 2001 should never be minimized or  
28 forgotten; and  
29  
30 Whereas, The United States Congress holds the authority to create a Federal Holiday according  
31 to Title V of the United States Code (5 U.S.C. 6103); therefore be it  
32  
33 RESOLVED, That our American Medical Association support and recognize September 11th as  
34 an annual day of observance to remember and recognize all who died and who continue to  
35 suffer health consequences from the events of 9/11, to honor first- and all responders from  
36 around the country, and to recognize and forever remind us of the unity our country experienced  
37 on 9/11/01 and the months that followed. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000  
Received: 10/11/21

**AUTHORS STATEMENT OF PRIORITY**

This year marked the passing of twenty years since the attack on both towers of the World Trade Tower and the Pentagon, and the tragedy memorialized at Shanksville, Pennsylvania. The horror of that day remains for those who lived through it and should not be ignored by those who have not. Too many innocent people lost their lives to the worst terrorist attack on US soil and many more have died or become ill as a consequence of those events. That terrible day should be recognized annually as a day of remembrance to honor America's dead resulting from that day as well as those who lost their lives or health as a consequence of "working the pile" and those subsequent effects. The unprovoked and unprecedented 9/11 attack changed the history of the United States, its people and the world. The AMA should officially recognize, remember and memorialize that day.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 612  
(N-21)

Introduced by: New York

Subject: UN International Radionuclide Therapy Day Recognition

Referred to: Reference Committee F

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- 1 Whereas, The General Assembly of the United Nations advocates for proclaiming International  
2 days of recognition to highlight specific values of worldwide human interest; and  
3
- 4 Whereas, The United Nations General Assembly documents describe the purpose of  
5 proclaiming “International Days” as follows: “International days are occasions to educate the  
6 general public on issues of concern, to mobilize political will and resources to address global  
7 problems, and to celebrate and reinforce achievements of humanity”; and  
8
- 9 Whereas, The year marks the 80th year from the first recorded use of radioiodine therapy to  
10 treat human disease; and  
11
- 12 Whereas, Saul Hertz, MD (1905 - 1950) discovered the medical uses of radionuclides, and his  
13 breakthrough work with radioactive iodine (RAI) created a dynamic paradigm change integrating  
14 the sciences of physics, biology, physiology and medicine; and  
15
- 16 Whereas, Radioactive iodine (RAI) is the first and remains the Gold Standard of targeted cancer  
17 therapies; and  
18
- 19 Whereas, In early 1941, Dr. Hertz administered the first therapeutic treatment of (Cyclotron-  
20 produced) radioactive iodine (RAI) at the Massachusetts General Hospital, which led to the first  
21 series of twenty-nine patients with hyperthyroidism being treated successfully with RAI; and  
22
- 23 Whereas, Dr. Hertz expanded the successful use of RAI of treating hyperthyroidism and Graves’  
24 disease to the treatment of thyroid cancer in 1946; and  
25
- 26 Whereas, This work generating and utilizing radioactive material for medical therapy leaves an  
27 enduring legacy, impacting countless generations of patients, numerous institutions worldwide  
28 and setting the cornerstone for the field of Nuclear Medicine, and has for all future generations,  
29 augmented and forever altered the approach to medical therapies; and  
30
- 31 Whereas, This novel work marks the advent of what we now recognize as modern medicine,  
32 utilizing molecular medicine and the ever evolving promise of targeted molecular therapies for  
33 the treatment of human disease; and  
34
- 35 Whereas, To appropriately recognize and honor this groundbreaking scientific and medical  
36 breakthrough on its 80th year anniversary, and to honor Dr. Saul Hertz and to remember and  
37 celebrate this extraordinary accomplishment; therefore be it

- 1 RESOLVED, That our American Medical Association support the efforts of the American  
2 College of Nuclear Medicine to create and introduce a United Nations General Assembly  
3 (UNGA) Resolution for the creation of a new International Day of recognition with the suggested  
4 name of "International Radionuclide Therapy Day." (Directive to Take Action)

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

Received: 10/11/21

#### AUTHORS STATEMENT OF PRIORITY

The discovery of radionuclides and their use in medical applications cannot be extolled loud enough. The number of lives that have been saved because of this discovery are too many to count. AMA should support the efforts to declare this an International Day of recognition. The uses of radionuclide therapy continue to be expanded and discovered and have benefitted innumerable patients. An entire medical specialty has been built around this discovery and its medical use, that should be honored.

Perhaps of more overall impact, this is a chance to highlight the overall importance of the science of the Practice of Medicine, nationally and internationally.

This Resolution fits the Top Priority criteria as it is:

1. Within our AMA mission plan of facilitating education to the public about the importance of evidence-based medicine
2. Requires new policy to implement
3. No current policy exists on this topic, and it is an advantageous issue on which to have policy
4. AMA action will have a positive impact
5. AMA is most appropriate body to bring this issue forward.

Also, delaying this Resolution until June would necessarily have the negative impact of delaying the development of a UNGA Resolution for an additional year, due to UN Resolution submission schedule.

Another important consideration for urgent timing is that Barbara Hertz, the daughter of Saul Hertz, is still alive and well and we should want to get this done while she can still enjoy and celebrate this commemoration of her father's work.

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#### A few References for interest:

Hertz B. A tribute to Dr. Saul Hertz: The discovery of the medical uses of radioiodine. *World J Nucl Med.* 2019;18(1):8-12.  
doi:10.4103/wjnm.WJNM\_107\_18

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6357704/>

<https://endocrinenews.endocrine.org/january-2016-thyroid-month-the-saga-of-radioiodine-therapy/>

<https://www.intechopen.com/books/thyroid-cancer-advances-in-diagnosis-and-therapy/dr-saul-hertz-1905-1950-discovers-the-medical-uses-of-radioactive-iodine-the-first-targeted-cancer-t>

[Radioactive Iodine in the Study of Thyroid Physiology. VII. The Use of Radioactive Iodine Therapy in Graves' Disease. \(Dec. 1946\)](#)

<http://saulhertzmd.com/home>

**TABLE I AN ANALYSIS OF CASES "NOT CURED" BY Ra-I + KI (TO MARCH '46)**

SERIES NO.	CASE-HOSP. NO.	BMR PRIOR TO I <sup>130</sup> DATES OF ADMINISTRATION	DOSAGE OF I <sup>130</sup> AND DATES OF ADMINISTRATION	BMR PRIOR TO SUB-TOTAL THYROIDECTOMY	POSTOP. BMR	THYROID WEIGHT	HISTOLOGY	TOTAL THYROID IRRADIATION (%)		ESTIMATED THYROID WT. BEFORE I <sup>130</sup>	% OF Ra-I (URINE) EXCRETED - 72 HRS. FOLLOWING THE ADMINISTRATION OF I <sup>130</sup>
								12 HR.	9 DAY		
1	ELIZABETH D.	+30	21mC 3-31-41 } 3.4 1.5mC 4-16-41 } mC	(-3)(-7)	(-29)	34	INVOLUTION	470 220	660 290	35	20 28
5		+35	57mC 7-11-41	PLANNED EXAMINATION	(-20)	31	HYPERTROPHIA NO INVOL.	1000	1150	40	27
10		+55	07mC 2-2-42	(+3)	(-26)	26 30	HYPERTROPHIA MOD. INVOL.	120	80	60	38
14		+50	15mC 7-15-42	(-15)	(-24)	55	HYPERTROPHIA + INVOLUTION	650	—	60	71
16		+25	10mC 8-11-42	(-8)	(24)	28	INVOLUTION	1800	—	45	6
19		+65	10mC 8-28-42 } 28 8mC 3-8-43 } mC 5mC 3-3-43 } mC	(+8) TO (-18)	(+36) TO (-18)	35	HYPERPLASIA + INVOLUTION	2000 1500	—	60	9 15 7
2		+35	14mC 5-10-41 } 5.6 0.9mC 41 } mC 24mC 42 } mC 0.8mC 42 }	NOT OPERATED PERSISTENT THYROTOXICOSIS ANOTHER 20mC PROPOSED				160 110 120 100	140 100 120 100	40	54 48 78 —
4		+30	34mC 7-14-41 } 5.8 22mC 7-31-41 } mC	EYES BETTER. NO GAITER. BMR (+3) OFF MED. - 4 YRS				270 170	300 180	60	55 56
3		+50	34mC 6-6-41 } 20mC 1-9-46 }	REMISSION FOR 1 YR - THEN (RECENTLY FOR TRUE RECURRENCE)				430 4300	410 —	45 30 (RECURRENT)	45 35

**a** \* OPHTHALMOPATHIC TYPE

**TABLE II - ANALYSIS OF 20 CASES "CURED" BY Ra-I + KI ON BASIS OF EXAMINATION MARCH 3, 1946**

SERIES NO.	CASE-HOSP. NO.	DOSE OF I <sup>130</sup> AND DATE OF ADMINISTRATION	BMR BEFORE I <sup>130</sup>	BMR LEVEL OFF IODIDES	TIME OFF IODIDES	THYROID SIZE '46	ESTIMATED THYROID WT. (8m)	% OF Ra-I EXCRETED 72 HOURS	ESTIMATED IRRADIATION (M) 12 HOUR	THYROID IRRADIATION (M) 8 DAYS*
6		2.3mC 7-24-41 } 4.0 1.7mC 7-30-41 } mC	+45	DEC. '42 (-9) MAY '43 (-16) JAN. '46 (-7)	4 YRS. +	N	45	35 22	320 280	390 300
7		ET 9 ) 1.4mC 9-19-41 } 2.9 1.5mC 9-21-41 } mC	+65	1-8-46 (-6)	4 YRS.	N	45	9 20(?)	260 260(?)	280 220(?)
8		ET 9 ) 1.6mC 9-24-41	+30	7-17-45 (-3) 5-27-46 (+4)	7 MOS	FIRM 2 X N	40	15	300	250
9		4.9mC 11-26-41	+30	5-8-45 (-10)	4 YRS.	N	60	17	650	420
11		5.8mC 4-9-42	+37	7-9-42 (-12) 2-24-44 (+9) 2-3-46 (-13)	3.5 YRS.	N	60	17	750	380
12		7.5mC 5-15-42	+55	45 (+11) 2-3-46 (-13)	3 YRS.	HARD 1.5 X N	60-75	26	950	500
13		12mC 6-9-42	+30	3-25 (+6) 2-3-46 (-10)	3 YRS.	N	40	71	750	
15		6mC 8-11-42 } 10 4mC 8-11-42 } mC	+35	4-45 (-6) 2-3-46 (+2)	10 MOS.	N	40	10	2000	
17		13mC 8-15-42	+50	6-10-44 (-15) 1-6-46 (-9)	3 YRS. +	N	60	14	1300	
18		10.5mC 8-15-42	+35	8-22-44 (+19) 2-16-46 (+4)	3 YRS. +	N	40	15	2000	
20		10mC 11-14-42	+50	4-3-45 (-1) 2-16-46 (-5)	2 YRS. +	N	45	20	1600	
21		14mC 11-20-42	+45	1-8-46 (-13)	3 YRS. +	N	50	15(?)	2000	
22		13mC 3-9-43	+20	6-30-43 (-8)	2 YRS. +	? N (LMB)	55	33	2200	
23		8mC 3-15-43 } 18 10mC 3-16-43 } mC	+55	6-9-43 (-11) 2-16-46 (-3)	2 YRS. +	FIRM 1.5 X N	75	76 67	500	
24		10.5mC 3-26-43 } 15 4.5mC 3-27-43 } mC	+40	12-45 (-5)	2 YRS. +	N (DR. J.C.) (ZILHARDT)	50	57 31	1000	
25		16mC 4-2-43	+44	9-28-44 (-7) 4-27-45 (+9) 3-20-46 (+4)	2 YRS. +	N (DR. J.C.) (AUG)	50	20.6 63.0	750	
26		12mC 4-6-43	+39	45 (-8) 1-16-46 (+2)	2 YRS. +	N	45	85	350	
27		13mC 4-12-43	+40	7-17-45 (-16) 2-15-46 (-10)	2 YRS. +	N	50	33	1600	
28		10.5mC 4-13-43 } 21 11.0mC 4-13-43 } mC	+55	12-45 (+6) 2-3-46 (+6)	2 YRS. +	N	75	---	2000	
29		8mC 3-29-43 } 12 4mC 3-30-43 } mC	+30	2-46 (+4)	2 YRS. +	N	55	10 53(?)	1200 250	

**b** \* 8 DAY ISOTOPE FIGURES ASSUME NO LOSS OF IODINE FROM THYROID DURING DECAY; THEY ARE THEREFORE EXCESSIVE. THEY WERE NOT MEASURED FOR CASES 13-29 ---

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 613  
(N-21)

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

Subject: Due Process at our AMA

Referred to: Reference Committee F

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1 Whereas, Most Americans assume the US Constitution guarantees due process before the  
2 government may deprive someone of “life, liberty, or property,” particularly as stated in the Fifth  
3 and Fourteenth Amendments to the United States Constitution, including notice, opportunity for  
4 hearing, confrontation and cross-examination, discovery, basis of decision, and availability of  
5 counsel in the United States” (quote from the Library of Congress at Congress.gov, Amt5.4.1  
6 “The Right to Due Process: Overview);” and  
7

8 Whereas, Since 1980 the AMA has supported the right of physician due process and has  
9 adopted general guidelines for due process to be adapted in each instance to suit the  
10 circumstances and conditions of health care organizations (Guidelines for Due Process  
11 H-265.998); and  
12

13 Whereas, Most American physicians believe that AMA members deserve the right to due  
14 process before any adverse action may be taken against them by the Council on Ethical and  
15 Judicial Affairs (CEJA), the Conduct Liaison or Committee on Conduct at AMA Meetings and  
16 Events (CCAM) pursuant to the Policy on Conduct at AMA Meetings and Events H-140.837, or  
17 the AMA Speakers office, or the Speakers Elections Committee, or the AMA House of  
18 Delegates staff office; therefore be it  
19

20 RESOLVED, That any American Medical Association member accused of any offense internal  
21 to AMA, such as a complaint on/to the AMA Code of Conduct Hotline at 800-398-1496 ([AMA](#)  
22 [Code of Conduct for meeting attendees and employees | American Medical Association \(ama-](#)  
23 [assn.org\)](#) be entitled to due process based on principles of fundamental fairness before any  
24 adverse action may be taken against such AMA member as a result of any such complaint,  
25 including but not limited to notice of complaint and opportunity to be heard coincident with any  
26 AMA based investigation (New HOD Policy); and be it further  
27

28 RESOLVED, That our AMA prohibit inappropriate usage of AMA public or private media  
29 platforms and take reasonable steps to enforce the existing Digital Code of Conduct ([Code of](#)  
30 [Conduct | American Medical Association \(ama-assn.org\)](#) including but not limited to prompt and  
31 thorough investigation of alleged violations of the Digital Code of Conduct as if the complaint  
32 were formally filed on the Code of Ethics Hotline. (New HOD Policy)  
33

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

Received: 10/11/21

## AUTHORS STATEMENT OF PRIORITY

Due process is important to ALL physicians and particularly at our AMA. We need to act NOW to avoid further damage from our rampant recent ill-behaviors on AMA sponsored social media platforms and the Complaint Hotline. We all agree that fairness and diversity are now viewed as among our CORE AMA VALUES. We need NEW policy to rein in abuses seen over the last 12 months or so. The HOD action will obviously have positive impact and only the AMA can act on this important and timely internal action.

Reference: from the above AMA web page  
Digital Code of Conduct

By accessing and using this website you agree to the following Code of Conduct. If you do not agree to the Code of Conduct, [Terms of Use](#), and [Privacy Policy](#), you must immediately terminate use of this site.

To help the American Medical Association (AMA) maintain dialogue that is relevant and respectful of the rights of others, you understand that when you submit comments, posts or images on AMA's digital platforms, you will not:

- Spread false and/or defamatory information.
- Include content that is discriminatory, abusive, vulgar, hateful, harassing, obscene, profane, sexually oriented, threatening, invasive of a person's privacy or right to publicity, or otherwise violative of any law.
- Infringe on copyrights, trademarks or trade secrets.
- Post content that includes private and/or personal information, such as home phone numbers and email addresses.
- Seek medical advice (consult your personal physician) or disclose personal health information.
- Promote commercial services and products or causes.
- Post in manner that would constitute spamming (e.g., posting with such frequency or repetitiveness that others may be discouraged from posting, posts that are irrelevant to the topic and/or the AMA's mission, and "follow me" posts) or trolling (defined as comments that appear intended to send the discussion in a fruitless direction).

## RELEVANT AMA POLICY

### Guidelines for Due Process H-265.998

While it is not possible to develop universal guidelines for due process, voluntary utilization of the following general guidelines for due process, adapted in each instance to suit the circumstances and conditions of the health care organization and within the requirements of the applicable laws of the jurisdiction, should assist in providing the type of hearing which the law in each jurisdiction requires:

- (1) The physician should be provided with a statement, or a specific listing, of the charges made against him or her.
- (2) The physician is entitled to adequate notice of the right to a hearing and a reasonable opportunity of no less than 30 days to prepare for the hearing.
- (3) It is the duty and responsibility of the hearing officer to conduct a fair, objective, expeditious and independent hearing pursuant to established rules.
- (4) The rules of procedure should clearly define the extent to which attorneys may participate in the hearing.
- (5) The physician against whom the charges are made should have the opportunity to be present at the hearing and hear all of the evidence against him or her.
- (6) The physician is entitled to the opportunity to present a defense to the charges against him or her.
- (7) To the extent feasible, the hearing panel should evaluate the issues and evidence presented related to the proposed corrective action while blinded to the patient outcome.
- (8) The hearing panel should render a decision based on the evidence produced at the hearing.
- (9) The hearing panel should include in its decision the conclusions reached and actions recommended and, as an important focus if feasible, remedial steps for the physician and for the health care facility itself. When feasible, the hearing panel should include terms that permit measurement and validation of the completed remediation process.
- (10) The hearing panel should endeavor to state its findings, the clinical basis and support for its findings, its recommendations, and actions as clearly as possible.

(11) Within 10 days of the receipt of the hearing panel's decision, the physician, medical executive committee or health care organization, if it brought the correction action, has the right to request an appellate review. The written request for an appellate review shall include an identification of the grounds for appeal and a clear and concise statement of the facts and/or evidence in support of the appeal. The grounds for an appeal of the decision shall be: (a) substantial non-compliance with the procedures required in the medical staff bylaws; or (b) the decision is against the manifest weight of the evidence. If an appellate review is to be conducted, the appeal board shall schedule the appellate review and provide notice to the physician, medical executive committee and the health care organization. The MEC shall appoint an appeal board consisting of members of the medical staff who did not sit on the original hearing panel, or, at the request of the MEC, the governing body or at least three members thereof may sit as the appeal board. The appeal board shall consider the record of the hearing before the hearing panel. If the appeal board determines that significant relevant evidence, which could bear on the outcome of the proceeding, was not entertained by the hearing panel, it may refer the matter back to the hearing panel for further deliberation or, at the appeal board's discretion, it may receive and consider the new evidence. Similarly, if the appeals board determines that there was not substantial compliance with the hearing procedures in the medical staff bylaws, the appeal board may refer the matter back to the hearing body or, at the appeal board's discretion, it may convene additional hearings to correct any defect in the process. Upon completion of the appeal board's deliberations, the appeal board shall present its recommendation(s) to the governing body as to whether the recommendations(s) of the hearing body should be affirmed, modified, or reversed.

(12) In any hearing, the interest of patients and the public must be protected.

Citation: BOT Rep. II, A-80; Reaffirmed: Sunset Report, I-98; Amended: BOT Action in response to referred for decision BOT Rep. 23, A-05; Reaffirmed: Res. 12, A-06; Reaffirmed: BOT Rep. 06, A-16; Reaffirmed: Res. 235, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 614  
(N-21)

Introduced by: New Jersey, District of Columbia, Oklahoma, Pennsylvania, South Carolina, Tennessee, California, American Society of Anesthesiologists, New York, Florida, American College of Allergy, Asthma and Immunology

Subject: Insurance Industry Behaviors

Referred to: Reference Committee F

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1 Whereas, In 2000, the AMA with several state medical societies, led by Florida, California,  
2 Missouri and New York, and specialty societies, led by OB-GYN, and several individual  
3 physicians, successfully sued the commercial health insurance carriers in a RICO lawsuit. The  
4 settlement was substantial, paying costs of all parties and leading to at least two foundations,  
5 including the Physicians Foundation for Health System Excellence; and  
6

7 Whereas, In 2009 the AMA again, with other partners, successfully sued the Aetna and Cigna  
8 groups of companies for \$11 Million each with success for similar offences listed in the United  
9 Healthcare suit; and  
10

11 Whereas, Many insurers are once again treating physicians and other claimants unfairly; and  
12

13 Whereas, The recent published September 28, 2021 AMA Report "*Competition in Health*  
14 *Insurance: A comprehensive study of U.S. markets – an 2021 Update*" demonstrates increasing  
15 market share across the United States of certain insurance companies in certain regions of the  
16 United States and points out " Research finds evidence that insurer consolidation leads to the  
17 exercise of monopsony power vis-à-vis physicians in the form of lower physician earnings and  
18 employment." (page 3-4); and  
19

20 Whereas, The health insurance industry in particular is using its market share to unfairly gain  
21 leverage against physicians and medical practices resulting in:

- 22 1) Unilateral reductions in reimbursements
- 23 2) Retroactive audits without cause
- 24 3) Manufactured claims denials
- 25 4) Egregious and unnecessary payment delays
- 26 5) Forced arbitration on abusive terms, requiring physicians to pay for the process
- 27 6) Scurrilous interpretation the AMA CPT Code and Vignettes to the disadvantage of  
28 the physician
- 29 7) Cancellation of contracts and/or arbitrary termination of certain providers and  
30 reduction of networks; therefore be it  
31

32 RESOLVED, That our American Medical Association step up its ongoing review of the proper  
33 use of the AMA CPT Code and Vignettes in medical billing claims payments and its misuse by  
34 the US Health Insurance Industry (Directive to Take Action); and be it further

1 RESOLVED, That our AMA undertake as soon as practical a formal, legal review of ongoing  
2 grievous behaviors of the health insurance industry including: (1) a search for potential litigation  
3 partners across the medical federation; and (2) dissemination of the findings to the appropriate  
4 internal AMA divisions and Councils for review and preparation for potential civil, regulatory  
5 and/or legislative action by/in the US Court System, the US Federal or State regulatory  
6 agencies and/or the US Congress. (Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is \$300,000 annually.

Received: 10/11/21

#### AUTHORS STATEMENT OF PRIORITY

Growing Insurance Industry coding and payment Misbehavior effects most physicians. We need to act at this meeting to start what might be a several year process. Protection of physician practice viability and economics is our AMA CORE ACTIVITY. We need to authorize new policy to get going on this key issue, particularly in this time of "COVID." AMA is the expected and only organization to take on such a project.

#### RELEVANT AMA POLICY

##### **Third Party Payer Coverage Process Reform and Advocacy D-185.986**

1. Our AMA, working with interested state medical and national specialty societies, will develop model legislation and/or regulations to require that commercial insurance companies, state Medicaid agencies, or other third party payers utilize transparent and accountable processes for developing and implementing coverage decisions and policies, and will actively seek the implementation of such model legislation and/or regulations at the national and state levels.
2. Our AMA will work with specialty and service organizations to advocate that private insurance plans and benefit management companies develop transparent clinical protocols as well as formal processes to write / revise them; that those processes should seek input from the relevant national physician organizations; and that such clinical coverage protocols should be easily and publicly accessible on their websites, just as Medicare national and local coverage determinations are publicly available.
3. Our AMA will advocate that when private insurance plans and benefit management companies make changes to or revise clinical coverage protocols, said companies must inform all insured individuals and participating providers in writing no less than 90 days prior to said change(s) going into effect.

Citation: (Res. 820, I-11; Appended: Res. 807, I-12)

##### **Physician Reimbursement by Health Insurance and Managed Care Companies H-190.959**

1. Our AMA shall make it a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within fourteen days.
2. When electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within five business days to allow prompt resubmission of a clean claim.
3. Our AMA shall advocate for heavy penalties to be imposed on health insurance and managed care companies, including their employees, that do not comply with laws and regulations establishing guidelines for claims payment.
4. Our AMA will continue to encourage regulators to enforce existing prompt pay requirements.

Citation: Sub. Res. 713, A-02; Modified: Res. 714, A-03; Reaffirmation I-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: Res 132, A-14; Reaffirmed: Sub. Res. 715, A-15; Appended: Res. 805, I-18

**Insurance Companies Use of Contractors to Recover Payments D-385.965**

1. Our AMA will seek legislation to limit insurance companies, their agents, or any contractors from requesting payment back on paid claims to no more than 90 days after payment is made.
  - (a) Such legislation would require insurance companies, their agents, or any contractors to have a defined and acceptable process for physicians to dispute these maneuvers to get payment back on claims already processed, verified, and paid.
  - (b) Such legislation would ban insurance companies, their agents or contractors from using re-pricers and re-reviewers and to adhere to their own pricing and reviewing guidelines as agreed upon in their contracts with physicians.
2. Our AMA will pursue legislation to regulate self-insured plans in this regard and apply the same rules to Medicare and other federal plans.

Citation: Res. 215, A-09; Reaffirmed: BOT Rep. 09, A-19

**Insurance Company Denial of Payment for Office Visit and Invasive Procedure Done on the Same Day H-385.944**

Our AMA supports insurance company payment for evaluation and management services and procedures performed on the same day, where consistent with CPT guidelines.

Citation: Sub. Res. 829, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmation I-07; Reaffirmed: CMS Rep. 01, A-17

**A Level Playing Field in Negotiations Between Health Insurance Companies and Physicians D-383.982**

Our AMA will make passage of legislation in the US Congress to exempt physicians from antitrust actions in their negotiations with insurance companies a top legislative priority of the AMA, remain vigilant on this issue, continue to regularly provide updates on our AMA Web site and through other AMA communication tools, request sponsors nationally, and allocate appropriate funding and resources necessary to successfully advocate its passage into law.

Citation: Res. 202, I-11; Reaffirmed: Res. 206, A-19

**Insurance Company Economic Profiling of Physicians D-406.996**

Our AMA will: (1) take all appropriate steps to actively oppose all efforts by third party payers to rank, profile or otherwise "score" physicians purely for corporate cost containment purposes; and (2) widely publicize insurance industry economic profiling practices and how they impact patient care and access.

Citation: Res. 820, I-07; Reaffirmed: CMS Rep. 01, A-17

**Inappropriate Bundling of Medical Services by Third Party Payers D-70.986**

Our AMA will study the problems associated with inappropriate bundling of medical services, including the bundling of preoperative assessment in making the decision for surgery with the procedure, and present a report with potential solutions, including an analysis of legislative, judicial, and regulatory remedies.

Citation: (Res. 813, I-00; Rescinded: CMS Rep. 6, A-10)

**Appropriate Use of Component Codes in Current Procedural Terminology (CPT) D-70.987**

- (1) Our AMA will pursue methods of wide distribution for existing coding products and services developed by national specialty societies in cooperation with the AMA and the CPT Editorial Panel.
- (2) Our AMA will advocate that the Department of Health and Human Services (DHHS) designate CPT guidelines and instructions as contained in the CPT Book and approved by the

CPT Editorial Panel as the national implementation standards for CPT codes. (3) The CPT Editorial Panel consider developing CPT coding combinations that comply with CPT coding rules and guidelines and that could serve as a basis for payer software programs.

Citation: BOT Rep. 8, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20

**Transition to ICD-10 Code Sets D-70.954**

Our American Medical Association will develop systems to help physicians transition to the ICD-10 coding system.

Citation: Res. 810, I-09; Rescinded: CEJA Rep. 03, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 615  
(N-21)

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

Subject: Employed Physicians

Referred to: Reference Committee F

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1 Whereas, The percentage of practicing US physicians who are employed is now heading  
2 towards 75% and may go higher with early retirement of older “private practice” physicians; and  
3  
4 Whereas, The Southeastern Delegation to AMA (SED) supports both pluralistic health insurer or  
5 payor mix and pluralistic physician practice styles and settings; and  
6  
7 Whereas, Many physicians are losing influence in the health care system under some  
8 employment models; and  
9  
10 Whereas, Physicians’ employment by a hospital completely changes any past relationships to  
11 the hospital administration, whether the hospital has an active Organized Medical Staff or not;  
12 and  
13  
14 Whereas, Many physicians are naïve about contract negotiations and terms and can’t afford  
15 legal or accounting review; and  
16  
17 Whereas, Many employed physicians are naïve about contract renewals and supporting  
18 employer accounting systems and can’t afford their own forensic accountants; and  
19  
20 Whereas, The AMA is currently limited in the scope of its potential work with employed  
21 physicians and hospital or corporate medical staffs; and  
22  
23 Whereas, The SED believes that continued membership growth of AMA will depend on the AMA  
24 adapting to the needs of employed physicians; and  
25  
26 Whereas, The process of providing additional support for employed physicians may take several  
27 years; may involve input from the AMA Councils; may require input from internal AMA or  
28 contract legal counsel; may require input and study by the AMA Board and AMA CEO; and  
29  
30 Whereas, The SED believes our AMA should start “the process” for change now; therefore be it  
31  
32 RESOLVED, That our American Medical Association dedicate full-time staff to the Employed  
33 Physician to aggressively address relevant AMA Policy pertaining to the Employed Physician  
34 (Directive to Take Action); and be it further

1 RESOLVED, That our AMA study amending Policy G-615.105 to read as follows:

2  
3 Employed Physicians and the AMA G-615.105

4 1. Our AMA will become the lead association for physicians who maintain  
5 employment or contractual relationships with hospitals, health systems, and other  
6 entities.

7 2. As a benefit of membership our AMA will provide assistance, such as information,  
8 advice, and legal opinions, as appropriate, to employed physicians, physicians in  
9 independent practice, and independent physician contractors in matters pertaining to  
10 their relationships with hospitals, health systems, and other entities, including, but not  
11 limited to, breach of contracts, contract negotiations and contract renewals, medical  
12 staff bylaws, sham peer review, economic credentialing, and the denial of due  
13 process.

14 3. Our AMA will also work through the Organized Medical Staff Section and other  
15 sections and special groups as appropriate to represent and address the unique  
16 needs of physicians who maintain employment or contractual relationships with  
17 hospitals, health systems, and other entities. (Directive to Take Action); and be it  
18 further

19  
20 RESOLVED, That the representation of the Organized Medical Staff Section (OMSS) in the  
21 AMA House of Delegates be increased from the current one Delegate to many Delegates based  
22 on AMA membership numbers of employed physicians using the mathematical model(s), to  
23 calculate the numbers of the New OMSS Delegates, currently being used at AMA for the  
24 Medical Student and Resident and Fellows Sections to calculate the numbers of Regional  
25 Medical Students and the numbers of Regional Resident/Fellows in the AMA House of  
26 Delegates. The AMA would develop a practical meaning of the phrase "Employed Physician"  
27 for the purposes of AMA membership counting, but as an editorial comment, the SED suggests  
28 starting with employed Non-Resident/Non-Fellow physicians who have no ownership interest  
29 (or, say, less than 1% ownership each) in their employer organization (New HOD Policy); and  
30 be it further

31  
32 RESOLVED, That the Organized Medical Staff Section have one designated member who is a  
33 defined employed physician on all AMA Boards and Committees and Councils to match the  
34 MSS, the RFS and the YPS. (New HOD Policy)

Fiscal Note: Estimated cost to implement this resolution is \$720,000 annually.

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

Over 70% of physicians are now employed. This time of COVID has placed employed physicians at INCREASED vulnerability and disadvantage for practice and personal sustainability as employers and insurance companies have taken advantage of the difficult COVID health care system situation. THIS is our top Core Value, Physician and Physician practice sustainability. This will start a process that could take several years, BUT THIS IS THE TIME TO START with important NEW POLICY and a new AMA Office of the Employed Physicians. Obviously, AMA can make a positive impact and of course is really the only organization to undertake this important task.

## HISTORY

H – 225.947 Physician Employment Trends  
H - 225.950 Principles of Physician Employment  
G – 615.105 Employed Physicians  
D – 225.973 Employed Physicians Bill of Rights

### References

The early Clinic histories from relevant Wikipedia articles.

Representation of Physicians in Emerging Delivery Systems; AMA Council on Long Range Planning and Development Report, 1994.

Rosemary Strevens. Health Care in the Early 1960's. Health Care Financing Review. Winter issue, 1996. Vol 1, #2.

Travis Singleton and Phillip Miller. The Physician Employment Trend: What you need to know. Fam Pract Manage 2015: August (4) 11-15.

The Physician Employment Movement. Career Letter, NEJM, July 23, 2014

Laura Dyrda. 70% Physicians now Employed by Hospitals or Corporations. July 1, 2021. VMG Health at [info@vmghealth.com](mailto:info@vmghealth.com)

The AMA OMSS web page: [Organized Medical Staff | American Medical Association \(ama-assn.org\)](https://www.ama-assn.org/organized-medical-staff)

## EMPLOYMENT CONTRACTS

### AMA Policy

H - 225.964 Hospital Employed/Contracted Physicians Reimbursement  
H – 285.946 Fair Physician Contracts

### References

Scott Backer, Gretchen Townsend, Holly Carnell, Melesa Freerks and McGuire Woods. Physician Compensation. In the Beckers Hospital Review, August 19, 2013

Kim Stanger. Physician Contract Check List. Proprietary to the Holland and Hurt Law Firm, from Shaw Publications

## EMPLOYED PHYSICIAN SAFEGUARDS

### AMA Policy

D – 215. 990 AMA Assistance to Physician-Hospital/Healthcare System Relationships  
H – 383.999 Physician Negotiations  
H – 385.976 Physician Collective Bargaining  
D – 225.977 Physician Independence  
H – 235.999 All Physicians Employed by Hospitals Required to be on Staff

### References

Brendan Murphy, AMA staff writer - So, you are an employed physician: what you need to know. June 2017.

<https://es4p.com> - Essentials for Physicians – Business Podcasts and Seminars

Travis Singleton and Phillip Miller. Physician Employment. August 2015 from the FPM Journal by the AAFP

Winn Halverhout, Husch Blackwell, Barbara Yosses. Compliance in Physician Employment. Proprietary to the Husch Blackwell Law Firm, published by the Health Care Compliance Association, 2010.

from the American College of Surgeons

[https://www.facs.org/-/media/files/advocacy/regulatory/2018\\_employed\\_surgeons\\_primer.ashx](https://www.facs.org/-/media/files/advocacy/regulatory/2018_employed_surgeons_primer.ashx)

## RELEVANT AMA POLICY

### 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.

Citation: Res. 601, I-11; Reaffirmed: Joint CCB/CLRPD Rep. 1, A-21

### Physician Employment Trends and Principles H-225.947

1. Our AMA encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with the following principles: A. Physician clinical autonomy is preserved. B. Physicians are included and actively involved in integrated leadership opportunities. C. Physicians are encouraged and guaranteed the ability to organize

under a formal self-governance and management structure. D. Physicians are encouraged and expected to work with others to deliver effective, efficient and appropriate care. E. A mechanism is provided for the open and transparent sharing of clinical and business information by all parties to improve care. F A clinical information system infrastructure exists that allows capture and reporting of key clinical quality and efficiency performance data for all participants and accountability across the system to those measures.

2. Our AMA encourages continued research on the effects of integrated health care delivery models (that employ physicians) on patients and the medical profession.

Citation: CMS Rep. 5, I-15; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19

## **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.*

Citation: BOT Rep. 6, I-12; Reaffirmed: CMS Rep. 6, I-13; Modified in lieu of Res. 2, I-13; Modified: Res. 737, A-14; Reaffirmed: BOT Rep. 21, A-16; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19; Reaffirmed: CMS Rep. 11, A-19; Modified: BOT Rep. 13, A-19

#### **Hospital Employed/Contracted Physicians Reimbursement H-225.964**

AMA policy states that: (1) all hospital employed/contracted physicians be prospectively involved if the hospital negotiates for them for capitation and global billing contracts; (2) hospital employed/contracted physicians be informed about the actual payment amount allocated to the physician component of the total hospital payment received by the contractual arrangement; and (3) all potential hospital/contracted physicians request a bona fide hospital plan which delineates the actual payment amount allocated to the employed or contracted physicians. Citation: (Sub. Res. 723, I-96; Reaffirmed: Res. 812, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: BOT Rep. 4, I-12)

#### **All Physicians Employed by Hospitals Required to be on Staff H-235.999**

The AMA believes that physicians having contractual or financial arrangements with hospitals should be members of the organized medical staff and responsible to it, should be subject to the bylaws of the medical staff, and should conduct their professional activities according to the standards, rules and regulations adopted by it.

Citation: BOT Rep. R, Rec. 3, A-77; Reaffirmed: I-81; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18

#### **Fair Physician Contracts H-285.946**

Our AMA will develop national (state) standards and model legislation for fair managed care/physician contracts, thereby requiring full disclosure in plain English of important information, including but not limited to:

- (1) disclosure of reimbursement amounts, conversion factors for the RBRVS system or other formulas if applicable, global follow-up times, multiple procedure reimbursement policies, and all other payment policies;
- (2) which proprietary "correct coding" CPT bundling program is employed;
- (3) grievance and appeal mechanisms;
- (4) conditions under which a contract can be terminated by a physician or health plan;
- (5) patient confidentiality protections;

- (6) policies on patient referrals and physician use of consultants;
  - (7) a current listing by name and specialty of the physicians participating in the plan; and
  - (8) a current listing by name of the ancillary service providers participating in the plan.
- Citation: Res. 727, A-97; Amended by CMS Rep. 3, A-98; Reaffirmed: Res. 814, A-00; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-08; Reaffirmed: CMS Rep. 01, A-18

### **Physician Negotiation H-383.999**

1. All activities of our American Medical Association regarding negotiation by physicians maintain the highest level of professionalism, consistent with the Principles of Medical Ethics and the Current Opinions of Council on Ethical and Judicial Affairs.
2. Our AMA continue to support the development of independent house staff organizations for employed, resident and fellow physicians and support the development and operation of local negotiating units as an option for all employed, resident and fellow physicians authorized to organize labor organizations under the National Labor Relations Act.
3. Our AMA continues to advance its private sector advocacy programs and explore, develop, advocate, and implement other innovative strategies, including but not limited to initiating litigation, to stop egregious health plan practices and to help physicians level the playing field with health care payers.

Citation: Sub. Res. 901, A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmation A-06; Reaffirmation A-08; Modified: BOT Rep. 09, A-18

### **Physician Collective Bargaining H-385.976**

- Our AMA's present view on the issue of physician collective negotiation is as follows: (1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians.
- (2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature.
  - (3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively.
  - (4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients.
  - (5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care.

Citation: BOT Rep. P, I-88; Modified: Sunset Report, I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-03; Reaffirmation A-04; Reaffirmed in lieu of Res. 105, A-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: BOT Rep. 17, A-09; Reaffirmation I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: Res. 215, A-11; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12; Reaffirmed: Res. 206, A-19

### **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.

Citation: Res. 826, I-11; Reaffirmed: BOT Action in response to referred for decision Res. 816, I-16

**Employed Physician Bill of Rights and Basic Practice Professional Standards D-225.973**

Our AMA will advocate that employed physicians should be provided sufficient administrative and clinical support to ensure that they can appropriately care for their patients.

Citation: BOT Rep. 13, A-19

**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.

Citation: (Res. 801, I-11; Modified: BOT Rep. 6, I-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 616  
(N-21)

Introduced by: Michigan

Subject: Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology® System

Referred to: Reference Committee F

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1 Whereas, The COVID-19 pandemic and restrictions brought unprecedented financial strain  
2 upon physicians, with the most recent Physician Foundation survey showing 12 percent of  
3 physicians either closing or planning to close their practice within the next year (75 percent of  
4 those physicians are in private practice), and nearly 75 percent of physicians reported lost  
5 income; and

6  
7 Whereas, During this time, physicians also had to implement the new Current Procedural  
8 Terminology® (CPT®) Evaluation and Management (E/M) code revisions, which became  
9 effective January 1, 2021; and

10  
11 Whereas, This was the first major change to the codes and guidelines for office and other  
12 outpatient evaluation and management (E/M) services in 24 years; and

13  
14 Whereas, Although the Centers for Medicare and Medicaid Services (CMS) signaled its intent to  
15 update E/M coding and documentation guidelines when it requested stakeholder feedback in  
16 the proposed 2017 Medicare Physician Fee Schedule rules and continued to propose updates  
17 in future rules, some stakeholders were hopeful for a delay as physicians were still reeling from  
18 the pandemic; and

19  
20 Whereas, Given that each patient encounter and experience is unique, medical coding system  
21 to accurately reflect the care given within hundreds of specialties and thousands of patient visits  
22 may be difficult or have a disparate impact on physicians in different specialties; and

23  
24 Whereas, The AMA reported that when the revisions became effective, the AMA received  
25 feedback on areas causing confusion, in response to which the CPT Editorial Panel issued  
26 technical corrections to add clarity and answer questions concerning the E/M code revisions;  
27 and

28  
29 Whereas, The intent of these E/M coding changes - to modernize billing and documentation,  
30 reduce administrative burdens on physicians, and recognize time spent evaluating and managing  
31 patients' care - is commendable; however, actual experiences and consequences should be  
32 studied and modified as necessary to further simplify E/M documentation and ease  
33 administrative burdens and to fairly and accurately reflect the evaluation and management  
34 services provided by private and employed physicians, reflective of the complexity of care within  
35 all specialties, and respectful of uncompensated care by our specialist colleagues; therefore be it

1 RESOLVED, That our American Medical Association survey physicians about and study the  
2 impact of the 2021 CPT® Evaluation and Management coding reform on physicians, among all  
3 specialties, in private and employed practices and report the findings and any recommendations  
4 at the June 2022 meeting of the House of Delegates. (Directive to Take Action)

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

Received: 10/13/21

#### AUTHOR'S STATEMENT OF PRIORITY

The 2021 American Medical Association (AMA) Current Procedural Terminology® (CPT®) Evaluation and Management code set went live on January 1, 2021. It is currently affecting physician reimbursement. Failure to address any potential harm in a timely manner will result in more practice closures and worsen patient access to physicians. This resolution asks the AMA to study an issue that is very pertinent to practicing physicians right now.

Source:

1. <http://physiciansfoundation.org/wp-content/uploads/2020/08/20-1278-Merritt-Hawkins-2020-Physicians-Foundation-Survey.6.pdf>

#### RELEVANT AMA POLICY

##### **AMA CPT Editorial Panel and Process H-70.973**

The AMA will continue (1) to work to improve the CPT process by encouraging specialty societies to participate fully in the CPT process; (2) to enhance communications with specialty societies concerning the CPT process and subsequent appeals process; and (3) to assist specialty societies, as requested, in the education of their members concerning CPT coding issues.

Citation: Sub. Res. 806, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmation: I-17

##### **Preservation of Evaluation/Management CPT Codes H-70.985**

It is the policy of the AMA to (1) oppose the bundling of procedure and laboratory services within the current CPT Evaluation/Management (E/M) services;

(2) oppose the compression of E/M codes and support efforts to better define and delineate such services and their codes;

(3) seek feedback from its members on insurance practices that advocate bundling of procedures and laboratory services with or the compression of codes in the CPT E/M codes, and express its views to such companies on behalf of its members;

(4) continue to work with the PPRC and all other appropriate organizations to insure that any modifications of CPT E/M codes are appropriate, clinically meaningful, and reflective of the considered views of organized medicine; and

(5) work to ensure that physicians have the continued opportunity to use CPT as a coding system that is maintained by the medical profession.

Citation: Sub. Res. 98, A-90; Reaffirmed by Res. 850, A-98; Reaffirmed: Res. 814, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20

##### **Use of CPT Editorial Panel Process H-70.919**

Our AMA reinforces that the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance issues and all interested stakeholders should avail themselves of the well-established and documented CPT Editorial Panel process for the development of new and revised CPT codes, descriptors, guidelines, parenthetical statements and modifiers.

Citation: BOT Rep. 4, A-06; Reaffirmation A-07; Reaffirmation I-08; Reaffirmation A-09; Reaffirmation A-10; Reaffirmation A-11; Reaffirmation I-14; Reaffirmed: CMS Rep. 4, I-15; Reaffirmation A-16; Reaffirmed in lieu of: Res. 117, A-16; Reaffirmed in lieu of: Res. 121, A-17; Reaffirmation: A-18; Reaffirmation: I-18; Reaffirmed: Res. 816, I-19

**CPT Coding System H-70.974**

1. The AMA supports the use of CPT by all third party payers and urges them to implement yearly changes to CPT on a timely basis.
2. Our AMA will work to ensure recognition of and payment for all CPT codes approved by the Centers for Medicare & Medicaid Services (CMS) retroactive to the date of their CMS approval, when the service is covered by a patient's insurance.

Citation: Sub. Res. 809, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Appended: Res. 803, I-11; Reaffirmed: CMS Rep. 1, A-21

**Physicians' Current Procedural Terminology H-70.972**

The AMA (1) continues to seek ways to increase its efforts to communicate with specialty societies and state medical associations concerning the actions and deliberations of the CPT Maintenance process; (2) urges the national medical specialty societies to ensure that their representatives to the CPT process are fully informed as to their association's policies and coding preferences; and (3) urges those specialty societies that have not nominated individuals to serve on the CPT Advisory Committee to do so.

Citation: BOT Rep. MM, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 617  
(N-21)

Introduced by: Louisiana

Subject: Together We are Stronger Marketing Campaign

Referred to: Reference Committee F

- 
- 1 Whereas, The AMA unveiled a new brand marketing campaign in 2005 that included the tagline  
2 “Together We are Stronger”; and  
3  
4 Whereas, The “Together We are Stronger” campaign was abandoned at sometime during 2018  
5 for a new campaign “Members Move Medicine”; and  
6  
7 Whereas, Since the “Together We are Stronger” campaign was replaced, our AMA has become  
8 fractured and often exclusive of some members; and  
9  
10 Whereas, Our AMA’s recent Organizational Strategic Plan to Embed Racial Justice and  
11 Advance Health Equity highlights has further weakened our AMA’s reputation among many  
12 members; therefore be it  
13  
14 RESOLVED, That our American Medical Association consider readoption of the “Together We  
15 are Stronger” tagline as the main marketing slogan and campaign for the organization.  
16 (Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

On June 1, 2021, Russ Kridel, MD, Chair, AMA Board of Trustees, issued a message to the members of the American Medical Association House of Delegates regarding certain recent events pertaining to the *AMA’s Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity, 2021–2023*. As noted by Dr. Kridel, “Our House has always dealt with challenging topics with the same professionalism that we try to exhibit daily as practicing physicians”. However, many at recent meetings of the AMA House, particularly those held virtually, we have witnessed a loss of professionalism during comments regarding the Strategic Plan. Some members of our House are being personally attacked and threatened by others for their thoughts and ideas. Name calling, unsettling calls to family members, and other unprofessional communications have occurred. As the strategic plan will once again be discussed at the November 2021 meeting, the debate and hopefully the adoption of these policies and principles are paramount in order to have a professional and courteous conversation regarding the production and contents of the equity report. We believe the Speakers saw this firsthand during the June meeting.