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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

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.

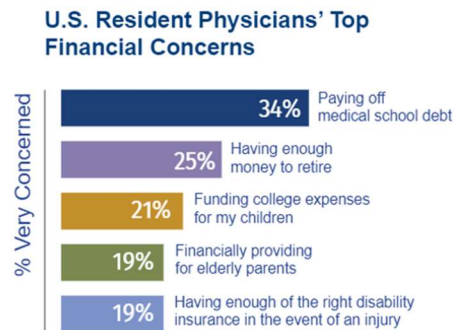
25
26 Medicare is the single largest funding source for graduate medical education (GME)¹ with the
27 federal government matching a portion of what state Medicaid programs pay teaching
28 institutions.^{2,3} Funding is limited, and Congress repeatedly considers cuts to GME. As a result,
29 training institutions 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.”⁴



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 *Education and advising*

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

22 *Existing AMA resources*

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

27 Physicians Financial Partners program ([https://www.amainsure.com/physicians-financial-](https://www.amainsure.com/physicians-financial-partners/about-us.html)
28 [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
29 find experienced and fully vetted financial professionals. Finally, the AMA offers member benefits
30 to help medical students and physicians organize personal finances and manage debt, most notably
31 through a partnership with Laurel Road offering discounted rates and other benefits on student loan
32 refinancing, mortgages, and personal loans ([https://www.ama-assn.org/member-benefits/personal-](https://www.ama-assn.org/member-benefits/personal-member-benefits-discounts/loans-financial-services)
33 [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

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

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

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

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

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

RESIDENT/FELLOW PHYSICIANS’ BILL OF RIGHTS

Residents and fellows have a right to:

[...]

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

[...]

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

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

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

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

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

DISCUSSION

Eliminating stigmatization

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

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

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

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

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

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

Enhancing inclusion

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

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

Securing legal protections

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Criterion 6: Accessibility - Provides opportunity for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the 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

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

12 APPLICATION OF CRITERIA TO THE INTEGRATED PHYSICIAN PRACTICE SECTION 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.

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

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

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

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

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

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

The IPPS has worked to develop policy in the HOD including advancing resolutions and offering input on council and board reports while they are still in development. At the November 2020 Special Meeting, the HOD adopted recommendations in BOT Report 6, "Covenants Not to Compete," which relates to restrictive covenants that the IPPS has particular interest in. The IPPS 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.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

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

RECOMMENDATION

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Integrated Physician Practice Section through 2026 with the next review no later than the 2026 Interim Meeting and that the remainder of this 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

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^{1,2}; 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 factors³; 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 hazards⁴; 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^{5,6}; 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 disparities⁷⁻¹¹; 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 neighborhoods¹²⁻¹⁶; 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 exposures¹⁷; 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 populations¹⁸; and

Whereas, Proximity to and exposure to hazards from the oil and gas, plastics, animal production, chemical manufacturing, endocrine-disrupting chemicals, and metal industries have been strongly linked to at least one of the following: neural tube defects, preterm birth, low-birth weight, diffuse interstitial lung fibrosis, chronic bronchitis, asthma exacerbation, diabetes, hypertension secondary to chronic inflammation, pneumonia, reduced child cognition from heavy metal exposure, neurologic diseases, cancers, hyperlipidemia, and thyroid disease¹⁹⁻²⁸; and

Whereas, Closures of industrial sites and reductions in pollution have been linked to improved fertility and reduced preterm births and respiratory hospitalizations²⁹⁻³¹; and

Whereas, Recent natural disasters such as hurricanes, the over 1,500 oil spills from the Dakota Access Pipeline and the Keystone Pipeline in the last decade alone, the Texas freeze, and states' responses to these natural disasters perpetuate environmental injustice by disproportionately affecting predominantly minoritized and low-income communities³²⁻³⁷; and

Whereas, The health of American Indian tribes depends on essential natural resources that have either been depleted and/or contaminated by mining and oil corporations, leading to adverse health outcomes³⁸⁻⁴¹; and

Whereas, Government agencies have failed to act on current policy and integrate current environmental science research or expertise into ongoing environmental regulations and public health initiatives, resulting in continued and amplified environmental hazards and failing to protect people, especially in Black and American Indian communities, from known and predictable environmental health dangers⁴²⁻⁴⁹; and

Whereas, Climate change represents an important tenet of environmental health that can significantly impact public and community health⁵⁰; and

Whereas, The United States healthcare system alone is responsible for 10% of national greenhouse gas emissions and, if it were its own country, it would be the 13th largest producer of greenhouse gas emissions in the world^{50,51}; and

Whereas, Extreme weather and climate events have significantly increased healthcare spending in the United States, with \$14 billion in additional spending through 760,000 additional patient encounters and 1,689 premature deaths between 2000 and 2009⁵²⁻⁵³; and

Whereas, The Intergovernmental Panel on Climate Change (IPCC) has determined it is possible to avoid warming past 1.5°C above pre-industrial levels by 2100 if extreme measures are taken to curtail anthropogenic emissions⁵⁴; and

Whereas, If global warming exceeds 1.5°C, the estimated global effects include 92,207 additional heat-related deaths per year by 2030, 350 million more humans exposed to severe heat by 2050, and 31 to 69 million humans exposed to flooding from sea level rise by 2100⁵⁴; and

Whereas, Compared to no action, limiting global warming to less than 1.5°C would result in ~50% lower annual health-related costs and prevention of ~50% of infectious disease cases in the United States by 2100^{52,53}; 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”⁵⁴; 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 period⁵²; 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 practices⁵⁵⁻⁵⁷; 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 Permanente⁵⁸⁻⁶¹; 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^{62,63}; 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.

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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 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 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

Whereas, 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 viewpoints¹; and

Whereas, Robust, “actualized” democracies, defined as “the ideal in which all citizens share full, informed, equal participation in decision making”, have been touted as superior forms of government with the best potential for freedom of expression and action, protection of human rights, and transparent and responsive governance²⁻⁶; and

Whereas, A 2019 study published in *The Lancet* found that “when enforced by free and fair elections, democracies are more likely than autocracies to lead to health gains for causes of mortality (eg, cardiovascular diseases and transport injuries) that have not been heavily targeted by foreign aid and require health-care delivery”⁷; and

Whereas, The United Nations recognizes the value of democracy and “promotes democratic governance as a set of values and principles that should be followed for greater participation, equality, security and human development”⁸; and

Whereas, 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”⁹; and

Whereas, At the Annual 2003 House of Delegates, Council on Constitution and Bylaws Report 2 was adopted, which codified the establishment of the Resolution Committee in the AMA Bylaws “to formally reflect the defined scope of the Interim Meeting”, as currently reflected in B-2.13.3¹⁰; and

Whereas, The number of resolutions not considered based on Resolutions Committee recommendations for the past eight Interim Meetings has never exceeded ten- 2 at the Interim 2019 House of Delegates, 8 at the Interim 2018 House of Delegates, 4 at the Interim 2017 House of Delegates, 3 at the Interim 2016 House of Delegates, 9 at the Interim 2015 House of Delegates, 8 at the Interim 2014 House of Delegates, 10 at the Interim 2013 House of Delegates, and 9 at the Interim 2012 House of Delegates¹¹, indicating that it has not been 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”¹²; 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”¹³⁻¹⁴; 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”¹³⁻¹⁴; 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 adopted¹⁴⁻¹⁵; 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 Committee¹⁴⁻¹⁵; 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.

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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

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

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

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

1 Whereas, Our AMA recognizes the urgent, ongoing health threats posed to our patients by
2 global climate change,^{1,5} 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”¹; 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”²; 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 fuel³; 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;⁴ 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 industry⁴; 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 21st 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
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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

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”¹ earning it the title of the “greatest public health
5 challenge of the 21st century”²; 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 levels³ higher than
9 ever before since the evolution of homo sapiens⁴; 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 alone⁵, 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 (CO₂) emissions continue to rise
17 steadily⁶, 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 level⁷; 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 workers⁸, communities disproportionately burdened by poor environmental quality⁹, and some
27 communities in the rural Southeastern United States¹⁰; 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 processes¹¹; 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 2050¹²; 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-benefits¹³; 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 areas¹⁴; 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 deaths¹⁵; and
9

10 Whereas, Worldwide, tobacco use causes more than seven million deaths per year¹⁶; and
11

12 Whereas, Our AMA has extensive policy to organize physician leadership vis a vis tobacco’s
13 public health harms¹⁷; 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 campaigns¹⁸; 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”¹⁹; 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”²⁰; 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.

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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

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*"¹ 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"^{2,3} earning it the title of the "greatest public
12 health challenge of the 21st century";⁴ 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*⁵, 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 deaths⁶; 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 level⁷; and
26

27 Whereas, Across all climate risks, children, older adults, low-income communities, outdoor
28 workers⁸ some communities of color, communities disproportionately burdened by poor
29 environmental quality^{9, 10} and those experiencing discrimination are disproportionately affected
30 by extreme weather and climate events, partially because they are often excluded in planning
31 processes¹¹; and
32

33 Whereas, Many climate change mitigation interventions have immediate local air
34 quality benefits-- among others-- and thus immediate health co-benefits¹² which is part
35 of why near-term benefits outweigh climate solution costs in many areas¹³; 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 latest¹⁴, UN Secretary General António

1 Guterres on the August 2021 IPCC report¹⁵ 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 messengers¹⁶, 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.

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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

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

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

Whereas, The rate of employed physicians climbed steadily from January 2019 to January 2020 from 62.5% to 64.5% and that number continues to rise; and

Whereas, Up to 70% of physicians are employed by hospitals or corporations; and

Whereas, 48,000 physicians left independent practice for employment by hospitals, health systems or corporate entities; and

Whereas, Hospital medical staffs struggle with challenges associated with employed physicians, and have yet to resolve numerous challenges and conflicts that arise between the demands of hospital administrators and physician patient-care responsibilities; and

Whereas, There are numerous conflicts of interest for employed medical staff leaders; and

Whereas, Many employed physicians have low trust and confidence as well as sense a lack of accountability that hospital administrator's goal is to provide excellence in patient care; and

Whereas, Employed physicians are in a disadvantaged position when negotiating and re-negotiating contracts; and

Whereas, Less than 150,000 practicing physicians are members of the American Medical Association while employed physicians currently do not appreciate any tangible benefit from joining the American Medical Association; and

Whereas, Offering a section, specifically dedicated to the challenges faced by employed physicians would attract new members; therefore be it

RESOLVED, That our American Medical Association study the necessity and feasibility to create a Section for Employed Physicians (Directive to Take Action); and be it further

RESOLVED, That the section would work toward determining problems associated with employment; recommend solutions; and utilize necessary resources when resolving conflicts 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.