

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its November 2021 Special Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (N-21)

Report of Reference Committee on Amendments to Constitution and Bylaws

Heidi Dunniway, MD, Chair

1 Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

- 5 1. Board of Trustees Report 5 – Terms and Languages in Policies Adopted to
6 Protect Populations from Discrimination and Harassment
- 7 2. Board of Trustees Report 11 – National Guidelines for Guardianship
- 8 3. Board of Trustees Report 13 – Study of Forced Organ Harvesting by China
- 9 4. Board of Trustees Report 15 – Opposing Attorney Presence at and/or Recording
10 of Independent Medical Examinations
- 11 5. Board of Trustees Report 16 – Research Handling of De-Identified Patient
12 Information
- 13 6. Board of Trustees Report 20 – Specialty Society Representation in the House of
14 Delegates Five-Year Review
- 15 7. Council on Constitution and Bylaws Report 1 – Further Action on Bylaw 7.5.2
- 16 8. Council on Constitution and Bylaws Report 2 – Recission of Bylaws Related to
17 Run-off Elections
- 18 9. Council on Constitution and Bylaws Report 3 – AMA Women Physicians Section:
19 Clarification of Bylaw Language
- 20 10. Council on Ethical and Judicial Affairs Report 1 – Short-term Medical Service
21 Trips
- 22 11. Council on Ethical and Judicial Affairs Report 2 – Amendments to Opinions
23 1.2.11, “Ethical Innovation in Medical Practice”; 11.1.2, “Physician Stewardship of
24 Health Care Resources”; 11.2.1, “Professionalism in Health Care Systems”; and
25 1.1.6, “Quality”
- 26 12. Speakers Report 2 – Establishing an Election Committee
- 27 13. Resolution 009 – Banning the Practice of Virginity Testing

RECOMMENDED FOR ADOPTION AS AMENDED

- 31 14. Speakers Report 1 – Report of the Election Task Force
- 32 15. Resolution 018 – Support for Safe and Equitable Access to Voting
- 33 16. Resolution 019 - Disaggregation of Demographic Data for Individuals of Middle
34 Eastern and North African (MENA) Descent

- 1 17. Resolution 020 – Recognizing and Remedyng "Structural Urbanism" Bias as a
- 2 Factor in Rural Health Disparities
- 3 18. Resolution 023 - AMA Council on Ethical and Judicial Affairs (CEJA) report on
- 4 Physician Responsibilities to Impaired Colleagues: CEJA E-9.3.2

5

6 **RECOMMENDED FOR REFERRAL**

- 7
- 8 19. Resolution 008 - Amendment to Truth and Transparency in Pregnancy
- 9 Counseling Centers, H-420.954

10

11 **RECOMMENDED FOR NOT ADOPTION**

- 12
- 13 20. Resolution 002 - Disaggregation of Race Data for Individuals of Middle Eastern
- 14 and North African (MENA) Descent
- 15 21. Resolution 021 - Free Speech and Civil Discourse in the American Medical
- 16 Association
- 17 22. Resolution 022 - Prohibition of Racist Characterization Based on Personal
- 18 Attributes

Amendments

If you wish to propose an amendment to an item of business, click here: [Submit New Amendment](#)

19

1 RECOMMENDED FOR ADOPTION 2

3 (1) BOARD OF TRUSTEES REPORT 5 – TERMS AND
4 LANGUAGE IN POLICIES ADOPTED TO PROTECT
5 POPULATIONS FROM DISCRIMINATION AND
6 HARASSMENT

7
8 **RECOMMENDATION:**
9

10 **Recommendations in Board of Trustees Report 5 be
11 adopted and the remainder of the Report be filed.**

12 **HOD ACTION: Recommendations in Board of Trustees
13 Report 5 adopted and the remainder of the Report filed.**

14 The Board of Trustees recommends that Policy G-600.067, "Terms and Language in
15 Policies Adopted to Protect Populations from Discrimination and Harassment," be
16 rescinded, the following be adopted, and the remainder of this report be filed:

17 1. That our AMA recommend preferred terminology for protected personal characteristics
18 to be used in AMA policies and position statements. (Directive to Take Action)

19 Testimony was heard in general support of Board of Trustees Report 5. Testimony noted
20 that the report aims to recommend consistency by optimizing language to protect
21 vulnerable populations. Speakers noted that it is essential that the House of Medicine
22 have a common definition of terms to prevent misunderstandings and facilitate
23 collaboration to move medicine forward. One amendment suggested that the report be
24 amended to replace "his/her" to "an individual's" in policy H-140.837, however, this
25 amendment was offered on existing policy cited in the body of the report and not within
26 the recommendations themselves. Your Reference Committee recommends that the
27 recommendations in Board of Trustees Report 5 be adopted and the remainder of the
28 report be filed.

29 Policy G-600.067, "Terms and Language in Policies Adopted to Protect
30 Populations from Discrimination and Harassment"

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

1 (2) BOARD OF TRUSTEES REPORT 11 – NATIONAL
2 GUIDELINES FOR GUARDIANSHIP

3
4 **RECOMMENDATION:**

5
6 **Recommendations in Board of Trustees Report 11 be
7 adopted and the remainder of the Report be filed.**

8
9 **HOD ACTION: Recommendations in Board of Trustees
10 Report 11 adopted and the remainder of the Report filed.**

11
12 The Board of Trustees recommends that the following be adopted in lieu of Resolution
13 17-A-19, and the remainder of this report be filed:

- 14
15 1. That Opinion 8.10, "Preventing, Identifying and Treating Violence and Abuse;" H-
16 515.961, "Elder Mistreatment;" and H-515-984, "Health Care Costs of Violence and
17 Abuse Across the Lifespan," be reaffirmed. (Reaffirm HOD Policy)
18
19 2. That our AMA support initiatives by the American Bar Association Commission on
20 Law and Aging and other associations and agencies of the federal government to
21 address elder abuse and to ensure consistent protection of elders' rights in all states.
22 (Directive to Take Action)

23
24 The report was introduced by the Board of Trustees, and no further testimony was heard.
25 Your Reference Committee recommends that the recommendations in Board of Trustees
26 Report 11 be adopted and the remainder of the report be filed.

27
28 Ethical Opinion E-8.10, "Preventing, Identifying and Treating Violence and Abuse"

29
30 All patients may be at risk for interpersonal violence and abuse, which may
31 adversely affect their health or ability to adhere to medical recommendations. In
32 light of their obligation to promote the well-being of patients, physicians have an
33 ethical obligation to take appropriate action to avert the harms caused by violence
34 and abuse.

35
36 To protect patients' well-being, physicians individually should:

- 37
38 (a) Become familiar with:
39 i. how to detect violence or abuse, including cultural variations in
40 response to abuse;
41 ii. community and health resources available to abused or vulnerable
42 persons;
43 iii. public health measures that are effective in preventing violence
44 and abuse;
45 iv. legal requirements for reporting violence or abuse.
46 (b) Consider abuse as a possible factor in the presentation of medical
47 complaints.
48 (c) Routinely inquire about physical, sexual, and psychological abuse as part
49 of the medical history.

- (d) Not allow diagnosis or treatment to be influenced by misconceptions about abuse, including beliefs that abuse is rare, does not occur in “normal” families, is a private matter best resolved without outside interference, or is caused by victims’ own actions.
 - (e) Treat the immediate symptoms and sequelae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise from being exposed to violence and abuse.
 - (f) Discuss any suspicion of abuse sensitively with the patient, whether or not reporting is legally mandated, and direct the patient to appropriate community resources.
 - (g) Report suspected violence and abuse in keeping with applicable requirements. Before doing so, physicians should:
 - i. inform patients about requirements to report;
 - ii. obtain the patient’s informed consent when reporting is not required by law. Exceptions can be made if a physician reasonably believes that a patient’s refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision.
 - (h) Protect patient privacy when reporting by disclosing only the minimum necessary information.

Collectively, physicians should:

- (i) Advocate for comprehensive training in matters pertaining to violence and abuse across the continuum of professional education.
 - (j) Provide leadership in raising awareness about the need to assess and identify signs of abuse, including advocating for guidelines and policies to reduce the volume of unidentified cases and help ensure that all patients are appropriately assessed.
 - (k) Advocate for mechanisms to direct physicians to community or private resources that might be available to aid their patients.
 - (l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse.
 - (m) Advocate for change in mandatory reporting laws if evidence indicates that such reporting is not in the best interests of patients.

Policy H-515.961, "Elder Mistreatment"

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

1 Policy D-515.984, "Health Care Costs of Violence and Abuse Across the Lifespan"
2

3 1. Our AMA urges the National Academies of Sciences, Engineering, and
4 Medicine to continue to study the impact and health care costs of violence and
5 abuse across the lifespan.

6 2. Our AMA encourages the National Institutes of Health, the Agency for
7 Healthcare Research and Quality, and the Centers for Disease Control and
8 Prevention to conduct research on the cost savings resulting from health
9 interventions on violence and abuse.

10 3. Our AMA encourages the appropriate federal agencies to increase funding for
11 research on the impact and health care costs of elder mistreatment.

12 (3) BOARD OF TRUSTEES REPORT 13 – STUDY OF
13 FORCED ORGAN HARVESTING BY CHINA

14 **RECOMMENDATION:**

15 **Recommendations in Board of Trustees Report 13 be
16 adopted and the remainder of the Report be filed.**

17 **HOD ACTION: Recommendations in Board of Trustees
18 Report 13 adopted and the remainder of the Report filed.**

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

21 1. That our American Medical Association continue to engage the Chinese Medical
22 Association and the transplant community in the People's Republic of China (PRC)
23 through promotion and support of relevant activities and policies of the World Medical
24 Association that relate to organ transplantation. (Directive to Take Action)

25 2. That our AMA, through its membership in the World Medical Association, continue to
26 call for the PRC's compliance with internationally recognized organ transplantation
27 standards, such as those of the World Health Organization, and for the PRC to make
28 available externally verifiable data on organ transplantation. (Directive to Take Action)

29 3. That our AMA condemn the retrieval of organs for transplantation without the informed
30 consent of the donor. (New HOD Policy)

31 4. That Policy D-370.981, "Study of Forced Organ Harvesting by China," be rescinded,
32 having been accomplished by this report. (Rescind HOD Policy)

33 Testimony was heard in unanimous support of Board of Trustees Report 13. Your
34 Reference Committee recommends that the recommendations in Board of Trustees
35 Report 13 be adopted and the remainder of the report be filed.

1 Policy D-370.981, "Study of Forced Organ Harvesting by China"
2

3 Our AMA will gather and study all information available and possible on the issue
4 of forced organ harvesting by China and issue a report to our House of Delegates
5 at the 2020 Annual Meeting.

6
7 (4) BOARD OF TRUSTEES REPORT 15 – OPPOSING
8 ATTORNEY PRESENCE AT AND/OR RECORDING OF
9 INDEPENDENT MEDICAL EXAMINATIONS
10

11 **RECOMMENDATION:**

12
13 **Recommendations in Board of Trustees Report 15 be**
14 **adopted and the remainder of the report be filed.**

15
16 **HOD ACTION: Recommendations in Board of Trustees**
17 **Report 15 adopted and the remainder of the report filed.**

18
19 The Board of Trustees recommends that the following recommendation be adopted in lieu
20 of Resolution 1-A-19 and that the remainder of the report be filed:

21
22 That, upon request of state medical associations and national medical specialty societies,
23 our AMA will provide assistance and consultation in opposing the ability of courts to
24 compel recording and videotaping of, or allow a court reporter or an attorney to be present
25 during the independent medical examination, as a condition precedent to allowing the
26 physician's medical opinion in court. (Directive to Take Action)

27
28 Testimony was heard in general support of this report. Supporting testimony noted that
29 the presence of recording devices or third parties may inhibit physicians' ability to receive
30 the information they need from patients. Additional supporting testimony noted that given
31 the variation in state laws regarding independent medical examinations and workers'
32 compensation, a blanket policy opposing this in all instances is not practical, and it thus
33 makes sense for the AMA to provide assistance and consultation on this matter at the
34 request of state medical associations and national specialty societies. Opposing testimony
35 noted that independent medical examinations are not truly independent, and recording
36 should be encouraged for the protection of those making claims of injury or disability. Your
37 Reference Committee believes that the recommendations given in this report are
38 supported by the preponderance of testimony, and therefore recommends that the
39 recommendations in Board of Trustees Report 15 be adopted and the remainder of the
40 report be filed.

41
42 (5) BOARD OF TRUSTEES REPORT 16 – RESEARCH
43 HANDLING OF DE-IDENTIFIED PATIENT INFORMATION
44

45 **RECOMMENDATION:**

46
47 **Recommendations in Board of Trustees Report 16 be**
48 **adopted and the remainder of the report be filed.**

1 **HOD ACTION: Recommendations in Board of Trustees**
2 **Report 16 adopted and the remainder of the report filed.**

3
4 The Board of Trustees recommends that the following be adopted and the remainder of
5 this report be filed:

- 6
7 1. That our American Medical Association (AMA) reaffirm Policies H-315.975, "Police,
8 Payer, and Government Access to Patient Health Information," H-315.978, "Privacy and
9 Confidentiality," and H-315.987, "Limiting Access to Medical Records." (Reaffirm HOD
10 Policy)
- 11
12 2. That our AMA adopt a technical change to Policy H-315.974, "Guiding Principles,
13 Collection and Warehousing of Electronic Medical Record Information," by addition as
14 follows: (Modify Current HOD Policy)

15
16 Policy H-315.974, "Guiding Principles, Collection and Warehousing of Electronic Medical
17 Record Information"

18
19 Our AMA expressly advocates for physician ownership of all claims data, transactional
20 data and de-identified and/or aggregate data created, established and maintained by a
21 physician practice, regardless of how and where such data is stored but specifically
22 including any such data derived from a physician's medical records, electronic health
23 records, or practice management system, while preserving the principle that physicians
24 act as trusted stewards of Protected Health Information.

- 25
26 3. That our AMA support efforts to promote transparency in the use of de-identified
27 patient data and to protect patient privacy by developing methods of, and technologies
28 for, de-identification of patient information that reduce the risk of re-identification of such
29 information. (New HOD Policy)

- 30
31 4. That our Council on Ethical and Judicial Affairs consider re-examining existing
32 guidance relevant to the confidentiality of patient information, striving to preserve the
33 benefits of widespread use of de-identified patient data for purposes of promoting quality
34 improvement, research, and public health while mitigating the risks of re-identification of
35 such data. (Directive to Take Action)

- 36
37 5. That Policy D-315.975, "Research Handling of De-Identified Patient Information," be
38 rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

39
40 This report was introduced by the Board of Trustees and further testimony was minimal.
41 An amendment was offered suggesting that additional language be added to specifically
42 state that use and disclosure of patient information be consistent with federal, state, local,
43 or tribal law, regulation, or policy, but your Reference Committee believes that these laws,
44 regulations and policies will be considered regardless. Your Reference Committee
45 recommends that the recommendations in Board of Trustees Report 16 be adopted and
46 the remainder of the report be filed.

1 Policy H-315.974, "Guiding Principles, Collection and Warehousing of Electronic
2 Medical Record Information"

3
4 Our AMA expressly advocates for physician ownership of all claims data,
5 transactional data and de-identified aggregate data created, established and
6 maintained by a physician practice, regardless of how and where such data is
7 stored but specifically including any such data derived from a physician's medical
8 records, electronic health records, or practice management system, while
9 preserving the principle that physicians act as trusted stewards of Protected Health
10 Information.

11
12 Policy H-315.975, "Police, Payer, and Government Access to Patient Health
13 Information"

14
15 (1) Our AMA advocates vigorously, with respect to the final privacy rule or other
16 privacy legislation, to define "health care operations" narrowly to include only those
17 activities and functions that are routine and critical for general business operations
18 and that cannot reasonably be undertaken with de-identified information.

19
20 (2) Our AMA advocates vigorously, with respect to the final privacy rule or other
21 privacy legislation, that the Centers for Medicare & Medicaid Services (CMMS) and
22 other payers shall have access to medical records and individually identifiable
23 health information solely for billing and payment purposes, and routine and critical
24 health care operations that cannot reasonably be undertaken with de-identified
25 health information.

26
27 (3) Our AMA advocates vigorously, with respect to the final privacy rule or other
28 privacy legislation, that CMMS and other payers may access and use medical
29 records and individually identifiable health information for non-billing, non-payment
30 purposes and non-routine, non-critical health care operations that cannot
31 reasonably be undertaken with de-identified health information, only with the
32 express written consent of the patient or the patient's authorized representative,
33 each and every time, separate and apart from blanket consent at time of
34 enrollment.

35
36 (4) Our AMA advocates vigorously, with respect to the final privacy rule or other
37 privacy legislation that no government agency, including law enforcement
38 agencies, be permitted access to medical records or individually identifiable health
39 information (except for any discretionary or mandatory disclosures made by
40 physicians and other health care providers pursuant to ethical guidelines or to
41 comply with applicable state or federal reporting laws) without the express written
42 consent of the patient, or a court order or warrant permitting such access.

43
44 (5) Our AMA continues to strongly support and advocate a minimum necessary
45 standard of disclosure of individually identifiable health information requested by
46 payers, so that the information necessary to accomplish the intended purpose of
47 the request be determined by physicians and other health care providers, as
48 permitted under the final privacy rule.

1 Policy H-315.978, "Privacy and Confidentiality"
2

3 Our AMA policy is that where possible, informed consent should be obtained
4 before personally identifiable health information is used for any purpose. However,
5 in those situations where specific informed consent is not practical or possible,
6 either (1) the information should have identifying information stripped from it or (2)
7 an objective, publicly accountable entity must determine that patient consent is not
8 required after weighing the risks and benefits of the proposed use. Re-identification
9 of personal health information should only occur with patient consent or with the
10 approval of an objective, publicly accountable entity.

11
12 Policy H-315.987, "Limiting Access to Medical Records"
13

14 Our AMA: (1) will pursue the adoption of federal legislation and regulations that
15 will: limit third party payers' random access to patient records unrelated to required
16 quality assurance activities; limit third party payers' access to medical records to
17 only that portion of the record (or only an abstract of the patient's records)
18 necessary to evaluate for reimbursement purposes; require that requests for
19 information and completion of forms be delineated and case specific; allow a
20 summary of pertinent information relative to any inquiry into a patient's medical
21 record be provided in lieu of a full copy of the records (except in instances of
22 litigation where the records would be discoverable); and provide proper
23 compensation for the time and skill spent by physicians and others in preparing
24 and completing forms or summaries pertaining to patient records; and (2) supports
25 the policy that copies of medical records of service no longer be required to be
26 sent to insurance companies, Medicaid or Medicare with medical bills.

27
28 Policy D-315.975, "Research Handling of De-Identified Patient Information"
29

30 Our AMA will study the handling of de-identified patient information and report
31 findings and recommendations back to the AMA House of Delegates.

32
33 (6) BOARD OF TRUSTEES REPORT 20 - SPECIALTY
34 SOCIETY REPRESENTATION IN THE HOUSE OF
35 DELEGATES FIVE-YEAR REVIEW
36

37 **RECOMMENDATION:**
38

39 **Recommendations in Board of Trustees Report 20 be
40 adopted and the remainder of the report be filed.**

41
42 **HOD ACTION: Recommendations in Board of Trustees
43 Report 20 adopted and the remainder of the report filed.**

44
45 The Board of Trustees recommends that the following be adopted, and the remainder of
46 this report be filed:

- 47
48 1. That the American Academy of Insurance Medicine, American Academy of Sleep
49 Medicine, American Society of Gastrointestinal Endoscopy, American Urological
50 Association, American Society of Plastic Surgeons, AMSUS The Society of Federal

Health Professionals and North American Spine Society retain representation in the American Medical Association House of Delegates. (Directive to Take Action)

2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5, American Society of Radiation Oncology, American Society for Surgery of the Hand, Society for Vascular Surgery, and the Society of American Gastrointestinal and Endoscopic Surgeons be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership. (Directive to Take Action)
 3. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5 after a year's grace period to increase membership, the American Society of Abdominal Surgeons and the International Association of Independent Medical Evaluators not retain representation in the House of Delegates. (Directive to Take Action)

This report was introduced by the Board of Trustees and limited supporting testimony was heard. Your Reference Committee recommends that the recommendations in Board of Trustees Report 20 be adopted and the remainder of the report be filed.

(7) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 1
- FURTHER ACTION ON BYLAW 7.5.2

RECOMMENDATION:

Recommendations in Council on Constitution and Bylaws Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Constitution and Bylaws Report 1 adopted and the remainder of the report filed.

The Council on Constitution and Bylaws recommends that the following amendments to the AMA Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.

7.5 Young Physicians Section. The Young Physicians Section is a fixed Section.

7.5.1 Membership. All active physician members of the AMA who are not resident/fellow physicians, but who are under 40 years of age or are within the first 8 years of professional practice after residency and fellowship training programs, shall be members of the Young Physicians Section until December 31 of the year of their 40th birthday or December 31 of the eighth year following completion of their graduate medical education, whichever comes last.

7.5.2 Cessation of Eligibility of Governing Council Members. If any Governing Council member ceases to meet the membership requirements of Bylaw 7.5.1 prior to the expiration of the term for which elected, the term of such member shall terminate and the

1 position shall be declared vacant. If any member's term would terminate prior to the
2 conclusion of an Annual Meeting, such member shall be permitted to serve in office until
3 the conclusion of the Annual Meeting ~~in the calendar year~~ following that when such
4 member ceases to meet the membership requirements of Bylaw 7.5.1, as
5 long as the member remains an active physician member of the AMA.

6
7 7.5.2.1 The chair position is a three-year commitment and divided into the roles of chair-
8 elect, chair, and immediate past chair. The young physician must meet the requirements
9 of Bylaws 7.5.1 and 7.5.2 when elected as chair-elect. The chair-elect, chair and
10 immediate past chair shall be granted membership in the Section and be permitted to
11 complete the term of office even if unable to continue to meet all of the requirements of
12 Bylaw 7.5.1, as long as the physician remains an active physician member of the AMA.

13
14 (Modify Bylaws)

15
16 The report was introduced by the author, and limited supporting testimony was heard.
17 Your Reference Committee recommends that the recommendations in Council on
18 Constitution and Bylaws Report 1 be adopted and the remainder of the report be filed.

19
20 (8) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 2
21 – RESCISSION OF BYLAWS RELATED TO RUN-OFF
22 ELECTIONS

23
24 **RECOMMENDATION:**

25
26 **Recommendations in Council on Constitution and**
27 **Bylaws Report 2 be adopted and the remainder of the**
28 **report be filed.**

29
30 **HOD ACTION: Recommendations in Council on**
31 **Constitution and Bylaws Report 2 adopted and the**
32 **remainder of the report filed.**

33
34 The Council on Constitution and Bylaws recommends that the following amendments to
35 the AMA Bylaws be adopted and that the remainder of this report be filed. Adoption
36 requires the affirmative vote of two-thirds of the members of the House of Delegates
37 present and voting.

38
39 3.4.2 Method of Election. Where there is no contest, a majority vote without ballot shall
40 elect. All other elections shall be by ballot.

41
42 ***

43
44 ~~3.4.2.2 At Large Trustees to be Elected to Fill Vacancies after a Prior Ballot. The~~
45 ~~nomination and election of Trustees to fill a vacancy that did not exist at the time of the~~
46 ~~prior ballot shall be held after election of other Trustees and shall follow the same~~
47 ~~procedure. Individuals so elected shall be elected to a complete 4-year term of office.~~
48 ~~Unsuccessful candidates in any election for Trustee, other than the young physician~~
49 ~~trustee and the resident/fellow physician trustee, shall automatically be nominated for~~

1 ~~subsequent elections until all Trustees have been elected. In addition, nominations from~~
2 ~~the floor shall be accepted.~~

3
4 [Subsequent bylaw provisions will be renumbered accordingly.]

5 ****

6
7 6.8 Election - Council on Constitution and Bylaws, Council on Medical Education,
8 Council on Medical Service, and Council on Science and Public Health.

9 ***

10
11 6.8.1.5 ~~Council Members to be Elected to Fill Vacancies after a Prior Ballot. The~~
12 ~~nomination and election of members of the Council to fill a vacancy that did not exist at~~
13 ~~the time of the prior ballot shall be held after election of other members of the Council,~~
14 ~~and shall follow the same procedure. Individuals elected to such vacancy shall be~~
15 ~~elected to a complete 4 year term. Unsuccessful candidates in the election for members~~
16 ~~of the Council shall automatically be nominated for subsequent elections to fill any such~~
17 ~~vacancy until all members of the Council have been elected. In addition, nominations~~
18 ~~from the floor shall be accepted.~~

19
20 (Modify Bylaws)

21
22 The report was introduced by the author and no further testimony was heard. Your
23 Reference Committee recommends that the recommendations in Council on Constitution
24 and Bylaws Report 2 be adopted and the remainder of the report be filed.

25
26 (9) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 3
27 – AMA WOMEN PHYSICIANS SECTION:
28 CLARIFICATION OF BYLAW LANGUAGE

29
30 **RECOMMENDATION:**

31
32
33 **Recommendations in Council on Constitution and**
34 **Bylaws Report 3 be adopted and the remainder of the**
35 **report be filed.**

36
37 **HOD ACTION: Recommendations in Council on**
38 **Constitution and Bylaws Report 3 adopted and the**
39 **remainder of the report filed.**

40
41 The Council on Constitution and Bylaws recommends: 1) that the following amendments
42 to the AMA Bylaws be adopted; and 2) that the remainder of this report be filed.
43 Adoption requires the affirmative vote of two-thirds of the members of the House of
44 Delegates present and voting.

45
46 7.10 Women Physicians Section. The Women Physicians Section is a delineated
47 Section.

48
49

1 7.10.1 Membership. All female physicians and female medical students who are active
2 members of the AMA shall be ~~eligible to be~~ members of the Women Physicians Section.
3 7.10.1.1 Other active members of the AMA who express an interest in women's issues
4 ~~may also~~ shall be ~~eligible to~~ join the section. (Modify Bylaws)

5
6 The report was introduced by the author, and limited supporting testimony was heard.
7 Your Reference Committee recommends that the recommendations in Council on
8 Constitution and Bylaws Report 3 be adopted and the remainder of the report be filed.

9
10 (10) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
11 REPORT 1 - SHORT-TERM MEDICAL SERVICE TRIPS

12 **RECOMMENDATION:**

13 **Recommendations in Council on Ethical and Judicial**
14 **Affairs Report 1 be adopted and the remainder of the**
15 **report be filed.**

16 **HOD ACTION: Recommendations in Council on Ethical and**
17 **Judicial Affairs Report 1 referred.**

18
19 In light of these deliberations, the Council on Ethical and Judicial Affairs recommends that
20 the following be adopted and the remainder of this report be filed:

21
22 Short-term medical service trips, which send physicians and physicians in training from
23 wealthier countries to provide care in resource-limited settings for a period of days or
24 weeks, have emerged as a prominent response for addressing global health inequities.
25 They also provide training and educational opportunities, thus offering benefit both to the
26 communities that host them and the medical professionals and trainees who volunteer
27 their time and clinical skills.

28
29 By definition, short-term medical service trips take place in contexts of scarce resources
30 and in the shadow of colonial histories. These realities define fundamental ethical
31 responsibilities to enable good health outcomes, promote justice and sustainability,
32 minimize burdens on host communities, and respect persons and local cultures.
33 Responsibly carrying out short-term medical service trips requires diligent preparation on
34 the part of sponsors and participants in collaboration with host communities.
35 Physicians and trainees who are involved with short-term medical service trips should
36 ensure that the trips with which they are associated:

37
38 (a) Focus prominently on promoting justice and sustainability by collaborating with the
39 host community to define mission parameters, including identifying community needs,
40 mission goals, and how the volunteer medical team will integrate with local health care
41 professionals and the local health care system. In collaboration with the host community,
42 short-term medical service trips should identify opportunities for and priority of efforts to
43 support the community in building health care capacity. Trips that also serve secondary
44 goals, such as providing educational opportunities for trainees, should prioritize benefits
45 as defined by the host community over benefits to members of the volunteer medical team.

1 (b) Seek to proactively identify and minimize burdens the trip may place on the host
2 community, including not only direct, material costs of hosting volunteers, but on possible
3 disruptive effects the presence of volunteers could have for local practice and practitioners
4 as well. Sponsors and participants should ensure that team members practice only within
5 their skill sets and experience, and that resources are available to support the success of
6 the trip, including arranging for local mentors, translation services, and volunteers' personal
7 health needs as appropriate.

8
9 (c) Seek to become broadly knowledgeable about the communities in which they will
10 work and take advantage of resources to begin to cultivate the "cultural sensitivity" they
11 will need to provide safe, respectful, patient-centered care in the context of the specific
12 host community. Members of the volunteer medical team are expected to uphold the ethics
13 standards of their profession and volunteers should insist that strategies are in place to
14 address ethical dilemmas as they arise. In cases of irreducible conflict with local norms,
15 volunteers may withdraw from care of an individual patient or from the mission after careful
16 consideration of the effect that will have on the patient, the medical team, and the mission
17 overall, in keeping with ethics guidance on the exercise of conscience.

18
19 Sponsors of short-term medical service trips should:

20
21 (d) Ensure that resources needed to meet the defined goals of the trip will be in place,
22 particularly resources that cannot be assured locally.

23
24 (e) Proactively define appropriate roles and permissible range of practice for members
25 of the volunteer team, including the training, experience, and oversight of team members
26 required to provide acceptable safe, high-quality care in the host setting. Team members
27 should practice only within the limits of their training and skills in keeping with the
28 professional standards of the sponsor's country.

29
30 (f) Put in place a mechanism to collect data on success in meeting collaboratively
31 defined goals for the trip in keeping with recognized standards for the conduct of health
32 services research and quality improvement activities in the sponsor's country.

33
34 (New HOD/CEJA Policy)

35
36 Limited, mixed testimony was heard on this report. Testimony in favor of referral
37 expressed concern that issues regarding scope of practice on medical service trips not
38 exceeding the scope of the licensee in the practitioner's home state, working with local
39 communities, supervising trainees, and potential harm caused by these trips were not
40 adequately addressed in the recommendations. Another speaker expressed concern that
41 sections (d) and (f) of the recommendations may be unrealistic. Testimony in favor of
42 adoption lauded the improved recommendations in this report over the previous version,
43 including support from those who organize medical service trips. Your Reference
44 Committee believes that the issues of concern are adequately addressed in the
45 recommendations, particularly in the first three points of guidance. Therefore, your
46 Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1
47 be adopted and the remainder of the report be filed.

1 (11) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
2 REPORT 2 - AMENDMENTS TO OPINIONS 1.2.11,
3 "ETHICAL INNOVATION IN MEDICAL PRACTICE";
4 11.1.2, "PHYSICIAN STEWARDSHIP OF HEALTH CARE
5 RESOURCES"; 11.2.1, "PROFESSIONALISM IN HEALTH
6 CARE SYSTEMS"; AND 1.1.6, "QUALITY"

7
8 **RECOMMENDATION:**
9

10 **Recommendations in Council on Ethical and Judicial
11 Affairs Report 2 be adopted and the remainder of the
12 report be filed.**

13 **HOD ACTION: Recommendations in Council on Ethical and
14 Judicial Affairs Report 2 adopted and the remainder of the
15 report filed.**

16 In light of the foregoing, the Council on Ethical and Judicial Affairs recommend that
17 Opinion 1.2.11, "Ethically Sound Innovation in Medical Practice"; Opinion 11.2.1,
18 "Professionalism in Health Care Systems"; Opinion 11.1.2, "Physician Stewardship of
19 Health Care Resources"; and Opinion 1.1.6, "Quality," be amended as follows and the
20 remainder of this report be filed:

21 1. Opinion 1.2.11, Ethically Sound Innovation in Clinical Practice

22 Innovation in medicine can span a wide range of activities. From It encompasses not
23 only improving an existing intervention, to introducing an innovation in one's own
24 clinical practice for the first time, to using an existing intervention in a novel way, or
25 translating knowledge from one clinical context into another but also developing or
26 implementing new technologies to enhance diagnosis, treatment, and health care
27 operations. Innovation shares features with both research and patient care, but it is
28 distinct from both.

29 When physicians participate in developing and disseminating innovative practices,
30 they act in accord with professional responsibilities to advance medical knowledge,
31 improve quality of care, and promote the well-being of individual patients and the
32 larger community. Similarly, these responsibilities are honored when physicians
33 enhance their own practices by expanding the range of tools, techniques, and or
34 interventions they offer to patients employ in providing care.

35 Individually, physicians who are involved in designing, developing, disseminating, or
36 adopting innovative modalities should:

- 37 (a) Innovate on the basis of sound scientific evidence and appropriate clinical
38 expertise.
- 39 (b) Seek input from colleagues or other medical professionals in advance or as early
40 as possible in the course of innovation.

- 1 (c) Design innovations so as to minimize risks to individual patients and maximize
2 the likelihood of application and benefit for populations of patients.
- 3
- 4 (d) Be sensitive to the cost implications of innovation.
- 5
- 6 (e) Be aware of influences that may drive the creation and adoption of innovative
7 practices for reasons other than patient or public benefit.
- 8
- 9 When they offer existing innovative diagnostic or therapeutic services to individual
10 patients, physicians must:
- 11 (f) Base recommendations on patients' medical needs.
- 12
- 13 (g) Refrain from offering such services until they have acquired appropriate
14 knowledge and skills.
- 15
- 16 (h) Recognize that in this context informed decision making requires the physician to
17 disclose:
- 18
- 19 (i) how a recommended diagnostic or therapeutic service differs from the
20 standard therapeutic approach if one exists;
- 21
- 22 (ii) why the physician is recommending the innovative modality;
- 23
- 24 (iii) what the known or anticipated risks, benefits, and burdens of the
25 recommended therapy and alternatives are;
- 26
- 27 (iv) what experience the professional community in general and the physician
28 individually has had to date with the innovative therapy;
- 29
- 30 (v) what conflicts of interest the physician may have with respect to the
31 recommended therapy.
- 32
- 33 (i) Discontinue any innovative therapies that are not benefiting the patient.
- 34
- 35 (j) Be transparent and share findings from their use of innovative therapies with
36 peers in some manner. To promote patient safety and quality, physicians should
37 share both immediate or delayed positive and negative outcomes.
- 38
- 39 To promote responsible innovation, health care institutions and the medical
40 profession should:
- 41
- 42 (k) Ensure that innovative practices or technologies that are made available to
43 physicians meet the highest standards for scientifically sound design and clinical
44 value.
- 45
- 46 (kl) Require that physicians who adopt innovative treatment or diagnostic techniques
47 innovations into their practice have appropriate relevant knowledge and skills.
- 48
- 49 (lm) Provide meaningful professional oversight of innovation in patient care.
- 50

1
2 (mn) Encourage physician-innovators to collect and share information about the
3 resources needed to implement their innovative therapies innovations safely,
4 effectively, and equitably.

5
6 2. Opinion 11.2.1, Professionalism in Health Care Systems

7
8 Containing costs, promoting high-quality care for all patients, and sustaining
9 physician professionalism are important goals. Models for financing and organizing
10 the delivery of health care services often aim to promote patient safety and to
11 improve quality and efficiency. However, they can also pose ethical challenges for
12 physicians that could undermine the trust essential to patient-physician relationships.

13
14 Payment models and financial incentives can create conflicts of interest among
15 patients, health care organizations, and physicians. They can encourage
16 undertreatment and overtreatment, as well as dictate goals that are not individualized
17 for the particular patient.

18
19 Structures that influence where and by whom care is delivered—such as
20 accountable care organizations, group practices, health maintenance organizations,
21 and other entities that may emerge in the future—can affect patients' choices, the
22 patient-physician relationship, and physicians' relationships with fellow health care
23 professionals.

24
25 Formularies, clinical practice guidelines, decision support tools that rely on
26 augmented intelligence, and other tools mechanisms intended to influence decision
27 making, may impinge on physicians' exercise of professional judgment and ability to
28 advocate effectively for their patients, depending on how they are designed and
29 implemented.

30
31 Physicians in leadership positions within health care organizations and the
32 profession should ensure that practices for financing and organizing the delivery of
33 care:

34
35 (a) Ensure that decisions to implement practices or tools for organizing the delivery
36 of care are transparent and reflect input from key stakeholders, including
37 physicians and patients.

38
39 (b) Reflect input from key stakeholders, including physicians and patients.

40
41 (eb) Recognize that over reliance on financial incentives or other tools to
42 influence clinical decision making may undermine physician professionalism.

43
44 (dc) Ensure ethically acceptable incentives that all such tools:

45
46 (i) are designed in keeping with sound principles and solid scientific evidence.

47
48 a. Financial incentives should be based on appropriate comparison groups
49 and cost data and adjusted to reflect complexity, case mix, and other
50 factors that affect physician practice profiles.

- 1
- 2 b. Practice guidelines, formularies, and ~~other similar~~ tools should be based
3 on best available evidence and developed in keeping with ethics
4 guidance.
- 5
- 6 c. Clinical prediction models, decision support tools, and similar tools such
7 as those that rely on AI technology must rest on the highest-quality data
8 and be independently validated in relevantly similar populations of
9 patients and care settings.
- 10
- 11 (ii) are implemented fairly and do not disadvantage identifiable populations of
12 patients or physicians or exacerbate health care disparities;
- 13
- 14 (iii) are implemented in conjunction with the infrastructure and resources needed
15 to support high-value care and physician professionalism;
- 16
- 17 (iv) mitigate possible conflicts between physicians' financial interests and patient
18 interests by minimizing the financial impact of patient care decisions and the
19 overall financial risk for individual physicians.

20 (ed) Encourage, rather than discourage, physicians (and others) to:

- 21
- 22 (i) provide care for patients with difficult to manage medical conditions;
- 23
- 24 (ii) practice at their full capacity, but not beyond.

25 (fe) Recognize physicians' primary obligation to their patients by enabling physicians
26 to respond to the unique needs of individual patients and providing avenues for
27 meaningful appeal and advocacy on behalf of patients.

28 (gf) ~~Are~~ Ensure that the use of financial incentives and other tools is routinely
29 monitored to:

- 30
- 31 (i) identify and address adverse consequences;
- 32
- 33 (ii) identify and encourage dissemination of positive outcomes.

34 All physicians should:

35 (hg) Hold physician-leaders accountable to meeting conditions for
36 professionalism in health care systems.

37 (ih) Advocate for changes ~~in health care payment and delivery models how the~~
38 ~~delivery of care is organized~~ to promote access to high-quality care for all patients.

39 3. Opinion 11.1.2, Physician Stewardship of Health Care Resources

40 Physicians' primary ethical obligation is to promote the well-being of individual
41 patients. Physicians also have a long-recognized obligation to patients in general to
42 promote public health and access to care. This obligation requires physicians to be

1 prudent stewards of the shared societal resources with which they are entrusted.
2 Managing health care resources responsibly for the benefit of all patients is
3 compatible with physicians' primary obligation to serve the interests of individual
4 patients.

5 To fulfill their obligation to be prudent stewards of health care resources, physicians
6 should:

- 7 (a) Base recommendations and decisions on patients' medical needs.
- 8 (b) Use scientifically grounded evidence to inform professional decisions when
9 available.
- 10 (c) Help patients articulate their health care goals and help patients and their
11 families form realistic expectations about whether a particular intervention is
12 likely to achieve those goals.
- 13 (d) Endorse recommendations that offer reasonable likelihood of achieving the
14 patient's health care goals.
- 15 (e) Use technologies that have been demonstrated to meaningfully improve clinical
16 outcomes to Choose the course of action that requires fewer resources when
17 alternative courses of action offer similar likelihood and degree of anticipated
18 benefit compared to anticipated harm for the individual patient but require
19 different levels of resources.
- 20 (f) Be transparent about alternatives, including disclosing when resource constraints
21 play a role in decision making.
- 22 (g) Participate in efforts to resolve persistent disagreement about whether a costly
23 intervention is worthwhile, which may include consulting other physicians, an
24 ethics committee, or other appropriate resource.

25 Physicians are in a unique position to affect health care spending. But individual
26 physicians alone cannot and should not be expected to address the systemic
27 challenges of wisely managing health care resources. Medicine as a profession must
28 create conditions for practice that make it feasible for individual physicians to be
29 prudent stewards by:

- 30 (h) Encouraging health care administrators and organizations to make cost data
31 transparent (including cost accounting methodologies) so that physicians can
32 exercise well-informed stewardship.
- 33 (i) Advocating that health care organizations make available well-validated
34 technologies to enhance diagnosis, treatment planning, and prognosis and
35 support equitable, prudent use of health care resources.
- 36 (j) Ensuring that physicians have the training they need to be informed about health
37 care costs and how their decisions affect resource utilization and overall health
38 care spending.

1
2 (jk) Advocating for policy changes, such as medical liability reform, that promote
3 professional judgment and address systemic barriers that impede responsible
4 stewardship.

5
6 4. Opinion 1.1.6, Quality

7
8 As professionals dedicated to promoting the well-being of patients, physicians
9 individually and collectively share the obligation to ensure that the care patients
10 receive is safe, effective, patient centered, timely, efficient, and equitable.

11
12 While responsibility for quality of care does not rest solely with physicians, their role
13 is essential. Individually and collectively, physicians should actively engage in efforts
14 to improve the quality of health care by:

15
16 (a) Keeping current with best care practices and maintaining professional
17 competence.

18
19 (b) Holding themselves accountable to patients, families, and fellow health care
20 professionals for communicating effectively and coordinating care appropriately.

21
22 (c) Using new technologies and innovations that have been demonstrated to
23 improve patient outcomes and experience of care, in keeping with ethics
24 guidance on innovation in clinical practice and stewardship of health care
25 resources.

26
27 (ed) Monitoring the quality of care they deliver as individual practitioners—e.g.,
28 through personal case review and critical self-reflection, peer review, and use of
29 other quality improvement tools.

30
31 (Modify HOD/CEJA policy)

32
33 Limited testimony was heard that generally supported Council on Ethical and Judicial
34 Affairs Report 2, acknowledging the timeliness of this issue in providing guidance to
35 individual physicians and institutions alike. One speaker who supported the report
36 reminded physicians that implicit bias exists in certain algorithms, and that it is essential
37 to keep this in mind when considering the use of emerging technologies. Speakers
38 suggested adding clarifying language with regard to “augmented intelligence” and
39 “artificial intelligence,” and suggested avoiding referring to augmented intelligence as “AI”
40 to prevent confusion. However, your Reference Committee notes that our American
41 Medical Association has adopted the use of the term “augmented intelligence”. Testimony
42 was also offered that seems to transfer accountability of patient needs away from the
43 physician and to the health care organization. Your Reference Committee believes that
44 this is appropriate, given the employed status of many physicians which necessitates them
45 using technologies adopted by their institutions. Your Reference Committee recommends
46 that Council on Ethical and Judicial Affairs Report 2 be adopted and the remainder of the
47 report be filed.

1 (12) SPEAKERS REPORT 2 - ESTABLISHING AN ELECTION
2 COMMITTEE

3
4 **RECOMMENDATION:**

5
6 **Recommendations in Speakers Report 2 be adopted**
7 **and the remainder of the report be filed.**

8
9 **HOD ACTION: Recommendations in Speakers Report 2**
10 **referred for decision.**

11
12 It is recommended that the following recommendations be adopted and the remainder of
13 the report be filed.

14
15 1. A Campaign Complaint Reporting, Validation, and Resolution Process shall be
16 established as follows:

17
18 Campaign violation complaints should be directed to the Speaker, the Vice Speaker, or
19 the AMA General Counsel and should include the following details:

- 20
21 • The name of the person(s) thought to have violated the rules
22 • The date of the alleged violation and the location if relevant
23 • The specific violation being alleged (i.e., the way the rules were violated)
24 • The materials, if any, that violate the rules; original materials are preferred over
25 copies.

26
27 Where necessary, arrangements for collection of these materials will be made.

28
29 Campaign violation complaints will be investigated by the Election Committee, which will
30 determine penalties for validated complaints as appropriate. Penalties may include an
31 announcement of the violation by the Speaker to the House. (New HOD Policy)

32
33 2. The Election Committee will review the Campaign Complaint Reporting, Validation,
34 and Resolution Process as implemented and make further recommendations to the
35 House as necessary. (Directive to Take Action)

36
37 3. Policy D-610.998, Paragraph 6 be rescinded. (Rescind HOD Policy)

38
39 Your Reference Committee heard testimony that generally supported this report.
40 Speakers suggested that any validated election violations that may occur should be
41 delineated and reported, and that the potential exists for misunderstandings, false
42 accusations and accusations not made in good faith. In response, an amendment was
43 offered suggesting the inclusion of the language "in accordance with due process".
44 However, this term can be confused with legal due process. Your Reference Committee
45 believes that the language of the report is acceptable as written, and existing mechanisms
46 exist to report violations. Your Reference Committee recommends that the
47 recommendations in Speakers Report 2 be adopted and the remainder of the report be
48 filed.

1 Policy D-610.998, "Directives from the Election Task Force"
2

3 Campaign Receptions
4

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

14 Campaign literature
15

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

20 Interviews
21

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

24 Voting Process and Election Session
25

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

31 Election Committee
32

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

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

46 Review of Implementation
47

48 7. After an interval of 2 years a review of our election process, including the
49 adopted Recommendations from this report, be conducted by the Speaker and, at

1 the Speaker's discretion the appointment of another election task force, with a
2 report back to the House.

3
4 (13) RESOLUTION 009 – BANNING THE PRACTICE OF
5 VIRGINITY TESTING

6
7 **RECOMMENDATION:**

8
9 **Resolution 009 be adopted.**

10
11 **HOD ACTION: Resolution 009 adopted.**

12
13 RESOLVED, That our American Medical Association advocate for the elimination of the
14 practice of virginity testing exams, physical exams purported to assess virginity
15 (Directive to Take Action); and be it further

16
17 RESOLVED, That our AMA support culturally-sensitive counseling by health
18 professionals to educate patients and family members about the negative effects and
19 inaccuracy of virginity testing and where needed, referral for further psychosocial
20 support (New HOD Policy); and be it further

21
22 RESOLVED, That our AMA support efforts to educate medical students and physicians
23 about the continued existence of the practice of virginity testing and its detrimental
24 effects on patients. (New HOD Policy)

25
26 Testimony was heard in strong support of Resolution 009. Speakers noted the timeliness
27 of the resolution, as the topic has been part of recent national conversation. Speakers
28 noted that virginity is not a scientific or medical term, and the practice of virginity testing is
29 not evidence-based nor does it exist in medical literature. Further, speakers noted that the
30 practice is unreliable, intrusive, harmful and is often performed without consent. Your
31 Reference Committee recommends that Resolution 009 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(14) SPEAKERS REPORT 1 - REPORT OF THE ELECTION
TASK FORCE

RECOMMENDATION A:

Paragraph 12(e)(ii) be amended by addition and deletion to read as follows:

ii. It is encouraged that interviews be conducted on weeknights must be scheduled between 5 pm and 10 pm or on weekends between 8 am and 10 pm based on the candidate's local time, unless another mutually acceptable time outside these hours is arranged.

RECOMMENDATION B:

Recommendations in Speakers Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Speakers Report 1 adopted as amended and the remainder of the report filed.

(12) Interviews conducted with current candidates must comply with the following rules:

- a. Interviews may be arranged between the parties once active campaigning is allowed.
 - b. Groups conducting interviews with candidates for a given office must offer an interview to all individuals that have officially announced their candidacy at the time the group's interview schedule is finalized.
 - i. A group may meet with a candidate who is a member of their group without interviewing other candidates for the same office.
 - ii. Interviewing groups may, but are not required to, interview late announcing candidates. Should an interview be offered to a late candidate, all other announced candidates for the same office (even those previously interviewed) must be afforded the same opportunity and medium.
 - iii. Any appearance by a candidate before an organized meeting of a caucus or delegation, other than their own, will be considered an interview and fall under the rules for interviews.
 - c. Groups may elect to conduct interviews virtually or in-person, but not both. All interviews for an office

- 1 **must be conducted using the same format and**
2 **platform.**
- 3 d. **In-person interviews may be conducted between**
4 **Friday and Monday of the meeting at which**
5 **elections will take place.**
- 6 e. **Virtual interviews are subject to the following**
7 **constraints:**
- 8 i. **Interviews may be conducted only during a**
9 **window beginning on the Thursday Friday**
10 **evening two weekends prior to the scheduled**
11 **Opening Session of the House of Delegates**
12 **meeting at which elections will take place and**
13 **must be concluded by that Sunday (four days**
14 **later) evening one week before the scheduled**
15 **Opening Session of the House.**
- 16 ii. **Interviews conducted on weeknights must be**
17 **scheduled between 5 pm and 10 pm or on**
18 **weekends between 8 am and 10 pm based on**
19 **the candidate's local time, unless another**
20 **mutually acceptable time outside these hours is**
21 **arranged.**
- 22 iii. **Caucuses and delegations scheduling**
23 **interviews for candidates within the parameters**
24 **above are not obligated to must offer**
25 **alternatives to those candidates who have**
26 **conflicts with the scheduled time but are**
27 **encouraged to do so if possible.**

29 This report from your speakers spells out the expectations for interviews, particularly
30 virtual interviews, conducted with those seeking election to leadership positions within
31 our AMA. It is recommended that Policy G-610.020 be amended by addition and deletion
32 to read as follows and the remainder of this report be filed. [Note: Paragraph numbers
33 will be editorially corrected as required.]

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

44 ...

45 (11) The Speaker's Office will coordinate the scheduling of candidate interviews 1 for
46 general officer positions (Trustees, President-Elect, Speaker and Vice Speaker). Groups
47 wishing to conduct interviews must designate their interviewing coordinator and provide

1 the individual's contact information to the Office of House of Delegates Affairs. The
2 Speaker's Office will collect contact information for groups wishing to conduct interviews
3 as well as for candidates and their campaign teams and will provide the information as
4 requested.

5
6 (12) Interviews conducted with current candidates must comply with the following rules:
7

8 a. Interviews may be arranged between the parties once active campaigning is allowed.
9

10 b. Groups conducting interviews with candidates for a given office must offer an
11 interview to all individuals that have officially announced their candidacy at the time the
12 group's interview schedule is finalized.

13
14 i. A group may meet with a candidate who is a member of their group without
15 interviewing other candidates for the same office.

16
17 ii. Interviewing groups may, but are not required to, interview late announcing
18 candidates. Should an interview be offered to a late candidate, all other
19 announced candidates for the same office (even those previously interviewed)
20 must be afforded the same opportunity.

21
22 iii. Any appearance by a candidate before an organized meeting of a caucus or
23 delegation, other than their own, will be considered an interview and fall under
24 the rules for interviews.

25
26 c. Groups may elect to conduct interviews virtually or in-person, but not both. All
27 interviews for an office must be conducted using the same format and platform.

28
29 d. In-person interviews may be conducted between Friday and Monday of the meeting at
30 which elections will take place.

31
32 e. Virtual interviews are subject to the following constraints:

33
34 i. Interviews may be conducted only during a window beginning on the Friday
35 evening two weekends prior to the scheduled Opening Session of the House of
36 Delegates meeting at which elections will take place and must be concluded by
37 the Sunday evening one week before the scheduled Opening Session of the
38 House.

39
40 ii. Interviews conducted on weeknights must be scheduled between 5 pm and 10
41 pm or on weekends between 8 am and 10 pm based on the candidate's local
42 time, unless another mutually acceptable time outside these hours is arranged.

43
44 iii. Caucuses and delegations scheduling interviews for candidates within the
45 parameters above are not obligated to offer alternatives but are encouraged to
46 do so if possible.

47
48 f. Recording of interviews is allowed only with the knowledge and consent of the
49 candidate.

1 g. Recordings of interviews may be shared only among members of the group
2 conducting the interview.

3
4 h. A candidate is free to decline any interview request.

5
6 i. In consultation with the Election Committee, the Speaker, or where the Speaker is in a
7 contested election, the Vice Speaker, may issue special rules for interviews to address
8 unexpected situations.

9
10 Testimony unanimously supported the intentions of Speakers Report 1. There were
11 concerns, however, that the timing delineated in (e) did not work for individuals who work
12 overnight shifts, third shifts, or who have family and other obligations. Several
13 amendments were offered to address this, including to begin the interview window one
14 weekend prior to the scheduled opening session of the House of Delegates rather than
15 two, and to conclude the interview window by the opening session of the HOD, rather than
16 the Sunday evening one weekend before. Others suggested removing defined times
17 during which interviews should be scheduled to minimize conflict with candidate's working
18 hours and to allow interviews during times mutually acceptable by the interviewers and
19 interviewee. The sentiment of these amendments was supported, but others noted that
20 the interviewers' schedules would be burdened by a lack of defined interview windows.
21 The authors of the report noted that the proposed changes to the interview window had
22 been considered, and that the times ultimately selected and delineated in the report were
23 the result of extensive testimony from the HOD during discussion at the June 2021 Special
24 Meeting. Your Reference Committee believes that the language suggested in the above
25 amendment, which *encourages* interviews to take place during the stated times,
26 sufficiently names the guardrail times without being overly prescriptive, still allows for a
27 mutually acceptable alternate time to interview, and thus respects both the interviewer and
28 interviewee's schedules. Your Reference Committee recommends that Speakers Report
29 1 be adopted as amended and the remainder of the report be filed.

30
31 (15) RESOLUTION 018 – SUPPORT FOR SAFE AND
32 EQUITABLE ACCESS TO VOTING

33
34 **RECOMMENDATION A:**

35
36 **The first Resolve in Resolution 018 be amended by**
37 **addition to read as follows:**

38
39 **(g) use of a P.O. box for voter registration (New HOD**
40 **Policy);**

41
42 **RECOMMENDATION B:**

43
44 **Resolution 018 be adopted as amended.**

45
46 **HOD ACTION: Resolution 018 adopted as amended.**

47
48 RESOLVED, That our AMA support measures to facilitate safe and equitable access to
49 voting as a harm-reduction strategy to safeguard public health and mitigate unnecessary
50 risk of infectious disease transmission by measures including but not limited to:

- 1
2 (a) extending polling hours;
3 (b) increasing the number of polling locations;
4 (c) extending early voting periods;
5 (d) mail-in ballot postage that is free or prepaid by the government;
6 (e) adequate resourcing of the United States Postal Service and election
7 operational procedures;
8 (f) improve access to drop off locations for mail-in or early ballots (New HOD
9 Policy); and be it further

10
11 RESOLVED, That our AMA oppose requirements for voters to stipulate a reason in order
12 to receive a ballot by mail and other constraints for eligible voters to vote-by-mail. (New
13 HOD Policy)

14
15 Testimony was heard in general support of this resolution. While most speakers noted
16 their support for the intent of the resolution, several speakers noted that the process of
17 voting in the United States is decentralized, with voting procedures largely determined by
18 the states. Speakers in support noted that the COVID-19 pandemic has highlighted the
19 issues with current voting infrastructure, and the resolution represents both a harm
20 reduction strategy and a measure to improve equity for those for whom voting is difficult.
21 An amendment was offered to add another provision to the resolution allowing for use of
22 a P.O. box for voter registration to address individuals with nontraditional addresses or
23 non-numbered addresses (such as on American Indian or Alaska Native reservations and
24 in rural areas) and subsequent testimony was supportive. Your Reference Committee
25 recommends that Resolution 018 be adopted as amended.

26
27 (16) RESOLUTION 019 – DISAGGREGATION OF
28 DEMOGRAPHIC DATA FOR INDIVIDUALS OF MIDDLE
29 EASTERN AND NORTH AFRICAN (MENA) DESCENT

30
31 **RECOMMENDATION A:**

32
33 **Resolution 019 be amended by addition of a third**
34 **Resolve to read as follows:**

35
36 **RESOLVED, that our AMA study methods to further**
37 **improve disaggregation of data by race which most**
38 **accurately represent the diversity of our patients.**

39
40 **RECOMMENDATION B:**

41
42 **Resolution 019 be adopted as amended.**

43
44 **HOD ACTION: Resolution 019 adopted as amended.**

45
46 RESOLVED, That our American Medical Association add “Middle Eastern/North African
47 (MENA)” as a separate racial category on all AMA demographics forms (Directive to
48 Take Action); and be it further

49

1 RESOLVED, That our AMA advocate for the use of "Middle Eastern/North African
2 (MENA)" as a separate race category in all uses of demographic data including but not
3 limited to medical records, government data collection and research, and within medical
4 education. (Directive to Take Action)

5
6 Your Reference Committee heard testimony in strong support of Resolution 019.
7 Speakers suggested that the resolution is important for accurate data collection, and that
8 much of our misunderstanding of health disparities is the result of grouping individuals into
9 broad race categories. It was also noted that while the economic impact of this resolution
10 on the AMA is minimal, the social impact of no longer classifying those of Middle
11 Eastern/North African (MENA) descent as "white" or "other" is significant. Limited
12 testimony in opposition suggested that a standard definition of MENA does not currently
13 exist and needs to be established, and an amendment was offered suggesting that the
14 AMA "define and" add MENA as a separate racial category. Subsequent testimony
15 insisted that further study was unnecessary given that definitions not only exist, but this
16 data is self-reported. Finally, your Reference Committee agreed with the addition of a third
17 resolve asking for study of methods to further improve disaggregation of data in general.
18 Your Reference Committee recommends that Resolution 019 be adopted as amended.

19
20 (17) RESOLUTION 020 – RECOGNIZING AND REMEDYING
21 "STRUCTURAL URBANISM" BIAS AS A FACTOR IN
22 RURAL HEALTH DISPARITIES

23
24 **RECOMMENDATION A:**

25
26 The first Resolve in Resolution 020 be amended by
27 deletion to read as follows:

28
29 RESOLVED: that our AMA ~~1) formally recognize that~~
30 ~~systemic bias in healthcare financing {called~~
31 ~~"Structural Urbanism"}}, has been one of many a factors~~
32 ~~in leading to rural health disparities, 2) and advocate for~~
33 ~~elimination of these biases through payment policy~~
34 ~~reform in future AMA strategic planning to reduce all of~~
35 ~~America's health disparities, include plans to~~
36 ~~reduce/remedy the {structural urbanism} bias 3) in~~
37 ~~advocating for health equity for all Americans, point out~~
38 ~~that Medicare payment policies have played a role in to~~
39 ~~help reduce the shortage of rural physicians and~~
40 ~~eliminate the poorer health inequities outcomes in rural~~
41 ~~America (Directive to Take Action); and be it further~~

42
43 **RECOMMENDATION B:**

44
45 Resolution 020 be adopted as amended.

46
47 **RECOMMENDATION D:**

48
49 The title of Resolution 020 be changed to:

Recognizing and Remedy Payment System Bias As a Factor in Rural Health Disparities

HOD ACTION: Resolution 020 adopted as amended with a change in title to read as follows:

Recognizing and Remedyng Payment System Bias As a Factor in Rural Health Disparities

RESOLVED, That our American Medical Association: (1) formally recognize that systemic bias in healthcare financing, called "Structural Urbanism," has been a factor in leading to rural health disparities; (2) in future AMA strategic planning to reduce all of America's health disparities, include plans to reduce/remedy the structural urbanism bias; and (3) point out, in advocating for health equity for all Americans, that Medicare payment policies have played a role in the shortage of rural physicians and the poorer health outcomes in rural America (Directive to Take Action); and be it further

RESOLVED, That our AMA, as part of our current advocacy for telehealth reform, specify that geographic payment equity be required in any telehealth legislation. (Directive to Take Action)

Your Reference Committee heard testimony in unanimous support of Resolution 020. Speakers noted two main issues: the long standing rural/urban health care financing disparity, and that persons who live in rural areas have been shown in research to have considerable health inequities. The authors submitted amended language to make these points clearer, and to avoid any confusion regarding the term “structural urbanism”. Subsequent testimony supported those proposed resolutions. Your Reference Committee recommends that Resolution 020 be adopted as amended.

(18) RESOLUTION 023 – AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (CEJA) REPORT ON PHYSICIAN RESPONSIBILITIES TO IMPAIRED COLLEAGUES: CEJA E-9.3.2

RECOMMENDATION A:

The first Resolve of Resolution 023 be amended by addition and deletion to read as follows:

Resolved, that our AMA advocate that health system, corporate, and academic organizations provide for fair, objective, and external and independent review evaluations review for physicians who are requested or required to be assessed for a potential impairment potentially impairing health condition, and that such evaluations are independent of conflicts of interest by the examining and entity, and be it further

RECOMMENDATION B:

1 The second Resolve of Resolution 023 be amended by
2 addition and deletion to read as follows:
3

4 Resolved, that our AMA support the availability of
5 Physician Health Programs to enable physicians
6 who require assistance to receive provide safe and
7 effective care; and be it further for physicians who are
8 requested to be assessed for a potential impairment;
9 and be it further

10 RECOMMENDATION C:

11 Resolution 023 be amended by addition of a third
12 Resolve to read as follows:

13 Resolved, that our AMA support that any clinical
14 evaluation of a physician-in-training that is required by
15 their academic institution regarding a potentially
16 impairing health condition, be fair, objective, free of
17 conflicts, and external to said trainee's own academic
18 institution or location where they may be placed for
19 clinical rotations, and be it further

20 RECOMMENDATION D:

21 The final Resolve of Resolution 023 be amended by
22 addition and deletion to read as follows:

23 RESOLVED, That the Council on Ethical and Judicial
24 Affairs consider the following amendment to Opinion E-
25 9.3.2, "Physician Responsibilities to Colleagues with
26 Illness, Disability or Impairment":

27 (i) Advocating for supportive services including
28 physician health programs and accommodations to
29 enable physicians and physicians in training who
30 require assistance to provide safe, effective care.

31 ...

32 (k) Advocating for fair, objective, external, and
33 independent review evaluations for physicians when a
34 review is requested or required to assess a potential
35 impairment and its duration by an employer, academic
36 medical center, or hospital/health system where said
37 physician has clinical privileges or where said
38 physician-in training is placed for a clinical rotations.

1 **RECOMMENDATION E:**2 **Resolution 023 be adopted as amended.**3 **HOD ACTION: Resolution 023 adopted as amended.**4
5 **Resolved, that our AMA advocate that health system,**
6 **corporate, and academic organizations provide for fair,**
7 **objective, and external and independent review**
8 **evaluations review for physicians who are requested**
9 **or required to be assessed for a potential impairment**
10 **potentially impairing due to a health condition, and**
11 **that such evaluations are independent of conflicts of**
12 **interest by the examining and entity, and be it further**13
14 **Resolved, that our AMA support the availability of**
15 **Physician Health Programs to enable physicians**
16 **who require assistance to receive provide safe and**
17 **effective care; and be it further for physicians who are**
18 **requested to be assessed for a potential impairment;**
19 **and be it further**20
21 **Resolved, that our AMA support that any clinical**
22 **evaluation of a physician-in-training that is required by**
23 **their academic institution regarding a potential**
24 **impairment potentially impairing due to a health**
25 **condition, be fair, objective, free of conflicts, and**
26 **external to said trainee's own academic institution or**
27 **location where they may be placed for clinical**
28 **rotations, and be it further**29
30 **RESOLVED, That the Council on Ethical and Judicial**
31 **Affairs consider the following amendment to Opinion**
32 **E-9.3.2, "Physician Responsibilities to Colleagues with**
33 **Illness, Disability or Impairment":**34
35 **(i) Advocating for supportive services including**
36 **physician health programs and accommodations to**
37 **enable physicians and physicians in training who**
38 **require assistance to provide safe, effective care.**39
40 **...**41
42 **(I) Advocating for fair, objective, external, and**
43 **independent review evaluations for physicians when a**
44 **review is requested or required to assess a potential**
45 **impairment and its duration by an employer, academic**
46 **medical center, or hospital/health system where said**
47 **physician has clinical privileges or where said**
48 **physician-in training is placed for a clinical rotations.**

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

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

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

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

16 ...

17 (k) Advocating for fair, objective, external, and independent review for physicians when a
18 review is requested to assess a potential impairment and its duration.

19 Testimony was in favor of this resolution. Those who testified mentioned the importance
20 of a fair, objective and independent review of physicians who require assessment for
21 potential impairments. Several amendments were proffered on the online forum and
22 received widespread support in the hearing. Further, there was support for including
23 physicians-in-training, which is reflected in the added resolve. Lastly, several people
24 testified that they would like the Council on Ethical and Judicial Affairs to consider including
25 physician health programs specifically in Opinion 9.3.2 "Physician Responsibilities to
26 Colleagues with Illness, Disability or Impairment", as well as guidance regarding
27 advocating for the fair, objective and independent reviews mentioned in the earlier
28 resolves. Your Reference Committee recommends that Resolution 023 be adopted as
29 amended.

30 Ethical Opinion E-9.3.2, "Physician Responsibilities to Impaired Colleagues"

31 Physical or mental health conditions that interfere with a physician's ability to
32 engage safely in professional activities can put patients at risk, compromise
33 professional relationships, and undermine trust in medicine. While protecting
34 patients' well-being must always be the primary consideration, physicians who are
35 impaired are deserving of thoughtful, compassionate care.

36 To protect patient interests and ensure that their colleagues receive appropriate
37 care and assistance, individually physicians have an ethical obligation to:

38 (a) Intervene in a timely manner to ensure that impaired colleagues cease
39 practicing and receive appropriate assistance from a physician health
40 program.

- (b) Report impaired colleagues in keeping with ethics guidance and applicable law.

(c) Assist recovered colleagues when they resume patient care.

Collectively, physicians have an obligation to ensure that their colleagues are able to provide safe and effective care. This obligation is discharged by:

- (d) Promoting health and wellness among physicians.
 - (e) Establishing mechanisms to assure that impaired physicians promptly cease practice.
 - (f) Supporting peers in identifying physicians in need of help.
 - (g) Establishing or supporting physician health programs that provide a supportive environment to maintain and restore health and wellness.

RECOMMENDED FOR REFERRAL

- (19) RESOLUTION 008 – AMENDMENT TO TRUTH AND
TRANSPARENCY IN PREGNANCY COUNSELING
CENTERS. H-420.954

RECOMMENDATION:

Resolution 008 be referred.

HOD ACTION: Resolution 008 referred.

RESOLVED, That our American Medical Association amend 1 Policy H-420.954, "Truth and Transparency in Pregnancy Counseling Centers," by addition and deletion to read as follows, to further strengthen our AMA policy against the dissemination of purposely incomplete or deceptive information intended to mislead patients and the utilization of state and federal funds for potentially biased services provided by pregnancy counseling centers:

Truth and Transparency in Pregnancy Counseling Centers H-420.954

1. Our AMA supports advocates that any entity offering crisis pregnancy services disclose information on site, in its advertising; and before any services are provided concerning medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it does and does not provide, as well as fully disclose any financial, political, or religious associations which such entities may have:

2. Our AMA discourages the use of marketing, counseling, or coercion (by physical, emotional, or financial means) by any agency offering crisis pregnancy services that aim to discourage or interfere with a pregnant woman's pursuit of any medical services for the care of her unplanned pregnancy:

3. Our AMA advocates that any entity providing medical or health services to pregnant women that markets medical or any clinical services abide by licensing requirements and have the appropriate qualified licensed personnel to do so and abide by federal health information privacy laws, and additionally disclose their level of compliance to such requirements and laws to patients receiving services:

4. Our AMA opposes the utilization of state and federal funding to finance such entities offering crisis pregnancy services, which do not provide statistically validated evidence-based medical information and care to pregnant women. (Modify Current HOD Policy)

Testimony was heard in general support of the goals of the resolution, but a number of speakers expressed concern with the specific amendments in this resolution as written. Amendments were offered suggesting the removal of the term “marketing” in the proposed added part 2 of H-420.954 and removing the amendment by addition in part 3, with the speaker noting that it could not be monitored or enforced. Other amendments were proposed with the goal of preserving the intent of the resolution while mitigating unintended consequences. However, your Reference Committee heard compelling testimony that described the predatory actions by non-clinical pregnancy counseling

1 centers, and given the complexity of jurisdiction and enforcement, your Reference
2 Committee believes that a report examining these issues is the best approach for our AMA
3 to make an impact. Your Reference Committee recommends that Resolution 008 be
4 referred.

5

6 Policy H-420.954, "Truth and Transparency in Pregnancy Counseling Centers"
7

8 1. Our AMA supports that any entity offering crisis pregnancy services disclose
9 information on site, in its advertising, and before any services are provided
10 concerning the medical services, contraception, termination of pregnancy or
11 referral for such services, adoption options or referral for such services that it
12 provides; and be it further

13

14 2. Our AMA advocates that any entity providing medical or health services to
15 pregnant women that markets medical or any clinical services abide by licensing
16 requirements and have the appropriate qualified licensed personnel to do so and
17 abide by federal health information privacy laws.

RECOMMENDED FOR NOT ADOPTION

- (20) RESOLUTION 002 – DISAGGREGATION OF RACE DATA FOR INDIVIDUALS OF MIDDLE EASTERN AND NORTH AFRICAN (MENA) DESCENT

RECOMMENDATION:

Resolution 002 be not adopted.

HOD ACTION: Resolution 002 not adopted.

RESOLVED, That our American Medical Association add "Middle Eastern/North African (MENA)" as a separate race category on all AMA demographics forms (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders to promote the inclusion of “Middle Eastern/North African (MENA)” as a separate race category on all surveys conducted by the U.S. Census Bureau, and for all federally funded research using race categories (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders to promote the inclusion of "Middle Eastern/North African (MENA)" as a separate race category on all medical school and residency demographics forms. (Directive to Take Action)

Testimony for Resolution 002 was in strong support of the need of MENA as separate race category on both medical and governmental forms that ask for demographic data. Testimony reflected on the need for such a category while also referencing that the U.S. Federal government completed significant research on the topic and has taken steps to add this category to its census form. While testimony for the intent of Resolution 002 was positive, testimony was largely unanimous that the nearly analogous Resolution 019 better accomplishes the objectives of the authors and that Resolution 002 should not be adopted in favor of Resolution 019 being adopted instead. Notably, the authors of Resolution 002 agreed with this action. Therefore, your Reference Committee recommends that Resolution 002 be not adopted.

- (21) RESOLUTION 021 – FREE SPEECH AND CIVIL
DISCOURSE IN THE AMERICAN MEDICAL
ASSOCIATION

RECOMMENDATION:

Resolution 021 be not adopted.

HOD ACTION: Resolution 021 not adopted.

RESOLVED, That it be the policy of our American Medical Association that:

Our American Medical Association unequivocally commits to truly open discourse, debate, exchange of ideas, and argument;

1 Our American Medical Association unequivocally commits to a culture which recognizes
2 the inherent dignity and worth of its members, which resolves that freedom of expression
3 and civility must coexist, and where those who disagree will do so without enmity;
4
5 Our American Medical Association unequivocally commits to the principle that dissenting
6 and unpopular voices must be afforded the opportunity to be heard;
7
8 Our American Medical Association unequivocally commits that members of the
9 American Medical Association of different faiths, philosophies, and persuasions may
10 speak their minds and honor their deepest convictions without fear of punishment or
11 retaliation;
12
13 Our American Medical Association unequivocally commits that the mere exposure to
14 ideas that some may find offensive is not an act of violence or hatred;
15
16 Our American Medical Association unequivocally commits to a prohibition of the listing of
17 people or organizations to be regarded as unacceptable, untrustworthy, excluded, or
18 avoided based on ideological positions or differences;
19
20 Our American Medical Association unequivocally commits that ideological demonization
21 of opponents to block debate and to silence disagreement in the proceedings of the
22 American Medical Association is unprofessional conduct subject to appropriate
23 disciplinary action;
24
25 Our American Medical Association unequivocally commits that defamation, obscenity,
26 intimidation, threats, and incitement to violence, have no place in the proceedings of the
27 American Medical Association, and if exhibited are unprofessional conduct subject to
28 appropriate disciplinary action. (New HOD Policy)

30
31 Your Reference Committee heard overwhelming testimony in strong opposition to
32 Resolution 021. Speakers noted that the AMA has a Code of Conduct in place with an
33 extensive reporting system to investigate and discipline individuals who engage in
34 intimidation, threats or violence. Limited testimony was heard supporting reaffirmation of
35 AMA policies G-600.054, "Procedures of the House of Delegates" and H-140.837, "Policy
36 on Code of Conduct at AMA Meetings and Events" in lieu of the resolution. Your Reference
37 Committee recommends that Resolution 021 be not adopted.

38
39 Policy G-600.054, "Procedures of the House of Delegates"

40
41 1. Our AMA reaffirms The American Institute of Parliamentarians Standard Code
42 of Parliamentary Procedure as our parliamentary authority, including the use of the
43 motion to table and the motion to adopt in-lieu-of, and treat amendments by
44 substitution as first-order amendments.

45
46 2. The rules and procedures of the House of Delegates will be amended as
47 follows:

1 A. The motion to table a report or resolution that has not yet been referred
2 to a reference committee is not permitted and will be ruled out of order.
3

4 B. A new motion is added to the House of Delegates Reference Manual,
5 Object to Consideration. If a Delegate objects to consideration of an item
6 of business by our HOD, the correct motion is to Object to Consideration.
7 The motion cannot interrupt a speaker, requires a second, cannot be
8 amended, takes precedence over all subsidiary motions and cannot be
9 renewed. The motion requires a 3/4 vote for passage. Debate is restricted
10 to why the item should not be considered.
11

12 3. The procedures of our House of Delegates distinguish between a motion to
13 refer, which is equivalent to a motion to refer for report, and a motion to refer for
14 decision and that the motion to refer for decision be one step higher in precedence.
15

16 4. The procedures of our House of Delegates specify that both sides must have
17 been heard before a motion to close debate is in order and that absent an express
18 reference to "all pending matters" the motion applies only to the matter under
19 debate.
20

21 5. The procedures of our House of Delegates clarify that adjournment of any House
22 of Delegates meeting finalizes all matters considered at that meeting, meaning that
23 items from one meeting are not subject to a motion to recall from committee, a
24 motion to reconsider or any other motion at a succeeding meeting.
25

26 6. The Council on Constitution and Bylaws, in consultation with the speakers, will
27 review the House of Delegates Reference Manual and revise it accordingly.
28

29 Policy H-140.837, "Policy on Conduct at AMA Meetings and Events"
30

31 It is the policy of the American Medical Association that all attendees of AMA
32 hosted meetings, events and other activities are expected to exhibit respectful,
33 professional, and collegial behavior during such meetings, events and activities,
34 including but not limited to dinners, receptions and social gatherings held in
35 conjunction with such AMA hosted meetings, events and other activities.
36 Attendees should exercise consideration and respect in their speech and actions,
37 including while making formal presentations to other attendees, and should be
38 mindful of their surroundings and fellow participants.
39

40 Any type of harassment of any attendee of an AMA hosted meeting, event and
41 other activity, including but not limited to dinners, receptions and social gatherings
42 held in conjunction with an AMA hosted meeting, event or activity, is prohibited
43 conduct and is not tolerated. The AMA is committed to a zero tolerance for
44 harassing conduct at all locations where AMA business is conducted. This zero
45 tolerance policy also applies to meetings of all AMA sections, councils,
46 committees, task forces, and other leadership entities (each, an "AMA Entity"), as
47 well as other AMA-sponsored events. The purpose of the policy is to protect
48 participants in AMA-sponsored events from harm.
49

50 Definition

1
2 Harassment consists of unwelcome conduct whether verbal, physical or visual that
3 denigrates or shows hostility or aversion toward an individual because of his/her
4 race, color, religion, sex, sexual orientation, gender identity, national origin, age,
5 disability, marital status, citizenship or otherwise, and that: (1) has the purpose or
6 effect of creating an intimidating, hostile or offensive environment; (2) has the
7 purpose or effect of unreasonably interfering with an individual's participation in
8 meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely
9 affects an individual's participation in such meetings or proceedings or, in the case
10 of AMA staff, such individual's employment opportunities or tangible job benefits.

11
12 Harassing conduct includes, but is not limited to: epithets, slurs or negative
13 stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and
14 written, electronic, or graphic material that denigrates or shows hostility or aversion
15 toward an individual or group and that is placed on walls or elsewhere on the
16 AMA's premises or at the site of any AMA meeting or circulated in connection with
17 any AMA meeting.

18
19 Sexual Harassment

20
21 Sexual harassment also constitutes discrimination, and is unlawful and is
22 absolutely prohibited. For the purposes of this policy, sexual harassment includes:
23 - making unwelcome sexual advances or requests for sexual favors or other verbal,
24 physical, or visual conduct of a sexual nature; and
25 - creating an intimidating, hostile or offensive environment or otherwise
26 unreasonably interfering with an individual's participation in meetings or
27 proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such
28 individual's work performance, by instances of such conduct.

29
30 Sexual harassment may include such conduct as explicit sexual propositions,
31 sexual innuendo, suggestive comments or gestures, descriptive comments about
32 an individual's physical appearance, electronic stalking or lewd messages,
33 displays of foul or obscene printed or visual material, and any unwelcome physical
34 contact.

35
36 Retaliation against anyone who has reported harassment, submits a complaint,
37 reports an incident witnessed, or participates in any way in the investigation of a
38 harassment claim is forbidden. Each complaint of harassment or retaliation will be
39 promptly and thoroughly investigated. To the fullest extent possible, the AMA will
40 keep complaints and the terms of their resolution confidential.

41
42 Operational Guidelines

43
44 The AMA shall, through the Office of General Counsel, implement and maintain
45 mechanisms for reporting, investigation, and enforcement of the Policy on Conduct
46 at AMA Meetings and Events in accordance with the following:

- 47
48 1. Conduct Liaison and Committee on Conduct at AMA Meetings and Events
49 (CCAM)

1 The Office of General Counsel will appoint a “Conduct Liaison” for all AMA House
2 of Delegates meetings and all other AMA hosted meetings or activities (such as
3 meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT
4 Editorial Panel, or JAMA Editorial Boards), with responsibility for receiving reports
5 of alleged policy violations, conducting investigations, and initiating both
6 immediate and longer-term consequences for such violations. The Conduct
7 Liaison appointed for any meeting will have the appropriate training and
8 experience to serve in this capacity, and may be a third party or an in-house AMA
9 resource with assigned responsibility for this role. The Conduct Liaison will be (i)
10 on-site at all House of Delegates meetings and other large, national AMA meetings
11 and (ii) on call for smaller meetings and activities. Appointments of the Conduct
12 Liaison for each meeting shall ensure appropriate independence and neutrality,
13 and avoid even the appearance of conflict of interest, in investigation of alleged
14 policy violations and in decisions on consequences for policy violations.
15

16 The AMA shall establish and maintain a Committee on Conduct at AMA Meetings
17 and Events (CCAM), to be comprised of 5-7 AMA members who are nominated by
18 the Office of General Counsel (or through a nomination process facilitated by the
19 Office of General Counsel) and approved by the Board of Trustees. The CCAM
20 should include one member of the Council on Ethical and Judicial Affairs (CEJA);
21 provided, however, that such CEJA member on the CCAM shall be recused from
22 discussion and vote concerning referral by the CCAM of a matter to CEJA for
23 further review and action. The remaining members may be appointed from AMA
24 membership generally, with emphasis on maximizing the diversity of membership.
25 Appointments to the CCAM shall ensure appropriate independence and neutrality,
26 and avoid even the appearance of conflict of interest, in decisions on
27 consequences for policy violations. Appointments to the CCAM should be multi-
28 year, with staggered terms.
29

30 2. Reporting Violations of the Policy 31

32 Any persons who believe they have experienced or witnessed conduct in violation
33 of Policy H-140.837, “Policy on Conduct at AMA Meetings and Events,” during any
34 AMA House of Delegates meeting or other activities associated with the AMA
35 (such as meetings of AMA councils, sections, the RVS Update Committee (RUC),
36 CPT Editorial Panel or JAMA Editorial Boards) should promptly notify the (i)
37 Conduct Liaison appointed for such meeting, and/or (ii) the AMA Office of General
38 Counsel and/or (iii) the presiding officer(s) of such meeting or activity.
39

40 Alternatively, violations may be reported using an AMA reporting hotline (telephone
41 and online) maintained by a third party on behalf of the AMA. The AMA reporting
42 hotline will provide an option to report anonymously, in which case the name of the
43 reporting party will be kept confidential by the vendor and not be released to the
44 AMA. The vendor will advise the AMA of any complaint it receives so that the
45 Conduct Liaison may investigate.
46

47 These reporting mechanisms will be publicized to ensure awareness.
48

49 3. Investigations 50

1 All reported violations of Policy H-140.837, "Policy on Conduct at AMA Meetings
2 and Events," pursuant to Section 2 above (irrespective of the reporting mechanism
3 used) will be investigated by the Conduct Liaison. Each reported violation will be
4 promptly and thoroughly investigated. Whenever possible, the Conduct Liaison
5 should conduct incident investigations on-site during the event. This allows for
6 immediate action at the event to protect the safety of event participants. When this
7 is not possible, the Conduct Liaison may continue to investigate incidents following
8 the event to provide recommendations for action to the CCAM. Investigations
9 should consist of structured interviews with the person reporting the incident (the
10 reporter), the person targeted (if they are not the reporter), any witnesses that the
11 reporter or target identify, and the alleged violator.

12 Based on this investigation, the Conduct Liaison will determine whether a violation
13 of the Policy on Conduct at AMA Meetings and Events has occurred.

14 All reported violations of the Policy on Conduct at AMA Meetings and Events, and
15 the outcomes of investigations by the Conduct Liaison, will also be promptly
16 transmitted to the AMA's Office of General Counsel (i.e. irrespective of whether
17 the Conduct Liaison determines that a violation has occurred).

18 4. Disciplinary Action

19 If the Conduct Liaison determines that a violation of the Policy on Conduct at AMA
20 Meetings and Events has occurred, the Conduct Liaison may take immediate
21 action to protect the safety of event participants, which may include having the
22 violator removed from the AMA meeting, event or activity, without warning or
23 refund.

24 Additionally, if the Conduct Liaison determines that a violation of the Policy on
25 Conduct at AMA Meetings and Events has occurred, the Conduct Liaison shall
26 report any such violation to the CCAM, together with recommendations as to
27 whether additional commensurate disciplinary and/or corrective actions (beyond
28 those taken on-site at the meeting, event or activity, if any) are appropriate.

29 The CCAM will review all incident reports, perform further investigation (if needed)
30 and recommend to the Office of General Counsel any additional commensurate
31 disciplinary and/or corrective action, which may include but is not limited to the
32 following:

- 33
- 34 - Prohibiting the violator from attending future AMA events or activities;
 - 35 - Removing the violator from leadership or other roles in AMA activities;
 - 36 - Prohibiting the violator from assuming a leadership or other role in future AMA
37 activities;
 - 38 - Notifying the violator's employer and/or sponsoring organization of the actions
39 taken by AMA;
 - 40 - Referral to the Council on Ethical and Judicial Affairs (CEJA) for further review
41 and action;
 - 42 - Referral to law enforcement.

1 The CCAM may, but is not required to, confer with the presiding officer(s) of
2 applicable events activities in making its recommendations as to disciplinary and/or
3 corrective actions. Consequence for policy violations will be commensurate with
4 the nature of the violation(s).

5
6 5. Confidentiality
7

8 All proceedings of the CCAM should be kept as confidential as practicable.
9 Reports, investigations, and disciplinary actions under Policy on Conduct at AMA
10 Meetings and Events will be kept confidential to the fullest extent possible,
11 consistent with usual business practices.

12
13 6. Assent to Policy
14

15 As a condition of attending and participating in any meeting of the House of
16 Delegates, or any council, section, or other AMA entities, such as the RVS Update
17 Committee (RUC), CPT Editorial Panel and JAMA Editorial Boards, or other AMA
18 hosted meeting or activity, each attendee will be required to acknowledge and
19 accept (i) AMA policies concerning conduct at AMA HOD meetings, including the
20 Policy on Conduct at AMA Meetings and Events and (ii) applicable adjudication
21 and disciplinary processes for violations of such policies (including those
22 implemented pursuant to these Operational Guidelines), and all attendees are
23 expected to conduct themselves in accordance with these policies.

24
25 Additionally, individuals elected or appointed to a leadership role in the AMA or its
26 affiliates will be required to acknowledge and accept the Policy on Conduct at AMA
27 Meetings and Events and these Operational Guidelines.

28
29 [Editor's note: Violations of this Policy on Conduct at AMA Meetings and Events
30 may be reported at 800.398.1496 or online at <https://www.lighthouse->
31 services.com/ama. Both are available 24 hours a day, 7 days a week.

32
33 Please note that situations unrelated to this Policy on Conduct at AMA Meetings
34 and Events should not be reported here. In particular, patient concerns about a
35 physician should be reported to the state medical board or other appropriate
36 authority.]

37
38 (22) RESOLUTION 022 – PROHIBITION OF RACIST
39 CHARACTERIZATION BASED ON PERSONAL
40 ATTRIBUTES

41
42 **RECOMMENDATION:**

43
44 **Resolution 022 be not adopted.**

45
46 **HOD ACTION: Resolution 022 not adopted.**

47
48
49 RESOLVED, That it be the policy of our American Medical Association that no
50 person or group of persons shall be considered or characterized as racist based on

1 personal attributes of race, color, religion, sex (including pregnancy, sexual
2 orientation, or gender identity), national origin, age, disability, or genetic
3 information. (New HOD Policy)

4
5 Significant testimony was heard in opposition to Resolution 022. Speakers noted that
6 racism is structural, not personal, and passing this resolution could undermine recent and
7 ongoing work by the AMA to address systemic racism in the health care system. It was
8 noted that the AMA has established policy on racism, and limited testimony suggested
9 reaffirmation of existing AMA policy in lieu of this resolution. It was also noted that our
10 AMA has extensive guidelines on ethical and professional behavior to which all should
11 adhere. Limited supporting testimony suggested that the resolution should pass, and that
12 no physician should be considered to be racist based on personal attributes. Your
13 Reference Committee does not believe that it is the place of the AMA or AMA policy to
14 determine who is or is not racist on an individual level, and therefore recommends that
15 Resolution 022 be not adopted.

1 Doctor Speaker, this concludes the report of the Reference Committee on Amendments
2 to Constitution and Bylaws. I would like to thank George A. Fouras, MD, Tate Hinkle, MD,
3 Theodore Jones, MD, Candace E. Keller, MD, Robert Panton, MD and Abhishek Dharan.
4 I would also like to thank our staff and all those who testified before the Committee.

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