REPORTS OF THE BOARD OF TRUSTEES

The following reports were presented by Michael Suk, MD, JD, MPH, MBA, Chair:

1. AUGMENTED INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND USE IN HEALTH CARE

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ITEM 4f REFERRED FOR DECISION
REMAINING ITEMS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 206-I-23
REMAINDER OF REPORT FILED
See Policy H-480.931

INTRODUCTION

At the 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy H-480-935, "Assessing the Potentially Dangerous Intersection Between AI and Misinformation." This policy calls on the AMA to "study and develop recommendations on the benefits and unforeseen consequences to the medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content, and that our AMA propose appropriate state and federal regulations with a report back at A-24." This policy reflects the intense interest and activity in augmented intelligence (AI) prompted by the arrival of OpenAI's ChatGPT and other LLMs/generative AI.

Additionally, at the 2023 Interim Meeting, the AMA HOD referred Resolution 206-I-23, "The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice." Resolution 206-I-23 asked, "that our American Medical Association encourage physicians to educate our patients, the public, and policymakers about the benefits and risks of facing LLMs including GPTs for advice on health policy, information on health care issues influencing the legislative and regulatory process, and for information on scope of practice that may influence decisions by patients and policymakers."

Testimony on Resolution 206-I-23 highlighted the importance of physician understanding of LLMs and the ability to weigh the benefits and risks of these tools as the excitement and eagerness to implement them in everyday practice increases. Testimony emphasized that our AMA is currently in the process of fulfilling the directive in Policy H-480-935 (adopted at A-23) that directs our AMA to study and develop recommendations on the benefits and unforeseen consequences to the medical profession of LLMs, such as GPTs, and other augmented intelligence-generated medical advice or content. The HOD referred Resolution 206 so that the issues raised in this resolution could be considered along with the issues in Policy H-480.935.

At the 2024 Annual Meeting, a previous version of this report (BOT Report 15-A-24) was referred by the HOD for further consideration of testimony received from the online forum and during the Reference Committee B hearing. Some of those who testified expressed concern over omissions in the report regarding the use of AI in the development of scientific literature and its ability to propagate health care misinformation. Others expressed concern over the feasibility of some recommendations relating to transparency and disclosure of the use of AI, primarily that it may add additional burden on health systems, hospitals, and physicians. These issues are addressed in this report.

BACKGROUND

The issue of AI first presented itself as an area of potential interest to AMA physicians and medical students that necessitated creation of AMA policy in 2018. At that time, physicians and medical students primarily considered AI-enabled technologies within the context of medical device and clinical decision support, although administrative applications of AI began to grow exponentially and started to gain traction in the hospital, health system, and insurer space. Since the development of the AMA's foundational AI policy in 2018 and subsequent policy on coverage and payment for AI in 2019, the number of AI-enabled medical devices approved by the U.S. Food and Drug Administration (FDA) has grown to over 800. In 2022, the concept of "generative AI" and what it can do became better understood to the public. Generative AI is a broad term used to describe any type of artificial intelligence that can be used to create new text, images, video, audio, code, or synthetic data. Generative AI and LLMs have rapidly

transformed the use cases and policy considerations for AI within health care, necessitating updated AMA policy that reflects the rapidly evolving state of the technologies.

AMA policy adopted in 2018 and 2019 enabled the AMA to be a strong advocate on behalf of patients and physicians and has been the bedrock of AMA's advocacy on AI in the form of lobbying key congressional committees, participating in expert panel discussions, creating educational resources, and working with our Federation colleagues at the federal and state levels. However, as AI has rapidly developed beyond AI-enabled medical devices and into LLMs/generative AI, new policy and guidance are needed to ensure that they are designed, developed, and deployed in a manner that is ethical, equitable, responsible, accurate, and transparent.

As an initial step, in November 2023, the AMA Board of Trustees approved a set of advocacy principles developed by the Council on Legislation (COL) that serve as the framework of this Board report. The main topics addressed in the principles include AI oversight, disclosure requirements, liability, data privacy and security, and payor use of AI. In addition to the COL, these principles have been vetted among multiple AMA business units, and AMA staff has worked with several medical specialty societies that have an expertise in AI and has received additional guidance and input from outside experts that have further refined these principles. These principles build upon and are supplemental to the AMA's existing AI policy, especially Policy H-480.940, "Augmented Intelligence in Health Care," Policy H-480.939, "Augmented Intelligence in Health Care," and Policy D-480.956, "Use of Augmented Intelligence for Prior Authorization," as well as the AMA's Privacy Principles. The Board recommends adoption of these principles as AMA policy to guide our AMA's advocacy and educational efforts on LLM/generative AI issues.

This report highlights the AMA's recognition of the issues raised at the A-23 and I-23 HOD meetings, as well as the comments heard during the A-24 HOD meeting regarding BOT Report 15-A-24. It also introduces and explains major themes of the report's recommendations and provides background information on the evolution of AI policy in health care and the direction that policy appears to be headed.

Current Status of Oversight of Augmented Intelligence-Enabled Technologies

There is currently no whole-of-government strategy for oversight and regulation of AI. The U.S. Department of Health and Human Services (HHS) did establish an AI Office in March 2021 and developed a general strategy to promote the use of trustworthy AI but has not produced a department-wide plan for the oversight of AI. While many other federal departments and agencies also have some authority to regulate health care AI, many regulatory gaps exist. The Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) recently created a position for a Chief AI Officer. However, the job role is targeted at the internal use of AI within HHS and less about public policy. To address the lack of a national strategy and national governance policies directing the development and deployment of AI, the federal government has largely defaulted to public "agreements" representing promises by large AI developers and technology companies to be good actors in their development of AI-enabled technologies.

In December 2023, the Biden Administration released a reasonably comprehensive executive order on the "Safe, Secure, and Trustworthy Development and Use of Artificial Intelligence." While the executive order does not create new statutory or regulatory requirements, it does serve to direct federal departments and agencies to take action to provide guidance, complete studies, identify opportunities, etc. on AI across several sectors, including HHS. The AMA was pleased to see close alignment between the executive order's direction and AMA principles. However, executive orders do not represent binding policy, so the regulatory status quo remains unchanged at present.

The Biden Administration had also previously released a "Blueprint for an AI Bill of Rights," setting forth five principles that should guide the design, use, and deployment of AI. Those include recommendations for creating safe and effective systems; algorithmic discrimination protections; data privacy; notice and explanation; and human alternatives, considerations, and fallback. Like executive orders, this blueprint does not create new or binding policy with the force of law.

There have been few, but notable, additional actions by federal agencies that may serve to impact patient and physician interaction with AI-enabled technologies. In 2022, the Centers for Medicare & Medicaid Services (CMS) and HHS Office for Civil Rights (OCR) introduced a sweeping liability proposal within its Section 1557 Non-Discrimination in Health Programs and Activities proposed rule. The AMA submitted detailed comments opposing this section of the proposed rule. OCR ultimately finalized the rule, including the new section prohibiting

discrimination by clinical algorithms. The final rule requires physicians to make "reasonable efforts" at identifying and mitigating discriminatory harms from algorithms, including AI.

In addition, the ASTP/ONC[1] proposed and finalized, with some modifications, polices that will require electronic health record (EHR) technology developers to make certain information about AI used in EHRs available to physicians and other users. ASTP/ONC refers to these AI tools as Predictive Decision Support Interventions (Predictive DSI). Starting in 2025, EHR developers that supply Predictive DSIs as part of the developer's EHR offering must disclose specific attributes and inform users if patient demographic, social determinants of health, or health assessment data are used in the Predictive DSI. EHRs will be subject to regulatory requirements regarding the design, development, training, and evaluation of Predictive DSIs along with mandated risk management practices. ASTP/ONC's stated goal is to ensure that physicians understand how these tools work, how data are used, the potential for bias, and any known limitations.

FDA Approved AI-Enabled Medical Devices

The FDA continues to rapidly approve AI-enabled medical devices. While FDA approval and clearance of algorithmic-based devices date back to 1995, clearance and approval of these devices has rapidly accelerated in the last several years. As of May 2024, 882 devices that FDA classifies as Artificial Intelligence/Machine Learning (AI/ML) devices have been approved for marketing. The overwhelming number of these devices are classified as radiology devices and this category of devices has seen the steadiest increases in the number of applications for FDA approval. However, the number of applications is increasing in several specialties, including cardiology, neurology, hematology, gastroenterology, urology, anesthesiology, otolaryngology, ophthalmology, and pathology. A significant number of cleared or approved devices are considered diagnostic in nature and many currently support screening or triage functions.

In 2017, the FDA announced that it was evaluating a potentially new regulatory approach towards Software as a Medical Device, which would include AI/ML technologies. The so-called Pre-Certification program, or "Pre-Cert," progressed to an initial pilot program involving nine manufacturer applicants. The program proposed to pre-certify manufacturers of software-based medical devices. Devices developed by pre-certified manufacturers would be subject to varying levels of FDA review based on risk to patients, including potentially being exempt from review if the risk is low. However, the Pre-Cert program has been tabled and the pilot dismantled for the time being, leaving FDA to utilize traditional review pathways for AI-enabled medical devices. In the absence of new regulatory strategies tailored to Software as a Medical Device (SaMD) and AI/ML, FDA has issued some proposed guidance for developers of these devices but has not yet moved forward with additional guidance for important, physician-facing topics, such as transparency and labeling requirements. In June 2024, the FDA released a set of "guiding principles" for AI transparency in conjunction with Health Canada and the Medicines and Healthcare Products Regulatory Agency of the United Kingdom. However, these guiding principles do not represent official FDA guidance nor are they mandatory requirements of applicants for FDA review. The continued lack of transparency mandates leaves a critical gap in the oversight of AI-enabled medical devices.

Data Privacy and Cybersecurity Considerations in Health Care AI

The integration of AI into health care signifies a transformative era, with potential to greatly enhance patient care and operational efficiency. However, this advancement also introduces considerable challenges, particularly in data privacy and cybersecurity. As health care facilities, technology vendors, clinicians, and users increasingly adopt AI, it is vital to focus on protecting patient and user data and securing AI systems against cyber threats. Handling vast amounts of sensitive data raises critical questions about privacy and security. Survey data has shown that nine out of 10 patients believe privacy is a right and nearly 75 percent of people are concerned about protecting the privacy of their health data.[1] Addressing these concerns necessitates a multifaceted approach that includes advanced data privacy techniques, data use transparency, robust cybersecurity strategies, and compliance with regulatory standards.

Ensuring the protection of patient data in the context of AI requires sophisticated privacy techniques. Key methods such as anonymization and pseudonymization can remove or replace personal identifiers in data sets and significantly reduce the risk of re-identification. Additionally, implementing a robust data management system

[1] On July 25, 2024, HHS announced that ONC will be renamed the Assistant Secretary for Technology Policy and Office of the National Coordinator for Health Information Technology (ASTP/ONC).

empowers patients by providing clear ways to grant, deny, or revoke consent for the use of their data, enhancing patient trust and ensuring compliance with global data protection regulations such as the General Data Protection Regulation and the Health Insurance Portability and Accountability Act (HIPAA). Moreover, the collection of data should be kept to a minimum. By collecting only the data necessary for the intended purpose, AI systems can mitigate the risks associated with data breaches and misuse.

Cybersecurity plays a crucial role in health care, especially in the context of the increasing digitalization of medical records, patient data, and health care services. The health care sector is a prime target for cyber-attacks due to the sensitivity and value of the data it handles, including personal health information (PHI), financial data, and intellectual property related to medical research. The integration of technology in health care has undoubtedly brought significant benefits such as improved patient care, streamlined operations, and enhanced data analytics. However, it also introduces vulnerabilities. These include potential unauthorized access, data breaches, and disruptions to health care services, which can have dire consequences for patient privacy and safety. In 2017, 83 percent of surveyed physicians had already experienced a cyberattack and 85 percent stated that they want to share electronic PHI but were concerned about the data security necessary to protect it.[2] This risk is amplified by the recent increased use of interconnected devices and systems, such as EHRs, telemedicine platforms, and mobile health applications.

The attack on Change Healthcare in February 2024 is a stark reminder of the critical importance of cybersecurity in health care. Change Healthcare, a division of UnitedHealth Group, was struck by a ransomware attack that significantly disrupted the largest health care payment and operations system in the United States. This incident led to widespread disruptions, affecting thousands of medical practices, hospitals, pharmacies, and others. The attack was attributed to ransomware. Despite efforts to recover from this attack, the impact on health care operations was profound, including the disruption of claims processing, payments, and electronic prescriptions leading to financial strain on physicians and delays in patient care. The health care sector's reliance on interconnected digital systems for patient records, billing, and payments, means that the impact of a cyberattack can be both immediate and widespread, affecting patient care and operational continuity.

The implications of cybersecurity in health care AI are multifaceted. AI in health care, encompassing machine learning algorithms, predictive analytics, and robotic process automation, holds immense potential for diagnostic accuracy, personalized medicine, and operational efficiency. However, the deployment of AI in health care settings creates unique cybersecurity challenges. AI systems require large datasets to train and operate effectively, increasing the risk of large-scale data breaches. Additionally, the complexity of AI algorithms can make them opaque and vulnerable to manipulation, such as adversarial attacks that can lead to misdiagnoses or inappropriate treatment recommendations. AI-driven health care solutions often rely on continuous data exchange across networks, escalating the risk of cyber-attacks that can compromise both the integrity and availability of critical health care services.

A model stealing attack represents a significant cybersecurity threat in the realm of AI, where a malicious actor systematically queries an AI system to understand its behavior and subsequently replicates its functionality. This form of intellectual property theft is particularly alarming due to the substantial resources and time required to develop sophisticated AI models. An example of this issue involves a health care organization that has invested heavily in an AI model designed to predict patient health outcomes based on a wide range of variables. If a malicious entity were to engage in model stealing by extensively querying this predictive model, it could essentially duplicate the original model's predictive capabilities along with capitalizing on sensitive health care information and physicians, users, or the entity's intellectual property. Absent strong protections against input manipulation and malicious attacks, AI can become a new conduit for bad actors to compromise health care organizations and harm patients. This not only undermines the original investment but also poses a direct threat to the competitive advantage of the innovating organization.

Moreover, the risk extends beyond intellectual property theft to encompass serious privacy concerns. This is exemplified by incidents where generative AI models, trained on vast datasets, inadvertently reveal sensitive information contained within their training data in response to certain prompts. In the health care sector, where models are often trained on highly sensitive patient data, including personally identifiable information, the unauthorized extraction of this data can lead to significant breaches of patient confidentiality. The dual threat of intellectual property theft and data privacy breaches underscores the critical need for robust cybersecurity measures

in safeguarding AI models, particularly those developed and utilized within the health care industry, to maintain the integrity of both their intellectual property and the confidentiality of the sensitive data they handle.

While there are new federal policies to increase data transparency when AI is used in conjunction with health information technology, such as those issued by ASTP/ONC, these new policies only cover the certified EHR developer and stop short of holding AI developers accountable for robust data governance or data security and privacy practices.[3]

Generative AI

The broad introduction of generative AI into the public sphere in 2022 saw a paradigm shift in how physicians contemplated AI. Open-source LLM Chat GPT presented a new, easily accessible AI-enabled technology with significant capabilities to generate new content and provide readily available access to information from a huge number of sources. Generative AI tools have significant potential to relieve physician administrative burdens by helping to address actions such as in-box management, patient messages, and prior authorization requests. They also show promise in providing clinical decision support and highly personalized treatment recommendations.

However, these generative AI tools can also pose significant risk, particularly for clinical applications. As these LLMs are constantly evolving, they run the risk of providing inconsistent responses on the same fact pattern on potentially a daily, weekly, monthly, or yearly basis. The risks of these tools fabricating content are well known and could serve to propagate the spread of medical misinformation as content fabricated by the AI technologies is more broadly disseminated. They also pose potentially significant data privacy concerns.

At the present time, these technologies are largely unregulated, as there is no current regulatory structure for generative AI clinical decision support tools unless they meet the definition of a medical device regulated by the FDA. The U.S. Federal Trade Commission (FTC) has limited authority to regulate data privacy issues that may be associated with generative AI. The FTC does have some authority to regulate activities considered to be an unfair, deceptive, or abusive business practice and can enforce laws for consumer protection. However, these authorities are not specific to AI and the agency is generally under-resourced in this area. CMS has some authority to regulate use of AI by entities receiving funds from Medicare and Medicaid, including use by Medicare Advantage plans. OCR has some additional authorities to regulate data privacy and nondiscrimination.

While some federal agencies may have oversight and authorities to regulate some aspects of AI, there are many regulatory gaps. These regulatory gaps are particularly significant when considering generative AI, as tools like ChatGPT and others currently fall well outside the definition of a regulated medical device. While generative AI use for clinical applications is relatively limited currently, it is expected to grow and patients and physicians will need assurances that it is providing safe, accurate, non-discriminatory answers to the full extent possible, whether through regulation or generally accepted standards for design, development, and deployment.

Physician Liability for Use of AI

One of the most significant concerns raised by physicians regarding the use of AI in clinical practice is concern over potential liability for use of AI that ultimately performs poorly. The question of liability for the use of AI is novel and complex given that the use of AI for activities, such as clinical decision making and treatment recommendations, introduces an element of shared decision making between the patient, physician, and now the machine. While it is likely that liability will mostly be determined by the legal system through decisions in courts of law, some federal agencies have considered the idea of physician liability in these instances. Notably, the HHS Office of Civil Rights has finalized a rule creating new liability for physicians utilizing AI that results in discriminatory harms to patients. This could include, for example AI that utilizes algorithms with race adjustments or returns otherwise biased results to physicians and patients. The final rule prohibits discrimination by clinical algorithms and requires physicians, hospitals, health systems, and others to use “reasonable efforts” to both identify algorithmic discrimination and to mitigate resulting harms. While the AMA supports a prohibition on discrimination by clinical algorithms, the AMA strongly opposed efforts to create new physician liability for the use of AI.

Use of AI By Payors

There have been numerous reports recently regarding the use of what has been termed "automated decision-making tools" by payors to process claims. However, numerous reports regarding the use of these tools show a growing tendency toward inappropriate denials of care or other limitations on coverage. Reporting by ProPublica claims that tools used by Cigna denied 300,000 claims in two months, with claims receiving an average of 1.2 seconds of review.[4] Two class action lawsuits were filed during 2023, charging both United Health Care and Humana with inappropriate claims denials resulting from use of the nHPredict AI model, a product of United Health Care subsidiary NaviHealth. Plaintiffs in those suits claim the AI model wrongfully denied care to elderly and disabled patients enrolled in Medicare Advantage (MA) plans with both companies. Plaintiffs also claim that payors used the model despite knowing that 90 percent of the tool's denials were faulty.

There is growing concern among patients and physicians about what they perceive as increasing and inappropriate denials of care resulting from the use of these automated decision-making tools. In his recent Executive Order on AI, President Biden addressed this issue as an area of concern, directing HHS to identify guidance and resources for the use of predictive and generative AI in many areas, including benefits administration, stating that it must take into account considerations such as appropriate human oversight of the application of the output from AI.

There are currently no statutory and only limited regulatory requirements addressing the use of AI and other automated decision-making tools by payors. States are beginning to look more closely at this issue given the significant negative reporting in recent months and are a likely place for near-term action on this issue. Congress has also shown increasing concern and has convened hearings for testimony on the issue; however, there has been no further Congressional action or legislation to pursue further limitations on use of these algorithms. Additionally, CMS has not taken broad regulatory action to limit the use of these algorithms by entities administering Medicare and Medicaid benefits.

AMA POLICY

The AMA has existing policies, H-480.940 and H-480.939 both titled "Augmented Intelligence in Health Care," which stem from a 2018 and 2019 Board report and cover an array of areas related to the consequences and benefits of AI use in the physician's practice. In pertinent part to this discussion, AMA Policy H-480.940 seeks to "promote development of thoughtfully designed, high-quality, clinically validated health care AI, encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI, and explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI." This policy reflects not only the significance of attribution on the part of the developer, but furthermore emphasizes that physicians and other end users also play a role in understanding the technology and the risks involved with its use.

AMA Policy H.480.939 also addresses key aspects of accountability and liability by stating that "oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment." Furthermore, this policy asserts that "liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Specifically, developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users."

AMA Policy D-480.956 supports "greater regulatory oversight of the use of augmented intelligence for review of patient claims and prior authorization requests, including whether insurers are using a thorough and fair process that: (1) is based on accurate and up-to-date clinical criteria derived from national medical specialty society guidelines and peer reviewed clinical literature; (2) includes reviews by doctors and other health care professionals who are not incentivized to deny care and with expertise for the service under review; and (3) requires such reviews include human examination of patient records prior to a care denial."

AMA Policy H-480.935 directs our AMA to study and develop recommendations on the benefits and unforeseen consequences to the medical profession of LLMs such as generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content. In addition to a report back to the HOD, this policy directs AMA to work with the federal government and other appropriate organizations to protect patients from false or misleading AI-generated medical advice; encourage physicians to educate patients about the benefits and risks of consumers facing LLMs including GPTs; and support publishing groups and scientific journals in efforts to ensure transparency and accountability of authors in the use and validation of text generated by augmented intelligence.

DISCUSSION

As the number of AI-enabled health care tools and systems continues to grow, these technologies must be designed, developed, and deployed in a manner that is ethical, equitable, responsible, accurate, and transparent. With a lagging effort towards adoption of national governance policies or oversight of AI, it is critical that the physician community engage in development of policies to help drive advocacy, inform patient and physician education, and guide engagement with these new technologies. It is also important that the physician community help guide development of these tools in a way that best meets both patient and physician needs, and help define their own organization's risk tolerance, particularly where AI impacts direct patient care. AI has significant potential to advance clinical care, reduce administrative burdens, and improve clinician well-being. This may only be accomplished by ensuring that physicians engage only with AI that satisfies rigorous, clearly defined standards to meet the goals of the quadruple aim,[5] advance health equity, prioritize patient safety, and limit risks to both patients and physicians.

Oversight of Health Care Augmented Intelligence

There is currently no national policy or governance structure in place to guide the development and adoption of non-medical device AI. As discussed above, the FDA regulates AI-enabled medical devices, but many types of AI-enabled technologies fall outside the scope of FDA oversight.[6] This potentially includes AI that may have clinical applications, such as some generative AI technologies serving clinical decision support functions. While the FTC and OCR have oversight over some aspects of AI, their authorities are limited and not adequate to ensure appropriate development and deployment of AI generally, and specifically in the health care space. Likewise, ASTP/ONC's enforcement is limited and focused on EHR developers' use and integration of AI within their federally certified EHRs. While this is a major first step in requiring AI transparency, it is still the EHR developer that is regulated with few requirements on the AI developer itself. Encouragement of a whole-of-government approach to implement governance policies will help to ensure that risks to consumers and patients arising from AI are mitigated to the greatest extent possible.

In addition to the government, health care institutions, practices, and professional societies share some responsibility for appropriate oversight and governance of AI-enabled systems and technologies. Beyond government oversight or regulation, purchasers and users of these technologies should have appropriate and sufficient policies in place to ensure they are acting in accordance with the current standard of care. Similarly, clinical experts are best positioned to determine whether AI applications are high quality, appropriate, and whether the AI tools are valid from a clinical perspective. Clinical experts can best validate the clinical knowledge, clinical pathways, and standards of care used in the design of AI-enabled tools and can monitor the technology for clinical validity as it evolves over time.

Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies

As implementation of AI-enabled tools and systems increases, it is essential that use of AI in health care be transparent to both patients and physicians. Transparency requirements should be tailored in a way that best suits the needs of the end users. Care must be taken to preserve the integrity of data sets used in health care such that individual choice and data privacy are balanced with preserving algorithms that remain as pristine as possible to avoid exacerbating health care inequities. Disclosure should contribute to patient and physician knowledge without increasing administrative burden. When AI is utilized in health care decision-making at the point of care, that use should be disclosed and documented to limit risks to, and mitigate inequities for, both patients and physicians, and to allow each to understand how decisions impacting patient care or access to care are made. While transparency does not necessarily ensure AI-enabled tools are accurate, secure, or fair, it is difficult to establish trust if certain characteristics are hidden.

Heightened attention to transparency and additional transparency requirements serve several purposes. They help to ensure that the best possible decisions are made about a patient's health care and help patients and physicians identify critical decision points and possible points of error. They can also serve as mechanisms to help shield physicians from liability so that potential issues related to use of AI-enabled technologies can be isolated and accountability apportioned appropriately.

There are currently few federal requirements for transparency regarding AI. The FDA requires product labeling to provide certain information to physicians and other users, but requirements for device labeling are generally considered to be less stringent and have more leeway than drug product labeling. While FDA has stated that transparency is a key priority for the agency to address, they have not taken any additional action to update the labeling requirements for
AI-enabled medical devices or put into place additional transparency requirements for AI-enabled devices. As discussed above, ASTP/ONC also has new transparency requirements applicable to the use of AI within EHRs; however, again, those requirements are limited to AI within an EHR or other applications integrated and made available through the EHR. They will not apply to AI-enabled tools accessible through the Internet, cellular phones, etc. There is an urgent need for additional federal action to ensure AI transparency.

Transparency: Attributes and the Importance of Disclosure

During consideration of an earlier version of this report at the 2024 Annual Meeting, comments were heard during the online forum and Reference Committee B hearing regarding the recommendations on disclosure of use of AI to physicians and, ultimately, to patients. Commentors raised concerns that transparency regarding the use of AI would be overly burdensome to health systems and hospitals deploying AI and that transparency would entail disclosure of use of algorithms in any instance, including those used in EHRs, those for administrative purposes, and others that do not directly impact physician and patient decision-making. There were also concerns that the recommendations around transparency were akin to calling for burdensome informed consent for the use of AI and that disclosure of the use of AI to patients risks damaging the patient-physician relationship.

For the purposes of this report and its recommendations, "disclosure" should be understood to mean communicating to physicians or patients about the use of AI-enabled systems or technologies that directly impact medical decision making and treatment recommendations at the point of care.

Documentation involves recording of an AI system's design, development, and decision-making processes. This is primarily intended for internal teams, regulators, and researchers, and to enhance understanding, maintenance, and improvement of AI systems. Disclosure, on the other hand, refers to communicating essential information about AI systems to external stakeholders, e.g., end users. Disclosure focuses on essential aspects and, in this context, denotes the "when" and not the "what" to disclose. Concise and targeted disclosure is easier to disseminate and understand than comprehensive and nuanced details. It is important to note that disclosure should not be confused with informed consent. Informed consent is multifaceted, including benefits and drawbacks depending on its implementation and context of use. It can introduce burdens such as time-consuming paperwork, complex legal language, and potential delays in receiving care or participating in research. These burdens can deter individuals from providing their medical information or utilizing AI. Disclosure, on the other hand, is a form of transparency that builds trust, ensures accountability, supports risk management efforts, and informs users about the AI system's behavior without adding undue burden. Together, documentation and disclosure foster a comprehensive approach to AI transparency, addressing both internal and external needs.

The National Institute of Standards and Technology (NIST) frames AI risk management as a path to minimize potential negative impacts of AI systems, such as threats to civil liberties and rights, while also providing opportunities to maximize positive impacts. NIST adopted the International Organization for Standardization's (ISO) position that transparency and ethical behavior are a social responsibility when decisions and activities impact society and the environment (ISO 26000:2010).[7] NIST further states that addressing, documenting, disclosing, and managing AI risks and potential negative impacts effectively can lead to more trustworthy AI systems.[8] Moreover, multiple medical specialty organizations, including the American College of Radiology (ACR) and the American College of Physicians (ACP) support disclosure.

ACR's *Ethics of AI in Radiology* states that, for a model to be transparent, it must be both visible and understandable to outsiders, including patients. A practical approach to achieving transparency is through clear disclosure. Further,

when AI is the main point of contact in health care, it is ACR's position that patients should be clearly informed that they are interacting with an AI tool. In its 2024 position paper *AI in the Provision of Health Care,* ACP emphasizes that AI transparency is important for patients as well as physicians and other clinicians. Even if patients are not, at present, explicitly informed of all the ways technology is involved in their care—for example, they may or may not be told about computer-assisted electrocardiogram or mammography interpretation—ACP asserts that, due to the novelty of AI and its potential for significant clinical impacts, honesty and transparency about its use are crucial. [9,10]

Given that transparency and disclosure are not static, their practicality or applicability are dependent on the situation and environment. ACP, for example, recognizes that transparency with patients about the integration of AI into certain devices may be reasonably feasible. In these cases, disclosure is more attuned to AI used in medical treatment and decision making and not the underlying algorithm, which could be overly burdensome. Algorithms are not new in health care; they are widely used, and many have become the standard of care. On the other hand, transparency with patients about AI integration into EHR systems and other common sources of information may be less feasible, especially given that physicians are often not made aware of the integration.

Nevertheless, as NIST notes, meaningful transparency should provide access to appropriate levels of information based on the stage of the AI lifecycle and tailored to the role or knowledge of individuals interacting with or using the AI system.

Ethical Considerations for Disclosure of the Use of AI that Impacts Clinical Decision Making

The AMA was founded in part to establish the world's first national code of medical ethics. Opinions included in the AMA Code of Medical Ethics aim to address issues and challenges confronting the medical profession and represent AMA policy. Promoting adherence to the professional standards promulgated in the Code is essential to preserving patient trust and public confidence in the medical profession.

Included as part of the Code are the ethical responsibilities of physicians as they relate to transparency in health care.[11] The Code states that "[p]atients must rely on their physicians to provide information that patients reasonably would want to know to make informed, well-considered decisions about their health care," and that "physicians have an obligation to inform patients about…tools that influence treatment recommendations and care." The Code additionally states that, where treatment recommendations are concerned, "[p]atients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision-making."[12]

Physician use of AI is not an exception to the Code, nor is there separate ethical guidance for the use of AI at this time. The Code suggests that communication to physicians and patients about the use of AI that may directly impact medical decision making and treatment recommendations is in line with prevailing ethical principles. It may be particularly important seeing that, at this time, patients are expressing broad discomfort with the notion of their physicians relying on AI in their own health care.[13] To best foster trust, both between physicians and developers/deployers, and between physicians and patients, use of AI that may directly impact medical decision making should be communicated to parties involved in that decision making.

Intersections between Physician Liability and Disclosure of the Use of AI in Clinical Practice

AI transparency, both in disclosing use to physicians and to patients as well as disclosure of key information to physicians regarding the tools by AI developers and deployers, is an essential component to managing risk and potentially reducing physician liability resulting from the use of AI. As with hardware devices and other medical products, physicians are ultimately responsible for the appropriate selection and use of devices, diagnostics, and other products in clinical practice. Claims of lack of knowledge or understanding of the system in question will likely weaken a defense in any medical liability case involving AI-enabled technology. Therefore, it is essential that both physicians and patients are aware when AI impacts clinical decision-making and understand how it factors into the process. This ensures that accountability and liability can be appropriately assigned when poor AI performance leads to poor patient outcomes, or where the AI-technology is itself defective (similar to when a device or diagnostic product is defective).

Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies

Along with significant opportunity to improve patient care, all new technologies in health care will likely present certain risks and limitations that physicians must carefully navigate during the early stages of clinical implementation of these new systems and tools. AI-enabled tools are no different and are perhaps more challenging than other advances as they present novel and complex questions and risks. To best mitigate these risks, it is critical that physicians understand AI-driven technologies and have access to certain information about the AI tool or system being considered, including how it was trained and validated, so that they can assess the quality, performance, equity, and utility of the tool to the best of their ability. This information may also establish a set of baseline metrics for comparing AI tools. Transparency and explainability regarding the design, development, and deployment processes should be mandated by law where feasible, including potential sources of inequity in problem formulation, inputs, and implementation. Additionally, sufficient detail should be disclosed to allow physicians to determine whether a given AI-enabled tool would reasonably apply to the individual patient they are treating.

Physicians should be aware and understand that, where they utilize AI-enabled tools and systems without transparency provided by the AI developer, their risks of liability for reliance on that AI will likely increase. The need for full transparency is greatest where AI-enabled systems have greater impact on direct patient care, such as by AI-enabled medical devices, clinical decision support, and interaction with AI-driven chatbots. Transparency needs may be somewhat lower where AI is utilized for primarily administrative, practice-management functions.

While some of this information may be provided in labeling for FDA cleared and approved medical devices, the labeling requirements for such devices have not been specifically tailored to clearly convey information about these new types of devices. Updated guidance for FDA-regulated medical devices is needed to provide this critical information. Congress should consider actions to ensure appropriate authorities exist to require appropriate information to be provided to users of AI so that they can best evaluate the technology to determine reported performance, intended use, intended population, and appropriateness for the task. Developers and vendors should provide this information about their products, and physicians and other purchasers should consider this information when selecting the AI tools they use.

Generative AI

Generative AI is a type of AI that can recognize, summarize, translate, predict, and generate text and other content based on knowledge gained from large datasets. Generative AI tools are finding an increasing number of uses in health care, including assistance with administrative functions, such as generating office notes, responding to documentation requests, and generating patient messages. Additionally, there has been increasing discussion about clinical applications of generative AI, including use as clinical decision support to provide differential diagnoses, early detection and intervention, and to assist in treatment planning. While generative AI tools show tremendous promise to make a significant contribution to health care, there are a number of risks and limitations to consider when using these tools in a clinical setting or for direct patient care. These risks are especially important to consider for clinical applications that may impact clinical decision-making and treatment planning where risks to patients are higher.

Given that there are no regulations or generally accepted standards or frameworks to govern the design, development, and deployment of generative AI, consideration and mitigation of the significant risks are paramount. To manage risk, health care organizations should develop and adopt appropriate polices that anticipate and minimize negative impacts. Physicians who consider utilizing a generative AI-based tool in their practice should ensure that all practice staff are educated on the risks and limitations, including patient privacy concerns, and should have appropriate governance policies in place for its use prior to adoption. Also, as raised in Resolution 206-I-23, physicians should be encouraged to educate their patients about the benefits and risks of using AI-based tools, such as LLMs, for information about health care conditions, treatment options, or the type of health care professionals who have the education, training, and qualifications to treat a particular condition. Patients and physicians should be aware that chatbots powered by LLMs/generative AI could provide inaccurate, misleading, or unreliable information and recommendations. This principle is incorporated in the recommendations in this report and current AMA Policy H-480.940, "Augmented Intelligence in Health Care."

Liability

The question of physician liability for use of AI-enabled technologies presents novel and complex legal questions and poses risks to the successful clinical integration of AI-enabled technologies. It is also one of the most serious concerns for physicians when considering integration of AI into their practice. Concerns also arise for employed physicians who feel they may have no choice but to utilize the AI, should hospitals or health systems mandate its use or utilize an EHR system that incorporates AI-based applications as standard.

The challenge for physicians regarding questions of liability for use of AI is that there is not yet any clear legal standard for determining liability. While there are clear standards for physician liability generally and for medical device liability, AI presents novel and potentially complex legal questions. When AI has suggested a diagnosis, the question of how appropriate it is for a physician to rely on that result is yet to be determined and will likely continue to evolve as AI improves. Ultimately the "standard of care" will help guide physician liability. It is expected that, as it improves over time, AI will be incorporated into what is likely to be specialty-specific standards of care. However, until that occurs, AI-transparency is of critical importance and physicians will need to be diligent in ensuring that they engage with AI tools where performance has been validated in their practice setting.

As AI continues to evolve, there may ultimately be questions regarding liability when physicians fail to use AI and rely only on their professional judgment. Again, this question may ultimately turn on what evolves to be considered the standard of care.

It should be noted that, when using AI, physicians will still be subject to general legal theories regarding medical liability. Negligent selection of an AI tool, including using tools outside their intended use or intended population, or choosing a tool where there is no evidence of clinical validation, could be decisions that expose a physician to a liability claim.

Data Privacy and Augmented Intelligence

Data privacy is highly relevant to AI development, implementation, and use. The AMA is deeply invested in ensuring individual patient rights and protections from discrimination remain intact, that these assurances are guaranteed, and that the responsibility rests with the data holders. AI development, training, and use requires assembling large collections of health data. AI machine learning is data hungry; it requires massive amounts of data to function properly. Increasingly, more electronic health records are interoperable across the health care system and, therefore, are accessible by AI trained or deployed in medical settings. AI developers may enter into legal arrangements (e.g., business associate agreements) that bring them under the HIPAA Privacy and Security Rules. However, physicians and medical providers are often seen as the sole responsible parties, expected to bear the burden of data protection. This position is not sustainable. Given the newness of AI and its potential for clinically significant effects on care, equitable accountability must be established. While some uses of AI in health care, such as research, are not allowed by HIPAA absent patient authorization, the applicability of other HIPAA privacy protections to AI use is not as clear and HIPAA cannot protect patients from the "black box" nature of AI which makes the use of data opaque. AI system outputs may also include inferences that reveal personal data or previously confidential details about individuals. This can result in a lack of accountability and trust and exacerbate data privacy concerns. Often, AI developers and implementers are themselves unaware of exactly how their products use information to make recommendations.

It is unlikely that physicians or patients will have any clear insight into a generative AI tool's conformance to state or federal data privacy laws. LLMs are trained on data scraped from the web and other digital sources, including one well-documented instance where HIPAA privacy protections were violated.[14] Few, if any, controls are available to help users protect the data they voluntarily enter in a chatbot query. For instance, there are often no mechanisms in place for users to request data deletion or ensure that their inputs are not stored or used for future model training. While tools designed for medical use should align with HIPAA, many "HIPAA-compliant" generative tools rely on antiquated notions of deidentification, i.e., stripping data of personal information. With today's advances in computing power, data can easily be reidentified. Rather than aiming to make LLMs compliant with HIPAA, all health care AI-powered generative tools should be designed from the ground up with data privacy in mind. Additionally, some companies have intentionally misled the public and end-users by labeling their software tools as "HIPAA compliant", when the entity itself was not a covered entity or business associate and therefore not subject to HIPAA Privacy Rules.

The AMA's Privacy Principles were designed to provide individuals with rights and protections and shift the responsibility for privacy to third-party data holders. While the Principles are broadly applicable to all AI developers, e.g., entities should only collect the minimum amount of information needed for a particular purpose, the unique nature of LLMs and generative AI warrant special emphasis on entity responsibility and user education.

Augmented Intelligence Cybersecurity

Data privacy relies on strong data security measures. There is growing concern that cyber criminals will use AI to attack health care organizations. AI poses new threats to health IT operations. AI-operated ransomware and AI-operated malware can be targeted to infiltrate health IT systems and automatically exploit vulnerabilities. Attackers using ChatGPT can craft convincing or authentic emails and use phishing techniques that entice people to click on links—giving them access to the entire electronic health record system.

AI is particularly sensitive to the quality of data. Data poisoning is the introduction of "bad" data into an AI training set, affecting the model's output. AI requires large sets of data to build logic and patterns used in clinical decision-making. Protecting this source data is critical. Threat actors could also introduce input data that compromises the overall function of the AI tool. Failure to secure and validate these inputs, and corresponding data, can contaminate AI models—resulting in patient harm.

Because stringent privacy protections and higher data quality standards might slow model development, there could be a tendency to forgo essential data privacy and security precautions. However, strengthening AI systems against cybersecurity threats is crucial to their reliability, resiliency, and safety.

Mis- and Disinformation Propagated by AI

Health mis- and disinformation poses a serious threat to public health. It can cause significant confusion among patients, increase patient mistrust in science and in physicians, result in patients making decisions that cause themselves harm, and undermine the ability to manage public health threats. The dissemination of mis- and disinformation in health care significantly increased during the COVID-19 pandemic and shows no signs of abating. Whether intentionally or unintentionally, AI, in particular generative AI, runs the risk of contributing to the creation and dissemination of scientific and medical mis- and disinformation. Physicians, staff, and patients must all be aware of the risks of mis- and disinformation when engaging with generative and other forms of AI.
Generative AI can propagate mis- and disinformation in several ways. It can engage in the unintentional or intentional creation of incorrect information on its own. The risk of generative AI "hallucinating," "confabulating," or otherwise fabricating information in response to a user-generated query has been well documented.[15,16] Notably, tools such as ChatGPT have shown a not-uncommon tendency to falsify references cited in response to these queries. Generative AI tools have demonstrated the ability to generate fraudulent scientific/medical literature.[17] They are also capable of plagiarizing, falsifying, or misrepresenting data in ways that could compromise research integrity. Additionally, retracted papers may have the ability to continue to impact the content generated by LLM-based tools, potentially leading to dissemination or inaccurate or otherwise discredited information.

AI can also be responsible for intentionally or unintentionally disseminating false information or intentional misinformation, which can happen when that information is used as part of the training data set for the model, used as a reference in a response to a query, or otherwise presented to a user in a query response. Information presented to users by generative AI models can be extremely convincing, with the users potentially having little reason to doubt what is presented.

There is little opportunity currently to regulate AI's role in propagation of health mis- and disinformation under current oversight structures. The FTC is the most likely agency to take action against mis- and disinformation, as it has broad authorities to regulate unfair and deceptive business practices. However, as discussed above, the FTC will require additional resources to appropriately regulate the role of AI in propagating mis- and disinformation. Regulation of mis- and disinformation is further complicated by the intersection of false and misleading information with free speech rights guaranteed by the First Amendment.

It is critical that the health care industry and health care stakeholders broadly take action to limit AI's ability to create or disseminate mis- or disinformation. Developers of AI should be accountable for their product creating or

disseminating false information and should have mechanisms in place to allow for reporting of mis- and disinformation. Federal regulations should seek to eliminate the propagation of mis- and disinformation by AI-enabled tools. Ethical principles for use of AI in medical and scientific research should be in place to ensure continued research integrity. Journals should ensure that they have clear guidelines in place to regulate the use of AI in scientific publications that include documenting and detailing the use of AI in research and to exclude the use of AI systems as authors. Policies should also detail the responsibility of authors to validate the veracity of any text generated by AI. (See Policy H-480.935, Assessing the Potentially Dangerous Intersection Between AI and Misinformation).

Payor Use of Augmented Intelligence in Automated Decision-Making

Payors and health plans are increasingly using AI and algorithm-based decision-making in an automated fashion to determine coverage limits, make claim determinations, and engage in benefit design. Payors should leverage automated decision-making systems that improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. While the use of these systems can create efficiencies such as speeding up prior authorization and cutting down on paperwork, there is concern these systems are not being designed or supervised effectively creating access barriers for patients and limiting essential benefits.

Increasingly, evidence indicates that payors are using automated decision-making systems to deny care more rapidly, often with little or no human review. This manifests in the form of increased denials, stricter coverage limitations, and constrained benefit offerings. For example, a payor allowed an automated system to cut off insurance payments for Medicare Advantage patients struggling to recover from severe diseases, forcing them to forgo care or pay out of pocket. In some instances, payors instantly reject claims on medical grounds without opening or reviewing the patient's medical record. There is also a lack of transparency in the development of automated decision-making systems. Rather than payors making determinations based on individualized patient care needs, reports show that decisions are based on algorithms developed using average or "similar patients" pulled from a database. Models that rely on generalized, historical data can also perpetuate biases leading to discriminatory practices or less inclusive coverage.[18,19,20,21]

While AI can be used inappropriately by payors with severe detrimental outcomes to patients, it can also serve to reduce administrative burdens on physicians, providing the ability to more easily submit prior authorization and documentation requests in standardized forms that require less physician and staff time. Given the significant burden placed on physicians and administrative staff by prior authorization requests, AI could provide much needed relief and help to increase professional satisfaction among health care professionals. With clear guidelines, AI-enabled decision-making systems may also be appropriate for use in some lower-risk, less complex care decisions.

While payor use of AI in well-defined situations with clear guidelines has the potential to reduce burdens and benefit physician practices, new regulatory or legislative action is necessary to ensure that automated decision-making systems do not reduce needed care, nor systematically withhold care from specific groups. Steps should be taken to ensure that these systems do not override clinical judgment. Patients and physicians should be informed and empowered to question a payor's automated decision-making. There should be stronger regulatory oversight, transparency, and audits when payors use these systems for coverage, claim determinations, and benefit design. [See Policy D-480.956, "Use of Augmented Intelligence for Prior Authorization;" and Policy H-320.939, "Prior Authorization and Utilization Management Reform"]

CONCLUSION

As the number of AI-enabled health care tools and systems continue to grow, these technologies must be designed, developed, and deployed in a manner that is ethical, equitable, responsible, accurate, and transparent. In line with AMA Policy H-480-935 and Resolution 206-I-23, this report highlights some of the potential benefits and risks to the medical profession and patients of LLMs (e.g., GPTs) and other AI-generated medical decision-making tools, and recommends adoption of policy to help inform patient and physician education and guide engagement with this new technology, as well as position the AMA to advocate for governance policies that help to ensure that risks arising from AI are mitigated to the greatest extent possible.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted as new policy in lieu of Resolution 206-I-23 and that the remainder of the report be filed:

AUGMENTED INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND USE IN HEALTH CARE

1. General Governance
   a) Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.
   b) Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
   c) Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
   d) AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.
   e) Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduce. [See also Augmented Intelligence in Health Care H-480.939 at (1)]
   f) AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.
   g) Clinical decisions influenced by AI must be made with specified qualified human intervention points during the decision-making process. A qualified human is defined as a licensed physician with the necessary qualifications and training to independently provide the same medical service without the aid of AI. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a qualified human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.
   h) Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff.
   i) Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]

2. When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care
   a) Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.
      i) AI disclosure should align and meet ethical standards or norms.
      ii) Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.
      iii) When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.
      iv) When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.

b) AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.
c) When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.
d) The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.

3. What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies
   a) When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:
      i) Regulatory approval status.
      ii) Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology.
      iii) Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use.
      iv) Intended population and intended practice setting.
      v) Clear description of any limitations or risks for use, including possible disparate impact.
      vi) Description of how impacted populations were engaged during the AI lifecycle.
      vii) Detailed information regarding data used to train the model:
         1. Data provenance.
         2. Data size and completeness.
         3. Data timeframes.
         4. Data diversity.
         5. Data labeling accuracy.
      viii) Validation Data/Information and evidence of:
         1. Clinical expert validation in intended population and practice setting and intended clinical outcomes.
         2. Constraint to evidence-based outcomes and mitigation of "hallucination"/"confabulation" or other output error.
         3. Algorithmic validation.
         4. External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation.
         5. Comprehensiveness of data and steps taken to mitigate biased outcomes.
         6. Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings.
         7. Post-market surveillance activities aimed at ensuring continued safety, performance, and equity.
      ix) Data Use Policy:
         1. Privacy.
         2. Security.
         3. Special considerations for protected populations or groups put at increased risk.
      x) Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training.
      xi) Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review.
   b) Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]

4. Generative Augmented Intelligence
   a) Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).
   b) Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
      i) Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.
      ii) Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
      iii) Lack of regulatory or clinical oversight to ensure performance of the tool.
      iv) Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.
      v) Data privacy.
      vi) Cybersecurity.
      vii) Physician liability associated with the use of generative AI tools.
   c) Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]
   d) Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians and healthcare organizations should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.
   e) Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (e.g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.
   f) Governance policies should prohibit the use of confidential, regulated, or proprietary information as prompts for generative AI to generate content. [Editor note: item 4f was referred for decision]
   g) Data and prompts contributed by users should primarily be used by developers to improve the user experience and AI tool quality and not simply increase the AI tool's market value or revenue generating potential.

5. Physician Liability for Use of Augmented Intelligence-Enabled Technologies
   a) Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]
      i) Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
      ii) Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
      iii) Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
   b) When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.
   c) Liability protections for physicians using AI-enabled technologies should align with both current and future AMA medical liability reform policies.

6. Data Privacy and Augmented Intelligence
    a) Entity Responsibility:
        i) Entities, e.g., AI developers, should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.
        ii) Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.
        iii) Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.
    b) User Education:
        i) Users should be provided with training specifically on generative AI. Education should address:
            1. Legal, ethical, and equity considerations.
            2. Risks such as data breaches and re-identification.
            3. Potential pitfalls of inputting sensitive and personal data.
            4. The importance of transparency with patients regarding the use of generative AI and their data.

[See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]

7. Augmented Intelligence Cybersecurity
    a) AI systems must have strong protections against input manipulation and malicious attacks.
    b) Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.
    c) Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
    d) Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.

8. Mitigating Misinformation in AI-Enabled Technologies
    a) AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training data. Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.
    b) Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
    c) Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.
    d) Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
    e) Academic publications and journals should establish clear guidelines to regulate the use of AI in manuscript submissions. These guidelines should include requiring the disclosure that AI was used in research methods and data collection, requiring the exclusion of AI systems as authors, and should outline the responsibility of the authors to validate the veracity of any referenced content generated by AI.
    f) Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences.

9. Payor Use of Augmented Intelligence and Automated Decision-Making Systems
    a) Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.

b) Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.
c) Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.
d) Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
e) Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.
f) Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).
g) Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

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2. ON-SITE PHYSICIAN REQUIREMENTS FOR EMERGENCY DEPARTMENTS

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 207-I-23
REMAINDER OF REPORT FILED
See Policy H-130.929

INTRODUCTION

This American Medical Association (AMA) Board of Trustees report arises from Resolution 207-I-23, "On-Site Physician Requirement for EDs." As introduced by the Michigan Delegation. Resolution 207 called upon the AMA to develop model legislation and support requirements for the real-time, on-site presence of a physician in the emergency department (ED), whose primary duty is to treat patients seeking care in that ED.

The AMA House of Delegates (HOD) referred the following language for study (Resolution 207-I-23) (emphasis in original):

> RESOLVED, that our American Medical Association develop model state legislation and support federal and state legislation or regulation, **with appropriate consideration for limited rural exceptions**, requiring all facilities that imply the provision of emergency medical care have the real-time, on-site presence of a physician, and on-site supervision of non-physician practitioners (e.g., physician assistants and advanced practice nurses) by a licensed physician with training and experience in emergency medical care whose primary duty is dedicated to patients seeking emergency medical care in that ED. (Directive to Take Action)

Testimony in favor of Resolution 207 suggested that the AMA should take a firm stance on physician supervision in the ED based on existing AMA policy related to physician-led team-based care and as part of AMA's robust campaign promoting physician-led care. At the same time, robust testimony was heard against this resolution—exclusively from physicians representing rural delegations—expressing that the proposed requirement would be untenable for many rural hospitals and could lead to closures, ultimately depriving patients access to emergency care.

BACKGROUND

Brief Overview of Relevant AMA Policy

AMA policy that pre-dated this resolution, as well as policy that was passed concurrent with the drafting of this report, provides necessary context for the referred language. AMA has extensive policy promoting physician-led care. For example, AMA Policy H-160.949, "Practicing Medicine by Non-Physicians," provides that the AMA vigorously supports appropriate physician supervision of non-physician clinical staff in all areas of medicine, and AMA Policy H-160.947, "Physician Assistants and Nurse Practitioners," establishes that the physician should be responsible for managing the health care of patients in all settings.

More specifically to care provided in EDs, AMA Policy D-35.976, "Promoting Supervision of Emergency Care Services in Emergency Departments by Physicians," establishes AMA's support for laws that "ensure only physicians supervise the provision of emergency care services in an ED."[1] On top of that, after the referral of Resolution 207 at the AMA 2023 Interim Meeting and concurrent with the drafting of this report, the HOD at the 2024 Annual Meeting adopted new policy stating that, "AMA will support that all EDs be staffed 24/7 by a qualified physician."[2] Altogether, AMA policy promotes physician supervision of care in the ED and supports a requirement that a physician must staff the ED at all times. Notably, however, policy does not address whether a 24/7 staffing requirement always implies the real-time, on-site presence of the physician in the ED as suggested by Resolution 207.

Scope of This Report

Given the purview of the referred language and the strength of existing policy addressing physician-led care in the ED and in all health care settings, this report is narrow in scope and specific in focus. It considers the possibility of limited rural exceptions to potential legislation or regulation that would require the real-time, on-site presence of a physician in the ED, whose primary duty is to treat patients in that ED. In so doing, this report explores challenges faced by rural EDs that may impact their staffing decisions. It gives special consideration to the operational realities experienced by EDs in the country's most remote rural areas, and takes care to appreciate concerns, expressed by physicians with lived experience in rural areas, that a round-the-clock, on-site physician supervision requirement would be untenable and possibly devastating for many rural hospitals, many of which are at risk of closure.

The aforementioned AMA policies guide the Board's approach to this report. To summarize, existing AMA policy demands that any rural exceptions to a requirement that the ED be supervised by an on-site physician who is primarily responsible for care in that ED must (a) preserve physician-led care and (b) ensure that the ED remains "staffed 24/7" by a physician. To evaluate the appropriateness of limited rural exceptions to the requirement proposed by the resolution, the Board is therefore called to consider models of physician supervision that ensure the ED is adequately "staffed 24/7" by a physician and address the challenges rural EDs face in implementing the proposed model. In so doing, this report takes very seriously the concerns raised by rural physicians. It strives to pay due respect to these considerations while preserving the integrity of AMA policy on care in the ED. Ultimately, the recommendations proffered in this report aim to address the most salient challenges faced by rural EDs surrounding the proposed requirement (for the real-time, on-site presence of a physician in the ED whose primary duty is to provide care in that ED), while maintaining alignment with relevant AMA policy.

Laws Related to Physician-led Care in EDs

While federal law requires hospitals to maintain a list of physicians who are on call to provide treatment necessary to stabilize an individual with an emergency medical condition,[3] there is no requirement that care in an ED be led by a physician. Under the relevant federal regulations, the "qualified member of the medical staff" who must supervise

an ED may be a non-physician practitioner such as a physician assistant or a nurse practitioner where state law allows.[4] As such, federal law does not demand that EDs be supervised by a physician.

Governance of this issue is therefore left to the states. While most states do not have laws that expressly require physician supervision of emergency care services provided in the ED, there are a few notable exceptions. In the past two years, Indiana and Virginia have each passed state legislation requiring the on-site presence of a physician in the ED. Indiana enacted legislation in 2023 requiring that an ED must have at least one physician on site and on duty who is responsible for the ED whenever the ED is open.[5] Similarly, Virginia's 2024 law requires at least one physician who is primarily responsible for the ED to be on duty and physically present at all times at each hospital that operates or holds itself out as operating an emergency service.[6] Neither of these laws includes a rural exception. Comparable legislation has been considered but not yet enacted in a handful of additional states.

California and New Jersey also have in place longstanding regulations that promote physician-led care in the ED. California requires that a trained physician have overall responsibility for a hospital's emergency services and makes this physician responsible for ensuring that emergency services are staffed 24 hours a day by an experienced physician.[7] New Jersey's regulations around ED staffing require that at least one licensed physician be present in the ED to attend to all emergencies.[8] Both of these regulatory approaches effectively require "24/7 staffing" by a physician in the ED, with New Jersey specifically requiring the on-site presence of a physician in the ED.

State laws governing the scope of practice of non-physicians also influence the use of non-physicians in EDs. Hospitals or EDs in states where physician assistants or nurse practitioners are permitted to practice without physician supervision are more likely to employ a non-physician to supervise an ED in lieu of a physician. EDs in states that do require physician involvement in the practice of non-physicians are more likely to leverage non-physicians under some kind of physician supervision or collaboration model pursuant to state law—these models may or may not require the 24/7 on-site presence of a physician.

American College of Emergency Physicians Campaign

In June 2023, the American College of Emergency Physicians (ACEP) issued a policy statement on the role of nurse practitioners and physician assistants in emergency departments,[9] in which ACEP advocates for physician-led care teams in all EDs. As part of this campaign, ACEP has developed model legislative and regulatory language for use by states interested in advocating for on-site physician supervision in EDs. ACEP's model legislation requires that "[a] hospital with an emergency department must have a physician onsite and on duty who is primarily responsible for the emergency department at all times the emergency department is open."[10] Further, ACEP policy would require that the physician on duty in the ED solely determine what level of supervision is appropriate for patients being cared for by a nurse practitioner or a physician assistant in the ED. However, ACEP's policy statement on care in EDs also acknowledges the workforce limitations faced by certain rural hospitals and provides for the limited adoption of specified alternative supervision models where necessary in those rural hospitals facing staffing challenges.

Current ED Staffing Practices

EDs across the country are staffed by physicians from varying specialties as well as non-physicians such as nurse practitioners or physician assistants. A 2020 study found that of 48,835 clinically active emergency physicians, 92 percent were in urban areas, 6 percent were in large rural areas, and two percent were in small rural areas.[11] Those emergency physicians in urban areas were substantially younger than rural emergency physicians.[12] International medical graduates (IMGs) also make up a sizeable portion—about nine percent—of the emergency medicine workforce. About 20 percent of these IMGs are trained in specialties other than emergency medicine, and eight percent work in small rural areas.[13] Further, a 2018 study found that of all emergency medicine clinicians (i.e., inclusive of both physicians and non-physician practitioners), about 61.1 percent were physicians residency-trained in emergency medicine and about 14.3 percent were physicians trained in other specialties such as family practice or internal medicine.[14] Non-physician practitioners such as physician assistants or nurse practitioners made up about 24.5 percent of the total emergency medicine workforce.[15]

Rural EDs may directly employ physicians or other clinicians, or they may contract with management groups or individual clinicians to meet all or part of their staffing needs. In any case, the role each practitioner plays on the

care team in the ED varies depending on state law and institutional policy. As this report will explore, rural EDs often face unique challenges that impact staffing decisions.

While some EDs only staff physicians who are residency-trained and board certified in emergency medicine, it is also common for EDs to staff physicians from other specialties. A 2020 study on the emergency physician workforce found that 81 percent of practicing emergency medicine physicians were residency trained or board certified in emergency medicine, while 19 percent were trained in other specialties such as family medicine, internal medicine, or surgery.[16] There is evidence that physicians trained in specialties outside of emergency medicine are more prevalent in rural EDs than in urban ones.[17] Both literature and anecdote suggest that the staffing of these physicians may be crucial to the success of some rural EDs. The option to staff physicians from specialties outside emergency medicine emergency allows rural EDs to overcome recruitment hurdles and keep their doors open while preserving physician-led emergency care.[18] AMA policy supports all care in the ED that is physician-led and does not specify that a physician be board certified in emergency medicine or residency-trained in emergency medicine to be qualified to supervise an ED.[19]

That said, the unfortunate reality is that physician-led care in the ED is not guaranteed. Some EDs are run by nurse practitioners or physician assistants rather than by physicians. To indicate, a study of Iowa EDs found that nurse practitioners or physician assistants provided solo coverage for at least part of the week in 60 percent of the state's EDs in 2012—a number that jumped from about 39 percent in 2008.[20] More recent national research found that nearly a quarter of clinicians in EDs across the country were non-physicians (over two-thirds of whom were physician assistants and the rest nurse practitioners),[21] but notably, this study did not capture whether these non-physicians worked on physician-led teams or whether they worked in a supervisory role over the ED; other research suggests that physicians were involved with nearly 90 percent of ED visits between 2010 and 2017.[22] Still, there is speculation that use of non-physicians as a replacement for physicians in EDs is increasing,[23] and ongoing and anticipated physician shortages in rural areas support this hypothesis.[24]

Several factors may contribute to the replacement of physicians with non-physicians in both urban and rural EDs nationally, including private equity's increasing influence on health care.[25] However, there is a body of evidence that EDs in rural areas are more likely to be staffed by a non-physician than EDs in urban areas.[26] This includes workforce studies showing that urban counties have a higher proportion of emergency physicians compared with rural counties,[27] and research finding that physician assistants in rural areas are more likely to work without on-site physician supervision and to have a broader scope of practice in the ED than their urban counterparts.[28] Physicians who work in rural areas also report that recruitment challenges create the need to staff non-physicians instead of physicians in the ED, which may contribute to a trend toward use of non-physicians in rural EDs.

Rural Hospitals

Rural EDs—especially small institutions in very remote areas—face a different financial and operational situation than most EDs associated with larger metropolitan hospitals or otherwise located in urban areas. The realities associated with these differences may make a 24/7 on-site physician requirement impracticable for certain rural EDs.

Financial Vulnerability and Risk of Closure

Rural hospitals serve communities outside metropolitan areas and are often geographically isolated. EDs in these rural hospitals can be a keystone of the health care infrastructure in some areas—for example, especially in areas that are particularly remote, a single ED may serve as the sole health care safety net for patients experiencing medical emergencies. And yet, despite their role as a crucial health care resource, rural hospitals across the country are struggling to keep their doors open. Some research estimates that more than 30 percent of all rural hospitals in the U.S. are at risk of closing, and a third of those hospitals face risk of immediate closure.[29] Government Accountability Office data from 2020 reveals that more than 4 percent of rural hospitals closed from 2013 through 2020.[30] Closures have a serious impact on access to emergency services in rural areas, including by increasing the time and distance patients must travel to reach an ED. The closure of a rural ED raises grave concerns for the surrounding community's patients, as rural hospital closures have been linked to greater patient mortality.[31]

Rural hospitals confront a unique financial situation that often makes them more vulnerable than hospitals in metropolitan areas. In short, many insurers simply do not pay rural hospitals enough to cover the cost of providing services in low-population and rural communities,[32] which directly threatens the viability of many rural hospitals

and EDs. Financial vulnerability and challenges covering the cost of round-the-clock physician services may play some role in a rural hospital's ability to staff a physician 24/7 in the ED, at least insofar as it can be more cost-effective for a rural hospital to use a physician's services somewhere outside the ED for higher reimbursement than in the ED.

However, while the cost associated with hiring physicians to be on-site in the ED 24/7 could contribute to a rural ED's financial vulnerability, the hurdles associated with such a requirement are not primarily financial. These organizations also experience challenges with recruitment and retention of qualified physicians to staff an ED 24/7. On top of that, low census and low patient acuity in many rural EDs may warrant different approaches to resource utilization than those pursued by larger metropolitan EDs, which may see higher patient volumes.

Physician Recruitment and Retention Issues

Rural hospitals offering emergency services grapple with workforce challenges. Because a relatively small percentage of physicians choose to practice in rural communities, the workforce inherently differs in rural areas from that of more metropolitan areas.[33] Physicians who work in rural areas report that they struggle to attract and retain physicians to staff the ED, and workforce data tends to support this. As mentioned above, a 2020 study found that only eight percent of emergency physicians were located in rural areas, with a mere two percent located in small rural areas.[34] Physicians in rural areas were also, on average, significantly older than their urban counterparts and nearing the retirement age, with most having completed their training at least 20 years prior to 2020.[35] And despite the fact that rural EDs may be more likely to staff physicians who are not specialty trained in emergency medicine, workforce research shows that less than a quarter of clinically active family medicine-trained emergency physicians practice in rural areas.[36] Physicians who work in rural areas report that staffing challenges sometimes compound on themselves: for example, rural hospitals may require new physicians to help meet ED staffing needs as a condition of employment—such as by requiring that the physician staff the ED multiple nights per week—which may be unattractive to physicians not keen on providing emergency medical services or keeping nighttime hours.

The density of physicians providing care in EDs decreased in both large and small rural areas between 2008 and 2020.[37] One group of researchers identified a band of underserved states from North Dakota to Texas with particularly bad shortages of emergency physicians (both residency-trained in emergency medicine and in other specialties). These shortage areas are represented in white and light green on the map below (Figure A).

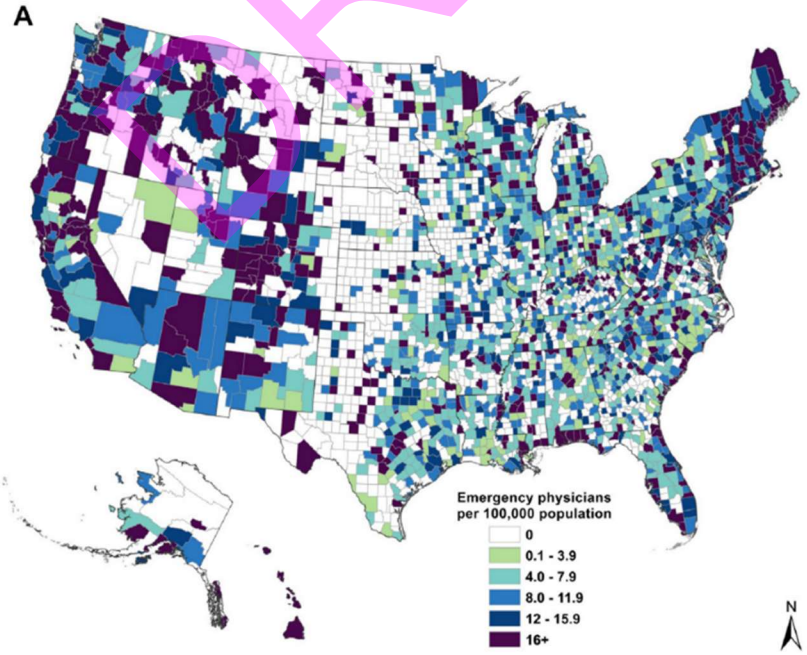

Figure A: density of emergency physicians across the country—emergency physicians per 100,000 population—includes physicians who are residency-trained or certified in emergency medicine and physicians trained in a non-emergency specialty. [38]

As a consequence of the physician shortage in rural areas—especially small rural areas—problems recruiting and retaining physicians to staff the ED emerge as a primary barrier to the ability of some rural hospitals to adhere to a 24/7 on-site physician requirement. Anecdotally, physicians on the ground in Nebraska, where at least 29 rural hospitals are at risk of closure,[39] report that "finances are not the problem"—rather, staffing is, and mention that a job listing seeking a physician to staff one ED in a remote area has been open for more than 18 months.[40] There is a concern that the inability to attract or retain a sufficient number of physicians to staff the ED on-site 24/7 in severe rural areas could result in ED closure should the proposed requirement be implemented. Further, the AMA Health Workforce Mapper and Geographic Mapping Initiative demonstrate that non-physician health care providers do not gravitate to rural areas even in states without a requirement for physician supervision or collaboration—as such, non-physicians cannot be assumed to be a robust workforce alternative to physicians.

Low Patient Volume and Low Acuity

Patient volume impacts the viability of rural hospitals and plays a role in staffing decisions. The patient volume of rural hospitals and affiliated EDs might vary significantly for several reasons, including the population of the community, the age and health status of the population, the availability of primary care options, and the accessibility of the hospital. However, rural physicians report that for many EDs—particularly ones in very remote areas—census is consistently low. Low census impacts the hospital's financial viability, in part due to a lack of service-based revenue, and because many commonly used quality measures cannot be employed when there are too few patients to reliably measure performance.[41] Patient volume also complicates decision-making around staffing models. EDs in remote areas may see lighter patient volume than urban EDs. Even though there are higher-volume EDs in some rural areas, and lower-volume EDs in some urban areas, one study found that a full 79 percentage of lower-volume EDs were located in rural areas.[42]

Survey data by non-medical chart reviewers using "a five-point scale, based on the immediacy with which the patient should be seen" provides some evidence that while visits to rural EDs have, on the whole, risen in the past 10 years, lower-acuity ED visits in rural areas may also be increasing.[43] However, that data contrasts with reports from the Emergency Department Benchmarking Alliance utilizing clinician determinations for ED patients' CPT codes that show an increase in acuity.[44] Rural physicians report that in the case of low-volume, low-acuity EDs—that is, where the ED sees light patient volume and where true emergencies are few and far between—it might become inefficient to staff the ED 24/7 with an on-site physician whose only duty is to see patients in the ED. Tending to support this, one study found that the presence of non-physician practitioners is higher among EDs that see fewer than 5,000 visits annually.[45] As discussed in more detail below, physician-led care that allows supervising physicians to provide services in areas of the hospital beyond just the ED may be appropriate for rural EDs with these characteristics.

The Importance of a Physician in Rural EDs

Even where patient volume is generally low, it is expected that patients facing life-threatening medical emergencies will present to the ED. When they do, it is critical that a physician be available to be on-site to provide care. A nurse practitioner or a physician assistant is not an adequate substitute for a physician in the ED: only physicians have the requisite training and experience to lead patient care. This remains true in rural hospitals. In rural hospitals—where there may be a dearth of community-based physicians in certain specialties that may be necessary to provide care for very high-acuity patients—assessment, stabilization, and arranging appropriate transfer of high acuity ED patients becomes critical. Physicians, who are trained in performing differential diagnosis and experienced in treating a broad range of acute illness and injury, are best equipped to provide this type of emergency care. As such, ideal rural ED staffing models will require the physical presence of a physician who might directly provide care to high-acuity patients.

24/7 Staffing Models and the On-site Presence of a Physician

As referenced in the Introduction to this report, AMA policy requires that all EDs be "staffed 24/7 by a qualified physician." This language does not necessarily imply the round-the-clock physical presence of a qualified physician. While the on-site presence of a qualified physician solely responsible for the ED is the preferred model for providing emergency medical services, some appropriate physician-led care models may allow a physician to be always staffed in certain rural EDs 24/7 but not necessarily physically present in that ED round the clock. This report explores three types of extended supervision models that require the staffing of and supervision by a physician in the ED (in alignment with AMA policy) but forego requirements that the physician be physically on-

site in the ED 24/7 or primarily responsible for care in that ED. Approaches like these may be appropriate for limited application in certain rural EDs, such as those facing the threat of closure or experiencing consistently low patient volume.
AMA policy supports physician-led care in all health care settings.[46] To be clear, for all the staffing models mentioned below, in any instance where a non-physician practitioner is on-site in the ED, that non-physician practitioner should be working as part of a physician-led care team under an appropriate collaboration or supervision agreement.

Permit Physicians to Perform Duties Beyond Staffing the ED

The proposed requirement would demand that an on-site physician in the ED be primarily responsible for supervising care in that ED. However, policies that allow supervising physicians to perform other duties in the hospital or health system beyond just staffing the ED may help rural EDs overcome staffing challenges and more efficiently leverage physician resources. This approach—sometimes called the "upstairs physician" model—may allow a physician who is supervising an especially low volume ED to perform rounds at the hospital or see patients at an outpatient clinic nearby to the ED (i.e., across the street or next door) in addition to seeing patients who present to the ED. Extending the reach of the ED physician in this way may make particular sense for rural EDs with low census.

Require that Supervising Physicians be Available but not Necessarily Physically Present

Some rural EDs currently require the *availability* of a supervising physician rather than the on-site physical presence of a physician. Under these staffing models, a supervising physician must be available to be physically present in the ED within a reasonable timeframe upon noticing that their services are necessary, for example within 20 minutes. These models work particularly well when emergency medical services are able to contact the ED or the supervising physician directly to inform them that a patient will be arriving by ambulance, thereby allowing the physician to meet the patient at the ED to provide emergency care. For lower-acuity patients, these physicians provide supervision under a supervision agreement.

Incorporation of Telehealth

Other models of extended supervision allow a physician to provide a degree of supervision via telehealth. Most recent research around telehealth use in the ED focuses on Tele-ED, a model that connects practitioners at rural or remote EDs, which may lack emergency medicine physicians or other specialists, to physicians at a well-resourced central hub ED through video technology. Literature suggests that most implementations of Tele-ED involve the connection of rural EDs to physicians who are "on call" for the rural ED (i.e., enlisted to provide consultation to fulfill the ED's obligations under the Emergency Medical Treatment and Active Labor Act) but they are often not supervising operations in that ED.[47] This is a great approach for bringing specialty expertise to under-resourced rural areas.

However, utilizing telehealth to supervise non-physicians in an ED raises other challenges. AMA Policy H-160.937, "The Promotion of Quality Telemedicine," supports the supervision of non-physicians via telehealth within certain parameters, recognizing that the physician retains the authority for, and safety and quality of services provided by the non-physician. The supervising physician must also be immediately available for consultation with ED non-physician staff and patients via telehealth. Importantly, AMA's Code of Medical Ethics 1.2.12, "Ethical Practice in Telemedicine" and other AMA policy on telehealth states that physicians have an obligation to ensure that the use of telehealth as a modality is appropriate for the type of medical care sought and individual patient needs. In other words, as a modality, telehealth must be medically appropriate for the care provided and needs of the individual patient, as well as aligned with clinical guidelines.

Real-time telehealth consultation may be part of an extended model of physician supervision of non-physicians in the ED. However, a telehealth-only supervision model does not allow for the physician to perform a physical examination or necessary interventions which may be crucial for high-acuity patients in an ED setting. Given the type of life saving, high-acuity care that may need to be provided in an ED and which necessitates the physical presence of a physician, a telehealth-only option may be inappropriate. Consequentially, telehealth-based supervision models may be best leveraged with local physicians and combined with other extended supervision

models—for example, a requirement that a physician supervising via telehealth also be in close proximity and available in-person on-site promptly to provide emergency care when needed.

Defining the Applicability of "Limited Rural Exceptions" to a 24/7 On-Site Physician Requirement

The preferred model of physician-led care in the ED is the full-time, on-site presence of a physician. However, "limited rural exceptions" to this ideal may be appropriate given the operational realities faced by certain rural EDs. The notion of "limited rural exceptions" to an on-site physician requirement calls for criteria to determine which rural EDs would qualify for such an exception. A blanket exception applicable to any ED located in a rural area may be so sweeping in breadth as to defeat the purpose of the requirement. This is supported by data from the American Hospital Association which suggests that a full 35 percent of American hospitals are located in rural areas,[48] as well as older research specific to emergency care finding that approximately 42 percent of American EDs are located in rural counties and estimating that these rural EDs see about 17 percent of all ED visits.[49] Further, not every rural hospital faces the challenges that make an on-site physician requirement impractical. Differences in EDs across the spectrum of rurality call for some nuance in determining which rural EDs might be most appropriately subject to an exception.

Likely, it is most appropriate to apply any exception to the subset of rural EDs located in the country's most remote areas that are likely to face insurmountable barriers to adherence to a 24/7 on-site physician policy. However, making proper delineations when it comes to the exception's applicability is difficult because there is no widely agreed-upon definition of "rural" or concrete spectrum of rurality. Also, rurality itself may not be determinative of the challenges most salient to the on-site supervision issue, such as low patient volume. Determinations made based on an EDs patient volume may therefore be worth considering; however, even low volume EDs may still see high acuity patients.

This report provides a few imperfect options for defining "rurality" and determining the subset of rural EDs that may most appropriately qualify for the exception at issue. Ultimately, there is no single best apparent one-size-fits-all approach; the characteristics and unique needs of each state will need to be considered when determining the scope of "limited rural exceptions" to a requirement that a physician always be on-site in the ED and primarily responsible for care in that ED.

Critical Access Hospital or Rural Emergency Hospital Status

One approach might base applicability of an exception on the U.S. Centers for Medicare & Medicaid Services' Critical Access Hospital (CAH) or Rural Emergency Hospital (REH) designation.
Hospitals classified as CAHs receive certain benefits that aim to reduce financial vulnerabilities, including cost-based reimbursement for Medicare services. A hospital's designation as a CAH would seem to imply a degree of rurality and the existence of an ED. Among other requirements, to become a CAH, a hospital must provide 24/7 emergency care and be located more than 35 miles from the nearest hospital (or 15 miles in mountainous terrain). Qualifying hospitals are also relatively small, maintaining 25 or fewer inpatient beds.[50] Given the ease of determining whether an ED is part of a CAH, and the fact that CAH designation would largely implicate small rural EDs, using CAH status as a basis for an exception to the on-site physician requirement might be an attractive option to policymakers. However, whether this approach would be adequately narrow in scope is worth considering. CAHs make up a sizeable portion of total hospitals across the country—about 22 percent of American hospitals (1,368 of the 6,120 hospitals in the United States). [51,52] Further, not all CAHs are in true rural areas; certain CAHs located within urban areas are "treated as being located in a rural area" for purposes of CAH designation.[53] As such, basing eligibility on CAH status alone may be overly inclusive.

Effective January 2023, CAHs and other small rural hospitals became eligible to apply for REH status in order to receive special Medicare payment for providing emergency services. Conversion to an REH is thought to prevent rural hospital closures.[54] To qualify for REH status, a hospital must be an acute care hospital with 50 or fewer inpatient beds, located in a rural area, and provide 24-hour emergency services as well as laboratory services, diagnostic radiologic services, and a pharmacy.[55] REHs generally provide outpatient care and cannot exceed an annual length of stay of 24 hours per patient. While REH status may indicate a degree of rurality and a small hospital size, the designation is quite new and not yet broadly utilized; further, not every state has passed legislation required to support REH status, and REH conversion may not be appropriate or feasible for all small rural hospitals.

U.S. Department of Agriculture Urban Influence Codes

The U.S. Department of Agriculture's (USDA) Urban Influence Codes (the Codes), which are applied at the county level, were developed to capture differences in economic opportunities among U.S. counties. The Codes distinguish metropolitan and nonmetropolitan areas, using population size of a metro area or the size of the largest city and proximity to both metro- and micropolitan areas.[56] The Codes are divided into a 12-part county classification made up of two metro and 10 nonmetro categories. Micropolitan and "noncore nonmetro" counties are classified by adjacency to and population of the county's largest town, which allows for a relatively fine rural-urban gradation that can be used by policy makers. [57] In short, the Codes may be useful in identifying rural counties, including remote areas—to indicate, Code 12 captures 182 "noncore" counties that are "not adjacent to [a] metro or micro area and [do not] contain a town of at least 2,500 residents."[58] As such, the Codes may be a feasible basis for determining rurality for the purpose of the limited rural exception at issue here. However, some concerns have been raised about the appropriateness of county-level determinations, both because there may be some very remote EDs on the outskirts of counties that are not considered remote under the Codes, and similarly, there may be non-remote EDs on the outskirts of counties that are generally considered very rural by the Urban Influence Code classification system.

Rural Urban Commuting Areas

The Economic Research Service (ERS) has established Rural Urban Commuting Areas (RUCA) codes using population data from the U.S. Census, urban area delineations from the U.S. Census Bureau, and commuting data from the American Community Survey. These codes apply to census tracts and make classifications using population density, urbanization, and daily commuting measures. USDA has published a version of the RUCA classifications that makes delineations by ZIP code, which makes it easy to determine a rural hospital's classification. RUCA classification contains 10 primary and 21 secondary codes. The primary codes reflect a spectrum of metropolitan and nonmetropolitan areas, with levels 4-10 loosely indicating a rural area. Notably, the U.S. Veteran's Health Administration relies on RUCA codes to determine rurality, making designations for urban, rural, and highly rural areas, whereby highly rural areas are tracts with a RUCA score of 10, (meaning that less than 10 percentage of workers travel to urbanized areas).[59] Importantly, though, these codes are not designed to represent a continuum of rurality—rather, each code has a specific meaning, and RUCA codes are interpreted and applied differently for every purpose for which they are used, which adds a layer of complication to the application of RUCA codes for the purpose considered here. Finally, there is some concern about the fact that some census tracts and ZIP codes are geographically very large, meaning that certain classifications may seem inappropriate.

Frontier and Remote Area Codes

Frontier and Remote Area (FAR) Codes were developed by USDA Economic Research Service and the Federal Office of Rural Health Policy to assist in policy-related considerations related to isolated areas of country, that is, areas with low population size and high geographic remoteness.[60] FAR codes were specifically designed to classify frontier and remote areas.[61] They apply at the zip-code level, are determined based on the time it takes to travel by car to nearby urban areas, and are assigned based on population size and travel time. FAR designations reflect a range of degree of remoteness, distributed from Level 1 to 4, with Level 4 being the most remote. While these codes uniquely reflect a spectrum of rurality that identifies frontier and remote areas, they have not been updated since 2010 and the literature suggests they are not widely used. Some research, however, determines that the FAR definition may work well for considerations of access to health care resources,[62] which may make them a viable option for determining rurality for purposes of an exception.

AMA POLICY

As mentioned in the Introduction to this report, AMA has extensive policy supporting physician-led care in all health care settings in addition to policy specific to physician-led care in EDs.

AMA policy supports physician-led, team-based care in all health care settings and covers the appropriate supervision of nurse practitioners and physician assistants. Relevant AMA polices include the following: Support for Physician Led, Team Based Care (D-35.985); Practicing Medicine by Non-Physicians (H-160.949); Scopes of Practice of Physician Extenders (H-35.973); Supervision of Non-Physician Practitioners by Physicians (D-35.978); Physician Assistants (H-35.989); Physician Assistants and Nurse Practitioners (H-160.947); and Guidelines for Integrated Practice of Physician and Nurse Practitioner (H-160.950).

AMA policy specific to care in EDs establishes AMA's support for legislation and regulation requiring physician-led care in the ED as well as AMA's support for "24/7 staffing" of EDs by physicians. See the following policies: On-Site Emergency Care (H-130.976) and Promoting Supervision of Emergency Care Services in EDs by Physicians (D-35.976).

Regarding telehealth, AMA Policy H-160.937 supports the supervision of non-physicians via telehealth within certain parameters.

DISCUSSION

The Board of Trustees is tasked with considering "limited rural exceptions" to a requirement, to be included in model legislation, that a physician always be on-site at the ED and primarily responsible for care in that ED always. To address this question, existing AMA policy and operational realities of rural EDs which may make the proposed requirement difficult to meet must be meaningfully examined.

AMA policy on this issue is robust and cannot be ignored. Our AMA has extensive policy supporting physician-led care in all health care settings, including the ED. AMA policy specific to care provided in EDs provides that only physicians should supervise care provided in EDs—this means that according to AMA policy, care should not be provided by non-physicians such as physician assistants or nurse practitioners in the absence of adequate physician supervision. On top of that, a new policy passed at the AMA 2024 Annual Meeting calls for "24/7 staffing" of the ED by a physician. In its consideration of possible rural exceptions to the proposed requirement, the Board must honor this codified AMA policy.

At the same time, it is clear that certain rural hospitals and EDs experience different financial and workforce challenges than those faced by EDs in metropolitan areas. This is evident based on a review of relevant literature as well as a series of focus-group style conversations with physicians and experts who work in very rural areas. Even though rural EDs are a key lifeline for patients in their communities, many are at risk of closure. Even so, while financial challenges are salient, physician recruitment and retention issues emerge as the most pressing barrier standing in the way of staffing certain EDs with an on-site, full-time physician. Further, if there is low patient volume and low patient acuity, this can make it inefficient to staff the ED with a physician who is only responsible for care in that ED—sometimes the physician's services may be most effectively put to use in other areas of the hospital or health system, even while that physician is supervising the ED. Altogether, the proposed requirement for an on-site, round the clock physician who is primarily responsible for care in the ED emerges as unfeasible for certain EDs, namely those in very remote rural areas which face both recruitment challenges and low patient volume. Indeed, should such a requirement be implemented in these very remote rural areas, EDs may face closure that would deprive local patients of access to emergency care.

The preferred model of physician-led care is the full-time, on-site presence of a physician. This is due to the nature of emergency medicine, in which, as articulated by ACEP, "patients present with a broad spectrum of acute, undifferentiated illness and injury, including critical life-threatening conditions."[63] As such, the on-site presence of a physician should be pursued in all cases and required wherever feasible. Model legislation developed by ACEP may be used in advocacy toward this objective. However, given the vulnerabilities and workforce limitations experienced by certain rural hospitals, "limited rural exceptions" to this preferred model may be acceptable if necessary. Round-the-clock physician-led care in the ED may still exist even in the absence of the on-site, full-time presence of a physician in the ED who is primarily responsible for care in that ED. It may be appropriate for the AMA to aid state medical associations who, based on the needs of the state, may choose to pursue certain alternative supervision models for care provided in EDs in remote rural areas, which may constitute a "limited rural exception" to the proposed requirement.

Possible supervision models may include requirements that a supervising physician be at all times available to be physically present in the ED within a reasonable amount of time, or they may include arrangements that allow a supervising physician to provide care in other, nearby areas of the hospital or health system in addition to managing care in the ED. Telehealth, when used appropriately, may also be incorporated into an appropriate alternative supervision model. In all cases, however, it is important that a physician maintain supervision of the ED and to ensure that a physician can be present to assess, stabilize, and manage high-acuity patients presenting to the ED. Without the availability of a physician's expertise, patient safety is put at risk.

While researchers have identified a band of localities—primarily rural—that face extreme emergency physician shortages, developing hard-and-fast criteria for the proper applicability of these rural exceptions is difficult to do at the national level. The composition of each state is highly variable, and the spectrum of rurality across the United States is broad. In any case, these rural exceptions likely most appropriately apply in very remote rural areas that face consistently low patient volume.

The recommendations provided herein aim to adhere to existing AMA policy while addressing the unique needs of rural EDs.

RECOMMENDATIONS

The AMA Board of Trustees recommends that the following be adopted in lieu of Resolution 207-I-23 entitled, "On-Site Physician Requirement for EDs," and the remainder of the report be filed:

1. That our American Medical Association recognize that the preferred model of emergency care is the on-site presence of a physician in the emergency department (ED) whose primary duty is to provide care in that ED, and support state and federal legislation or regulation requiring that a hospital with an ED must have a physician on-site and on duty who is primarily responsible for the emergency department at all times the emergency department is open.
2. That our AMA, in the pursuit of any legislation or regulation requiring the on-site presence of a physician who is primarily responsible for care in the emergency department (ED), will support state medical associations in developing appropriate rural exceptions to such a requirement if, based on the needs of their states, the association chooses to pursue certain alternative supervision models for care provided in EDs in remote rural areas that cannot meet such a requirement due to workforce limitations, ensuring that exceptions only apply where needed. These exceptions shall preserve 24/7 physician supervision of the ED and provide for the availability of a physician to provide on-site care.

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3. STARK LAW SELF-REFERRAL BAN

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

At the 2023 Interim Meeting, the House of Delegates referred Resolution 227-I-23, sponsored by the Private Practice Physicians Section. Resolution 227-I-23 asks the American Medical Association (AMA) to: 1) recognize the substantial impact of the Stark law's unequal restrictions on independent physicians; 2) support comprehensive Stark law reform aimed at rectifying the disparities by ending the ban on self-referral practices; and 3) advocate for equitable and balanced Stark law reform that fosters fair competition, incentivizes innovation, and facilitates the delivery of high-quality, patient-centered care.

The Reference Committee heard mixed testimony concerning Resolution 227. Some testimony stated that the Stark law has contributed to health care market consolidation. Other testimony noted that AMA policy opposes and calls on the AMA to continue to advocate against the misuse of the Stark law and regulations to cap or control physician compensation. Testimony highlighted that the Stark law includes an exception (the in-office ancillary services exception) that allows physicians in independent practices to self-refer Medicare and Medicaid patients, subject to certain requirements. For these reasons, the HOD referred Resolution 227 for a report to be considered at the 2024 Interim Meeting.

BACKGROUND

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. For example, if a physician invests in an imaging center, the Stark law requires the resulting financial relationship to fit within an exception or the physician may not refer patients to the facility and the entity may not bill for the referred imaging services.

"Designated health services" are:

- clinical laboratory services;
- physical therapy, occupational therapy, and outpatient speech-language pathology services;
- radiology and certain other imaging services;
- radiation therapy services and supplies;
- DME and supplies;
- parenteral and enteral nutrients, equipment, and supplies;
- prosthetics, orthotics, and prosthetic devices and supplies;
- home health services;
- outpatient prescription drugs; and
- inpatient and outpatient hospital services.

The Stark law is a strict liability statute, which means proof of specific intent to violate the law is not required. The Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. Penalties for physicians who violate the Stark law include fines as well as exclusion from participation in federal health care programs.

AMA POLICY AND ADVOCACY

The AMA has longstanding policy on the issue of self-referral by physicians. AMA Policy H-140.861, "Physicians' Self-Referral," states that physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services, when they have a financial interest in that facility.

In a similar vein, the AMA has well developed policy regarding physician ownership and referral for imaging services. AMA Policy D-270.995, "Physician Ownership and Referral for Imaging Services," states that the AMA will work collaboratively with state medical societies and specialty societies to actively oppose any and all federal and state legislative and regulatory efforts to repeal the in-office ancillary services exception to physician self-referral laws, including as they apply to imaging services.

In addition, the AMA has adopted principles emphasizing that, in regard to their involvement with Accountable Care Organizations (ACOs), the physician's primary ethical and professional obligation is the well-being and safety of the patient. AMA Policy H-160.915, "Accountable Care Organization Principles," emphasizes in Clause 5 that federal and state anti-kickback and self-referral laws and the federal Civil Monetary Penalties statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs.

Also, H-385.914, "Stark Law and Physician Compensation," calls on the AMA to oppose and continue to advocate against the misuse of the Stark law and regulations to cap or control physician compensation.

Finally, AMA Code of Medical Ethics 9.6.9, "Physician Self-Referral," states that, in general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility.

DISCUSSION

The Board understands and recognizes the challenges the Stark law may pose on many physician practices. The Board also recognizes that restrictions on self-referral may be a contributing factor to market consolidation. Some Stark waivers for integrated systems may put independent physicians at a disadvantage and thus contribute to consolidation. Although there is some overlap between the Anti-Kickback Statute and the False Claims Act, without an increase in Stark law waivers independent physicians are not on an even playing field. An additional waiver to allow hospitals to support independent physicians in quality improvement initiatives could lead to better care coordination and efficiency. The Stark law also includes a physician-owned hospital exception for existing physician owned hospitals. H.R. 1330 specifically targets the Stark law prohibition on physician ownership of hospitals. Current AMA policy, however, generally addresses the concerns expressed in this resolution. For example, AMA policy opposes and advocates against the misuse of the Stark law and regulations to cap or control physician compensation. Resolution 227 indicates that the Stark law provides a "blanket ban on self-referral practices." This, however, is not the case. The Stark law contains numerous exceptions, which if met, allow physicians to self-refer, e.g., when physicians self-refer to risk-bearing arrangements. Most importantly for the purposes of this report, the Stark law has a broad exception for both ownership interests and compensation arrangements that applies specifically to physician practices—the in-office ancillary services exception. Regarding any contributing factor the Stark law may have on consolidation, the AMA has extensive policy addressing issues raised by consolidated hospital markets and advocates aggressively with the goal of preventing further consolidation in those markets and restoring competition in those markets. If the Stark law were repealed, then the consolidated systems would have even less restriction, which may disadvantage the independent physician even more. Thus, a more focused approach may be better in addressing specific issues. The AMA supports the development of additional Stark law waivers that allow independent physicians, in addition to employed or affiliated physicians, to work with hospitals or health entities on quality improvement initiatives which may address issues including care coordination and efficiency.

RECOMMENDATION

The Board of Trustees recommends that the following policy be adopted in lieu of Resolution 227-I-23, and the remainder of the report be filed.

1. That our American Medical Association reaffirm AMA Policies H-140.861, "Physicians Self-Referral," D-270.995, "Physician Ownership and Referral for Imaging Services," and H-385.914, "Stark Law and Physician Compensation," be reaffirmed. (Reaffirm HOD Policy)

2. That our American Medical Association supports initiatives to expand Stark law waivers to allow independent physicians, in addition to employed or affiliated physicians, to work with hospitals or health entities on quality improvement initiatives to address issues including care coordination and efficiency. (New HOD Policy)

APPENDIX AMA POLICY

H-140.861, Physicians' Self-Referral
Business arrangements among physicians in the health care marketplace have the potential to benefit patients by enhancing quality of care and access to health care services. However, these arrangements can also be ethically challenging when they create opportunities for self-referral in which patients' medical interests can be in tension with physicians' financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as trust in the profession.

In general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationships--including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices--are expected to uphold their responsibilities to patients first. When physicians enter into arrangements that provide opportunities for self-referral they must:
(1) Ensure that referrals are based on objective, medically relevant criteria.
(2) Ensure that the arrangement:
(a) is structured to enhance access to appropriate, high quality health care services or products;
(b) within the constraints of applicable law:
(i) does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation;
(ii) does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and
(iii) adheres to fair business practices vis-a-vis the medical professional community--for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.
(3) Take steps to mitigate conflicts of interest, including:
(a) ensuring that financial benefit is not dependent on the physician-owner/investor's volume of referrals for services or sales of products;
(b) establishing mechanisms for utilization review to monitor referral practices; and
(c) identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.
(4) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral.

D-270.995, Physician Ownership and Referral for Imaging Services
Our AMA will work collaboratively with state medical societies and specialty societies to actively oppose any and all federal and state legislative and regulatory efforts to repeal the in-office ancillary exception to physician self-referral laws, including as they apply to imaging services.

H-385.914, Stark Law and Physician Compensation
Our AMA opposes and continues to advocate against the misuse of the Stark Law and regulations to cap or control physician compensation.

4. ADDRESSING WORK REQUIREMENTS FOR J-1 VISA WAIVER PHYSICIANS

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATION ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 217-I-23 REMAINDER OF REPORT FILED
See Policy D-255.972

INTRODUCTION

At the 2023 Interim Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 217 entitled, "Addressing Work Requirements for J-1 Visa Waiver Physicians," was introduced by the International Medical Graduates Section and called on the AMA to:

- Acknowledge that the requirement of 40-hours of direct patient care could impose a burden on IMG physicians and may hinder opportunities for professional growth; and
- Advocate for a revision in the J-1 waiver physician's requirement, proposing a transition to a comprehensive 40-hour work requirement that encompasses both direct clinical responsibilities and other professional activities.

Resolution 217 was referred to the Board of Trustees. One of the primary reasons for referral was the need for additional information concerning the accuracy of the 40-hours of direct patient care requirement as it relates to J-1 visa waivers.

BACKGROUND

J-1 Visas

A J-1 visa is a nonimmigrant exchange visitor visa that allows an individual to participate in an exchange visitor program in the United States.[1] In order to receive a J-1 visa there is a significant process that takes place that includes (but is not limited to) applying for the visa, participating in a visa interview, being accepted into a qualifying program, demonstrating certain competencies, providing a statement of need from the country of last permanent residence, and, except in very limited circumstances, being sponsored by the Educational Commission for Foreign Medical Graduates (ECFMG).[2] Once a J-1visa is acquired, the physician is expected to advance through training in the U.S. for up to seven years, though the length of the visa is usually limited to the time typically required to complete a program per the Accreditation Council of Graduate Medical Education (ACGME) and/or the American Board of Medical Specialties (ABMS).[3]

As part of these requirements, an individual who is in the U.S. on a J-1 visa must be enrolled in a "full course of study." For international medical graduates (IMGs), this means that they must participate "in a program in which a foreign medical school graduate will receive graduate medical education or training, which generally consists of a residency or fellowship program involving health care services to patients, but does not include programs involving observation, consultation, teaching or research in which there is no or only incidental patient care. This program may consist of a medical specialty, a directly related medical subspecialty, or both."[4] No specific hour requirements are given in the definition of a "full course of study." However, per ACGME, the clinical and educational work hours of residents "must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting."[5]

H-1B Visa

An H-1B visa is a nonimmigrant visa for individuals who want to perform a specialty occupation in the U.S.[6] In order to qualify for an H-1B visa the individual must engage in an occupation that requires the "theoretical and practical application of a body of highly specialized knowledge," attain a bachelor's degree or higher, and must engage in a job that requires the individual to have a bachelor's degree or higher.[7] For an H-1B worker, full-time employment is defined as 40 hours per week unless the employer can demonstrate that less than 40 hours per week is the regular course of business for the profession. However, full-time work may not drop below 35 hours of work per week.[8] Moreover, the statutes do not define what tasks the H-1B visa holder must undertake during the 35-to-40-hour work week.

J-1 Visa Waiver

If an individual participates in the J-1 visa program, and is in graduate medical education or training, a strict two-year home country physical presence requirement attaches to the individual per section 212(e) of the Immigration and Nationality Act.[9,10] This requirement is commonly referred to as the "home country return requirement" and means that the individual must return to their home country for a total of at least two years before they can change status, adjust status, receive an immigrant visa, or receive a temporary worker visa.[11]

To forgo the home country return requirement, some IMGs choose to participate in a waiver program. The waiver programs require that IMGs:

- Have been admitted to the U.S. in J-1 visa status to receive graduate medical training.
- Obtain a statement of "no objection" from their home country.
- Demonstrate a bona fide offer of full-time employment at an accepted facility.
- Begin employment within 90 days of receiving the waiver.
- Agree to work for not less than three years in that position.
- Upon acceptance into a waiver program, the Attorney General will change the IMG's visa status from J-1 to H-1B.

The U.S. Department of State (DOS) considers full-time employment to be 40 hours per week.[12] Additionally, U.S. Citizen and Immigration Services has noted that if a noncitizen physician averages, or will average, 40 hours per week, while working a minimum of 35 hours per week, that individual may be considered to have met the full time employment requirement.[13] However, these requirements do not specify what type of work must be undertaken within those hours.

Federal Government Agency Waivers

Any U.S. federal government agency can request a J-1 waiver for a physician.[14] However, at the federal level these requests are most frequently made for IMGs by the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Veterans Affairs (VA).

HHS has its own U.S. Exchange Visitor Program related to health research and clinical care. HHS can submit a waiver request to DOS on behalf of a physician that either preforms research in an area of priority or significant interest to the agency or provides health care services for a minimum of three years in a mental health or primary care Health Professional Shortage Area (HPSA).[15] To qualify for an HHS waiver, the physician must have completed their residency training no more than 12 months before the start of their employment through HHS.[16] Moreover, through the HHS waiver the physician must agree to work 40 hours per week providing primary care (family practice, general internal medicine, general pediatrics, or obstetrics/gynecology) or general psychiatric services.[17] This requirement does not specify that the services rendered must include 40 hours of direct patient care.[18]

The VA can also request visa waivers on behalf of physicians. For physicians that work for the VA the VA hospital that they work at does not have to be in an underserved area and instead of a three-year contract, the physicians must have a signed memorandum of agreement between themselves and the hospital.[19] Through the VA waiver the physician must agree to work 40 hours per week fulfilling the duties of the position including using 51 percent or

more of their time engaging in patient care duties at the Veterans Health Administration (VHA).[20] Again, this requirement does not specify that the services rendered must include 40 hours of direct patient care.

Conrad 30 Waiver Work Hour Requirements

One of the main waiver programs is the Conrad 30 Waiver Program, which is run through Regional Commissions and State Departments of Public Health or their equivalent.[21] In order to be eligible for the Conrad 30 Waiver Program, the physician must:

- Hold a J-1 visa.
- Have a bona fide full-time employment contract to practice medicine in H-1B nonimmigrant status for at least 3 years at a health care facility located in an area designated by HHS as a HPSA, Medically Underserved Area (MUA), or Medically Underserved Population (MUP) or serving patients who reside in a HPSA, MUA, or MUP geography.
- Have a "no objection" statement from their home country.
- Begin working at the approved health care facility within 90 days of receiving the waiver.[22]

Conrad 30 waiver recipients are required to work full time, which is defined as 40 hours per week.[23] There are no statutory requirements that these 40 hours must be comprised solely of direct patient care. However, individual states can set work hour requirements in their Conrad 30 waiver employment contracts.

As shown in Appendix A, the work hour requirements of individual states and regional commissions varies. While most states only require 40 hours of work per week in their Conrad 30 waiver contracts, without noting specific requirements about how that time must be spent, there are several states that do require a minimum number of hours of direct patient care (e.g., 32 hours, 40 hours).

Also, there are other federal programs intended to encourage physicians to practice in underserved areas, similar to the J-1 waiver program, that do require a minimum number of hours of direct patient care. For example, the National Health Service Corps requires physicians that are accepted to the program to work full-time which is defined as working "a minimum of 40 hours per week in a clinical practice, for a minimum of 45 weeks per service year, in a National Health Service Corps approved service site."[24] Of those 40 hours at least 36 hours each week must be spent providing direct patient care.[25] Other federal programs specify clinical practice hours without specifying direct patient care hours. The Indian Health Service Loan Repayment Program requires physicians to engage in full-time clinical practice which is defined "as working a minimum of 80 hours every two-week period for an average of at least 40 hours per week."[26] Moreover, for those physicians engaging in the Public Service Loan Forgiveness Program, they must work full-time which is defined as meeting the employer's definition of "full-time" or working at least 30 hours per week, whichever is greater.[27]

DISCUSSION

One of the whereas clauses in Resolution 217 states that "for a waiver application, physicians must possess a full-time employment contract, involving at least 40 hours of work per week as a direct care physician." This, however, is inaccurate. Though all J-1 waivers require IMGs to engage in full-time employment, which is considered to be an average of 40 hours per week, there is no statutory requirement that an IMG provide 40 hours of "direct" patient care per week. Instead, as noted in Appendix A, the work hour requirements that apply to J-1 waivers vary by state, regional commission, and federal agency. Moreover, the majority of states do not specify that an IMG utilizing a waiver must engage in 40 hours of direct patient care a week. Since the federal statutes that govern J-1 waivers do not have a requirement that IMGs must provide 40 hours of direct patient care each week, there is no need to advocate for a revision in the J-1 waiver requirements. Instead, it is up to the states to decide if they will require their J-1 waiver recipients to provide direct patient care or not.

It is important to acknowledge, however, the burden that IMGs experience when they do provide 40 hours of direct patient care per week, including having trouble balancing administrative tasks and not having opportunities for professional growth. Testimony from the 2023 Interim Meeting noted that physicians who are required to provide 40 hours of direct patient care a week find it difficult to navigate the complexities of continuous patient care while also aiming to dedicate time to administrative responsibilities and pursue non-clinical leadership roles. Testimony noted

that this rigid structure hampers IMGs' abilities to effectively deliver high-quality medical services while fostering their own professional progress.

CONCLUSION

Given that there is no federal statutory requirement for physicians utilizing J-1 visa waivers to provide direct patient care, the Board believes that Resolution 217-I-23 should not be adopted. However, as discussed above, some states and federal programs have established minimal direct patient care requirements. IMGs in these states may experience challenges balancing administrative tasks and may not have the same opportunities for professional growth as IMGs in other states. The Board is not in a position to determine where the balance lies, but believes that, generally, J-1 visa waiver recipients should have time within their 40-hour work week to provide direct patient care, engage in administrative duties, participate in professional development opportunities, and undertake other professional responsibilities. The Board therefore recommends adoption of policy consistent with this goal.

RECOMMENDATIONS

The Board of Trustees recommends that the following policy be adopted in lieu of Resolution 217-I-23, and the remainder of the report be filed:

Our American Medical Association advocate for federal visa and visa waiver policies to include time for administrative tasks, professional development opportunities, and other professional responsibilities within the federally mandated work week requirements for direct patient care.

APPENDIX A: STATE WORK REQUIREMENTS FOR J-1VISA WAIVER RECIPIENTS

State	Work Hour Requirements
States With 40 Hour Direct Patient Care Requirement	
Alabama	Primary care and mental health physicians must engage in direct patient care at least 40 hours per week (exclusive of hospital rounds and inpatient care).[28]
Florida	The physician will practice a minimum of 40 hours per week of direct patient care.[29]
Iowa	Direct care services must be provided for a minimum 3-year term and not less than forty (40) hours per week starting the first day of employment.[30]
Kansas	The physician must serve in the clinical practice of his/her profession full time, a minimum of 40 hours per week providing direct patient care at the approved practice site(s).[31]
New Mexico	Physicians must provide direct patient care services 40 hours per week.[32]
Ohio	The physician must spend a minimum of 40 hours per week in direct clinical care.[33]
Pennsylvania	The physician must practice a minimum of 40 clinical hours in direct patient care per week.[34]
South Carolina	The physician must spend a minimum of 40 hours weekly to provide care only.[35]
Utah	Physicians must provide direct patient care services 40 hours per week.[36]
Vermont	Physicians must work a minimum of 40 hours weekly to provide patient care only.[37]
Virginia	The physician will provide direct patient care for at least 40 hours per week.[38]
Washington	The physician will work not fewer than 40 hours per week providing direct clinical patient services.[39]
West Virginia	Full-time practice means providing hands-on, direct patient care for a minimum of 40 hours per week.[40]
Appalachian Regional Commission	The physician must agree to provide direct patient care for at least forty (40) hours a week.[41]
Delta Regional Authority	The physician must agree to provide 40 hours per week or 160 hours per month of direct patient care.[42]
Southeast Crescent	The physician must agree to provide 40 hours per week or 160 hours per month of direct patient care.[43]

Regional Commission	
States with 32 Hour Direct Patient Care Requirement	
Louisiana	The contract must state that the physician is a full-time employee working a minimum of 40 hours per week or 160 hours per month. The hours may include 8 hours of administrative time per week. This will not include hours in teaching settings, supervising residents, fellows, or students, supervising a clinic, or other administrative work.[44]
Maine	The physician must be employed full-time with the facility with 32 of the 40 hours spent providing direct patient care.[45]
Maryland	The physician must practice a minimum of 40 hours per week (at least 32 of the required 40 hours must be in direct patient care).[46]
New Hampshire	Physicians must work a minimum of 40 hours per week in an outpatient, clinical setting. At least 32 hours of the required 40 hours per week must be spent providing direct patient care in the outpatient ambulatory care setting at the approved service site. The remaining eight (8) hours must be spent providing clinical services for patients in the approved service site(s), in alternative settings (e.g., hospitals, nursing homes, shelters, etc.) as directed by the approved site(s), or in administrative activities. OB/GYN physicians, Family Practice physicians (who practice obstetrics on a regular basis) and Psychiatrists: the majority of the 40 hours per week (no less than 21 hours per week) is expected to be spent providing direct patient care. The remaining 19 hours must be spent providing inpatient care at the approved service site; providing clinical services in alternative settings (e.g., hospitals, nursing homes, shelters, etc.), as directed by the approved practice site(s); or performing practice related administration. Practice–related administrative activities shall not exceed 8 hours of the minimum 40 hours per week.[47]
North Carolina	The physician will provide at least forty (40) hours per week of clinic time that includes at least 32 hours per week in direct face-to-face patient care.[48]
South Dakota	The physician will perform an average of 40 hours of medical practice per week, meaning a four-week minimum of 128 hours seeing patients on an ambulatory or in-patient basis and 32 hours of administrative work for at least 48 weeks per year. Subject to approval by the Department, the physician may opt to practice down to a minimum of 64 hours per four-week period of direct patient care within the shortage area identified in the contract. In such instances, the J-1 physician will provide up to 96 additional hours per week under any of the following conditions: providing care to patients in either the hospital inpatient or outpatient department if the hospital is shown to serve a significant portion of shortage area residents; clinical outreach to underserved populations residing in a shortage area, whether directly in person or by electronic means; public health services if approved by the department; or direct patient care in a facility or setting that serves the underserved.[49]
Wisconsin	The physician must agree to work full-time (40 hours per week), with at least 32 hours per week spent in direct patient care.[50]
States With No Specific Direct Patient Care Requirement	
Alaska	Physicians will work for no less than 40 hours a week for three years.[51]
Arizona	Physicians must work 40 hours per week at an eligible service site.[52]
Arkansas	Physicians must provide primary or specialty medical care to patients for a minimum of 40 hours per week.[53]
California	The physician must practice medicine full-time.[54]
Colorado	The physician must practice full time in an underserved area for three years.[55]
Connecticut	The Physician Applicant will commit to three (3) years of full-time employment.[56]
Delaware	The site will employ the physician on a full-time basis (minimum of 40 hours per week).[57]
Georgia	The physician will practice medicine at least 40 hours per week (or at least 80 hours per two-week period) at the approved practice site(s) in the approved discipline for a minimum of three years.[58]

Hawaii	The physician must secure an employment contract to provide patient care for at least 40 hours per week.[59]
Idaho	The physician will engage in full-time (40 hours) employment at a health facility.[60]
Illinois	The physician will engage in full-time (40 hours) employment at a health care facility.[61]
Indiana	The physician will engage in full-time employment (at least 40 hours per week) at one or more eligible service sites.[62]
Kentucky	Physicians must work full-time (at least 40 hours per week at the approved worksite).[63]
Massachusetts	The physician must agree to practice medicine for a minimum of 40 hours per week providing clinical care only. Clinical care can include paperwork and phone calls related to patient care.[64]
Michigan	The physician will practice medicine (as defined by the signed contract with employer) for at least 40 hours per week.[65]
Minnesota	The physician must agree to work at the health care facility for at least 40 hours per week. Contracts that include protected time for activities other than patient care, such as research or teaching, must specify how many hours per week will be dedicated to those activities and how many hours per week will be dedicated to patient care.[66]
Mississippi	The physician must have an employment contract indicating full-time (40 hours per week) employment with the sponsoring medical facility.[67]
New Jersey	The physician must work for a minimum of forty (40) hours per week.[68]
New York	The physician will practice on a full-time basis providing patient care for a minimum of 40 hours per week.[69]
North Dakota	The physician will work full time (40 hours per week).[70]
Oklahoma	Full-time employment is defined as an average of 40 hours per week.[71]
Oregon	The physician will provide not less than 40 hours per week of patient services.[72]
Rhode Island	The physician must have a 40-hour, three-year position in a job consistent with the Department's mission.[73]
Tennessee	Each physician specialist must agree to practice his or her specialty in affiliation with the hospital for a minimum of forty (40) hours per week.[74]
Texas	The physician will provide patient care for a minimum of 40 hours per week.[75]
Wyoming	The physician must practice medicine a minimum of 40 hours per week.[76]
Northern Border Regional Commission	The physician must agree to practice primary medical care at least forty (40) hours a week.[77]

APPENDIX B: AMA POLICY

The following AMA policy is relevant to this Board Report:

J-1 Visas and Waivers D-255.993

1. Our AMA shall encourage HHS and other interested government agencies to continue sponsorship of the J-1 visa waiver program.
2. If the USDA does not continue in its role as an interested government agency (IGA), the AMA encourage HHS to expand its J-1 visa waiver program.
3. Our AMA will work with federal agencies to ensure better coordination of federal, state, and local agencies in monitoring the placement and enforcement of physicians service requirements through the J-1 waiver and Conrad-30 programs with a report back at A-03.
4. Our AMA will work towards regulation and/or legislation to allow physicians on H-1B visas for their J-1 visa waiver, who are limited to serving in medically underserved areas, to continue to care for their patients who require hospitalization in the closest appropriate medical facility which may not be in the underserved area.
5. Our AMA will work with state medical societies to study and report back on the feasibility of having a national data repository of J-1 Visa Waiver statistics so that J-1 Visa Waiver unoffered positions can be transferred to states as needed to treat underserved communities and to monitor the success of this program.

Conrad 30 - J-1 Visa Waivers D-255.985

1. Our AMA will:
    a. lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program;
    b. advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state;
    c. advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages;
    d. publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program;
    e. advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage;
    f. work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and
    g. continue to communicate with the Conrad 30 administrators and IMGS members to share information and best practices in order to fully utilize and expand the Conrad 30 program.
2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program.
3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs.
4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses.
5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA Litigation Center, if it meets the Litigation Center's established case selection criteria.

Expedited Immigrant Green Card Visa for J-1 Visa Waiver Physicians Serving in Underserved Areas D-255.976

Our American Medical Association will advocate that physicians who are on J-1 visas be granted a waiver and H-1B status for serving in underserved areas, be given highest priority in visa conversion to green cards upon completion of their service commitment, and be exempt from the per country limitation of H-1B visa to green card conversion.

J-1 Exchange Visitor Program (J-1 Visa) H-255.975

1. Policy of the AMA states: the purpose of the physician J-1 Visa Exchange Program is to ameliorate physician specialty shortages in other countries; and the AMA will work to correct the problems of inconsistency, lack of accountability, and non-compliance in the administration of the physician J-1 Visa Exchange Program.
2. Our AMA supports a model employment contract specific to J-1 Visa Waiver physicians.

AMA Principles on International Medical Graduates H-255.988

Our AMA supports:

1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.

8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement: (a) completion of medical school and residency training outside the U.S.; (b) extensive U.S. medical practice; and (c) evidence of good standing within the local medical community.

13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
23. Continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.

24. Continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.
25. Advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.

Visa Complications for IMGs in GME D-255.991

1. Our AMA will:
   a. work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice;
   b. promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and
   c. work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

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5. PROTECTING THE HEALTH OF INCARCERATED PATIENTS

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: **RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 202-I-23 REMAINDER OF THE REPORT FILED**
See Policies D-430.997, H-430.986 and H-430.997

INTRODUCTION

At the 2023 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 202-I-23 authored by the Medical Student Section for report at the 2024 Interim Meeting. The resolution asked, “That our American Medical Association advocate against the use of for-profit prisons” and “That our AMA advocate for for-profit prisons, public prisons with privatized medical services, and detention centers to be held to the same standards as prisons with public medical services, especially with respect to oversight, reporting of health-related outcomes, and quality of health care.”

This report provides background information on private (also referred to as "for-profit") correctional facilities and private companies providing health care services to public correctional facilities. This report further discusses the role of our AMA in ensuring that appropriate, quality health care is provided to inmates in all facilities, regardless of private or public status. Finally, this report recommends reaffirming existing AMA policy.

BACKGROUND

Private Correctional Facilities

In this report, "correctional facility" includes a jail, prison, or other detention facility used to house people who have been arrested, detained, held, or convicted by a criminal justice agency or a court. "Prisons" are facilities under state or federal control where people who have been convicted (usually of felonies) go to serve their sentences. "Jails" are city- or county-run facilities where a majority of incarcerated people are there awaiting trial (in other words, still legally innocent), many because they cannot afford to post bail. However, some people do serve their sentences in local jails, either because their sentences are short or because the jail is renting space to the state prison system.[1]

The U.S. has the highest rate and number of incarcerated individuals in the world, with 1.9 million people in the carceral system.[2] This includes individuals in 1,566 state prisons, 98 federal prisons, 3,116 local jails, 1,323 juvenile correctional facilities, 142 immigration detention facilities, and 80 Indian country jails, as well as in military prisons, civil commitment centers, state psychiatric hospitals, and prisons in the U.S. territories.[3] To complicate matters further, approximately eight percent of all incarcerated persons are in private prisons.[4] Given that the U.S. does not have one criminal legal system, but rather thousands of federal, state, local, and tribal systems, and the significant amount of churning in and out of facilities that occurs, it is impossible to generalize about conditions in facilities across the nation.

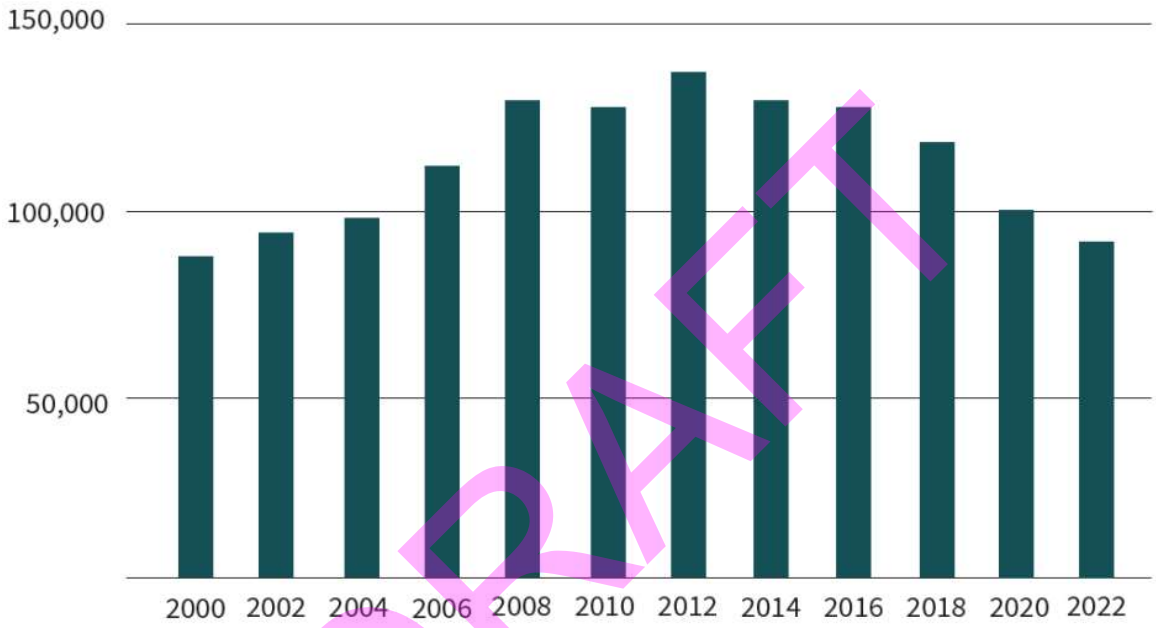
The War on Drugs in the 1970s and harsher sentencing policies, including mandatory minimum sentences, in the 1980s, contributed to a rapid expansion in the nation's incarcerated population. In 1994, former President Bill Clinton signed the Violent Crime Control and Law Enforcement Act into law. The act gave an additional $9.7 billion in funding towards the construction of new prisons. It also created the three-strikes law.[5] The burden on publicly funded prisons led to the rise of for-profit private prisons in many states and at the federal level.[6] Private prisons were seen by many policymakers in state and federal government as an effective solution to the rapid increase of inmates because they arguably could house more of them at a lower cost than state or federal prisons. Congress helped with public funding through the Appropriations Act of 1996, which amended the entire text of Subtitle A of the 1994 Violent Crime Control and Law Enforcement Act and included language specifically authorizing states to use the funding for privatization.[7]

The number of people incarcerated in private prison facilities increased 47 percent while the overall prison population increased only nine percent between 2000 and 2016.[8] At the state level, 27 states used private prison beds, with contracts ranging from 12 in South Carolina to 13,692 in Texas. Six states more than doubled the number of individuals in private prisons between 2000 and 2016, with Arizona having the largest increase, holding 479 percent more people in private facilities during that time period.[9] Privatization in the federal correctional system grew even more than among the states. The number of federal prisoners held in private facilities rose 120 percent from 15,524 in 2000 to 34,159 in 2016, while the number of state prisoners incarcerated privately grew only by 31 percent over the same time period, from 71,845 to 94,164.[10] In 2022, a total of 27 states were utilizing private companies to run some of their correctional facilities.[11]

After a reduction in the overall federal prison population beginning in 2014 and a small decrease in the private prison population, President Obama's Department of Justice (DOJ) decided to phase out federal private for-profit prison contracts.[12] However, the Trump Administration reversed this plan and indicated that the Bureau of Prisons (BOP) would continue to rely on private facilities.[13] This was despite numerous concerns raised by policymakers and advocates about the quality of services and safety in private correctional facilities, which have existed since the growth of the private corrections industry, including a comprehensive report released in August of 2016 by the Office of the Inspector General of the DOJ. This report reviewed the BOP's monitoring of contract prisons and found that contract prisons had more safety and security-related incidents per capita than BOP institutions for most of the indicators that were analyzed, that site visits revealed safety and security concerns and inappropriate housing assignments, and that the BOP's monitoring of contract prisons needed improvement.[14]

Despite the claims of their proponents that private facilities are more cost-efficient at providing services than publicly-run institutions, various studies conducted in the late 1990s and 2000s at both the federal and state levels did not support such assertions.[15] In addition, private prison companies are challenged by reducing costs while at the same time providing adequate services necessary to maintain security and safety, and doing so while also generating a profit for their shareholders.[16] Private prisons have been critiqued by many for prioritizing revenue over rehabilitating incarcerated individuals. Faced with these challenges, the private prison population has been steadily decreasing since 2012, as shown in the chart below.[17]

Number of People in Private Prisons, 2000-2022



In January 2021, as his term began, President Biden signed an executive order which directed the DOJ to phase out the federal criminal system's use of private prisons and eliminate their use. Since this executive order was signed, the BOP has ended its contracts with all for-profit prisons and has transferred the remaining inmates to other Bureau of Prison locations.[18] While this was an important step in limiting the transfer of federal funding to for-profit corporations, it did not cover the federal use of for-profit immigration detention facilities. And, according to an analysis from the American Civil Liberties Union (ACLU) National Prison Project, the U.S. Marshals Service continues to hold nearly a third of its entire detention population in for-profit facilities, totaling 20,000 people. The Marshals Service has obtained waivers from the Biden Administration that allow it to basically ignore the executive order and keep five for-profit facilities open. According to the ACLU, the Marshals Service is also skirting the requirements of the executive order through pass-through agreements, whereby the Service pays a city or county government, which keeps part of the payment and passes along most of the payment to the corporation that runs the facility.[19] An internal government investigation found that these agreements cost the Marshals Service more and provide less control and oversight over operations at its detention facilities.[20]

Privatized Health Care in Correctional Facilities

Privatized health care in federal prisons is a multi-billion-dollar industry led by a handful of companies.[21] Those contracted with these private health care providers pay them a fixed price, regardless of the level of care. Moreover, the company can retain any money that is not spent on health care services. The incentive for these prisons to contract with health care companies is that these privatized health care companies protect prisons from liability through indemnification provisions.[22] These indemnification provisions present themselves as contracts between health care companies and prisons that place the company in a position where they are liable for all liability-related expenses in prison. Critics have stated that this protection enables prisons to prioritize company profits over the

wellness of inmates.[23] This includes reports of prison health care services remaining understaffed or assigning employees to tasks they are not qualified to do to decrease costs intentionally. There are other reports of staff not working enough hours to adequately meet the health care needs of patients.[24] This low standard of care for prisons with health care managed by private companies also has a higher death rate in comparison to prisons that do not utilize privatized health care.[25]

Health of incarcerated populations

It is well documented that justice-involved people have a higher prevalence of acute and chronic health conditions than the general U.S. population.[26] Compared to the general population, individuals with a history of incarceration have worse mental and physical health; they are more likely to have high blood pressure, asthma, cancer, arthritis, and infectious diseases, such as tuberculosis, hepatitis C, and HIV. Several factors contribute to the prevalence of mortality due to illness and disease in this population. The incarcerated population is largely drawn from the most disadvantaged segments of society, with significant health care needs but limited access to regular care. As a result, many incarcerated individuals arrive at correctional facilities in poor health with conditions that were previously undiagnosed.[27] Over half of people in state prisons have a substance use disorder and overdose is a leading cause of death among currently and formerly incarcerated people.[28] [29] Moreover, according to government data last compiled in 2017, close to half of people in jails have a diagnosis of major mental illness.[30] Prisons have been historically ill-equipped to handle the influx of inmates experiencing substance use disorder and mental illness.

Once incarcerated, the conditions of confinement often have a negative impact on health. Stress associated with institutional life, overcrowding, inadequate access to exercise, improper diet,
exposure to infectious diseases, and poor sanitation and ventilation can all contribute to mortality. Further, while incarcerated individuals have a constitutional right to health care, the access to and
the quality of the care in correctional facilities are variable. As noted above, insufficient resources play a key role, especially limited budgets and regulations that require correctional facilities to prioritize treating certain diseases over others.[31]

National Commission on Correctional Health Care (NCCHC)

Several professional organizations, including the AMA, the American Public Health Association, and later, the National Commission on Correctional Health Care (NCCHC), have established national standards for correctional health care. NCCHC's origins date to the early 1970s, when an AMA study of jails found inadequate, disorganized health services and a lack of national standards. In collaboration with other organizations, the AMA established a program that in 1983 became the NCCHC, an independent, 501(c)(3) nonprofit organization. Forty years later, NCCHC remains the only national organization dedicated solely to improving correctional health care quality. This is done by establishing rigorous standards for health services in correctional facilities, operating a voluntary accreditation program for institutions that meet those standards, offering certification for correctional health professionals, conducting educational conferences and webinars, and producing industry-specific publications and other resources.[32]

EXISTING AMA POLICY AND ADVOCACY

Policy H-430.986, "Health Care While Incarcerated," advocates for adequate payment to health care providers, including primary care and mental health and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process. This policy also advocates for necessary programs and staff training to address the needs of incarcerated individuals. Moreover, this policy encourages state Medicaid agencies to accept and process Medicaid applications from individuals who are incarcerated, and to work with correctional facilities to assist individuals to apply and receive a Medicaid eligibility determination.

Policy H-430.997, "Standards of Care for Inmates of Correctional Facilities," states that correctional and detention facilities should provide medical, psychiatric, and substance use disorder care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.

Policy D-430.997 "Support for Health Care Services to Incarcerated Persons" supports NCCHC standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities; encourages all correctional systems to support NCCHC accreditation; and encourages the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding. This policy also calls on the AMA to work with an accrediting organization, such as NCCHC, in developing a strategy to accredit all correctional, detention and juvenile facilities and to advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025.

AMA Advocacy

The AMA and Manatt Health released a state toolkit to End the Nation's Drug Overdose Epidemic.[41] The toolkit provides recommendations across several domains, including that "States should provide evidence-based medical care to incarcerated populations, including continuing, initiating, and ensuring access to medications for opioid use disorder (MOUD). States should remove criminal and other penalties for pregnant, postpartum, and parenting women for whom MOUD is part of treatment for an opioid use disorder."

The AMA sent a letter of support for H.R. 955 and S. 285, the "Medicaid Reentry Act," which would provide states with the flexibility to allow Medicaid payment for medical services furnished to an incarcerated individual during the 30-day period preceding the individual's release.

DISCUSSION

The Board believes it is important to ensure that proper health care is administered to those in all correctional facilities, whether public or private, and that the same standards should apply to all health care services delivered in all facilities. As a leading organization committed to improving public health and advancing health equity, the AMA has long advocated for quality health care services, humane treatment, and healthy environments for justice-involved populations. The Board notes that, as discussed, our AMA already has existing policy that supports AMA advocacy for appropriate health care in all forms of correctional facilities, including policy stating that correctional and detention facilities should provide medical, including psychiatric and substance use disorder care, that meets prevailing community standards. Additional policy calls on the AMA to work with an accrediting organization, such as the NCCHC, in developing a strategy to accredit all correctional, detention, and juvenile facilities and to advocate that all such facilities be accredited by the NCCHC no later than 2025. The Board believes that the AMA should remain focused on ensuring that appropriate, quality health care is provided to inmates in all facilities, regardless of private or public status. Accordingly, the Board recommends that existing AMA policy be reaffirmed in lieu of Resolution 202.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 202-I-23, and that the remainder of the report be filed.

That our American Medical Association reaffirm existing AMA Policies H-430.986, "Health Care While Incarcerated;" H-430.997, "Standards of Care for Inmates of Correctional Facilities;" and D-430.997, "Support for Health Care Services to Incarcerated Persons."

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6. HEALTH TECHNOLOGY ACCESSIBILITY FOR AGING PATIENTS

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 213-I-23 REMAINDER OF REPORT FILED
See Policy H-480.937

INTRODUCTION

At the 2023 Interim Meeting, the House of Delegates (HOD) referred Resolution 213-I-23, "Health Technology Accessibility for Aging Patients," sponsored by the Medical Student Section (MSS). Resolution 213-I-23 asked our American Medical Association (AMA) to:

> "support the development of a standardized definition of 'age-friendliness' in health information technology (HIT) advancements; encourage appropriate parties to identify best practices to set expectations of HIT developers to ensure that they create devices and technology applicable to and easily accessible by older adults; work with relevant organizations to encourage the utilization of industry standards of web content accessibility to make electronic health record software accessible for patients with visual impairments without requiring them to use third-party programs; and require EHR providers to provide standardized, easily accessible digital storage space for advanced care paperwork."

Testimony was largely in support for the spirit of this resolution. Testimony highlighted the need for electronic health record (EHR) vendors to design applications that better assist the needs of aging patient populations to enable them to fully realize the potential of evolving devices and technologies. Others expressed that, while specific standards for EHR functionalities aimed at older adults is desired, a more holistic approach to addressing issues that affect a broader population, including underserved and marginalized patients and their barriers to fully utilizing health information technology, may be a more effective route for AMA advocacy.

BACKGROUND

The COVID-19 public health emergency (PHE) was the catalyst to a seismic shift in the way technology to deliver and receive care is utilized. With telehealth visits being the only mechanism to continue receiving most forms of care during the PHE, it was essential that patients could connect to their physician through video or audio technology. Aside from the known issues stemming from lack of access to a quality broadband connection for some, a separate issue persists pertaining to whether a patient has the technical ability or familiarity to successfully access an online portal, operate and troubleshoot audiovisual equipment, and communicate without the cues available during an in-person visit.[1] This is a major obstacle to achieving equitable access to telehealth and the optimal use of ancillary digital services such as a patient portal application to view clinical care summaries.

Disparities surrounding the use and adoption of technology in health care are varied and multidimensional and range from issues such as patients being unable to navigate the health care system to physician-patient communication difficulties, which are sometimes exacerbated despite implementation of new technologies.[2,3] Digital health literacy limitations as one example, create foundational barriers that are hard to overcome without the help from a physician or caretaker. Enhancements in technology may be extremely helpful in streamlining communications and other administrative functions; however, patients of any age with a mental or physical disability may be unable to experience the benefits because of that disability. More broadly, patients may have limitations due to inexperience with technology. Telehealth and other forms of health information technology (health IT) have proven to be essential tools for physicians but, the breadth of those who benefit is limited since it is not always designed in a way that is accessible to all.

AMA POLICY

Existing AMA policy encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations (H-480.937).[4] Additionally, this policy supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment, and individuals with disabilities.

AMA Code of Medical Ethics (Code) recognizes that "[i]nnovation in technology, including information technology, is redefining how people perceive time and distance. It is reshaping how individuals interact with and relate to others, including when, where, and how patients and physicians engage with one another." The Code states that collectively, through their professional organizations and health care institutions, physicians should:

(i) Support ongoing refinement of telehealth/telemedicine technologies, and the development and implementation of clinical and technical standards to ensure the safety and quality of care.
(j) Advocate for policies and initiatives to promote access to telehealth/telemedicine services for all patients who could benefit from receiving care electronically.
(k) Routinely monitor the telehealth/telemedicine landscape to:
    (i) identify and address adverse consequences as technologies and activities evolve; and
    (ii) identify and encourage dissemination of both positive and negative outcomes.

Policy H-480.937, however, does not explicitly address the needs for electronic structured advance care planning or adequate space to be available in the EHR to be accessible quickly. The Code states that physicians should routinely engage their patients in advance care planning in keeping with the following guidelines including incorporating notes from the advance care planning discussion into the medical record.[5]

DISCUSSION

Addressing Equity in Telehealth and Health IT

Access to telehealth services can be a lifeline to patients across the country and facilitates unprecedented expansion in access to crucial health care services. Also, telehealth and the use of other digital modalities will continue to be integrated into the health care system framework for treating patients and managing their care. Unfortunately, using technology to access care does not come easily for all older adults. In a 2020 *JAMA* study measuring the prevalence of telemedicine unreadiness among older adults, the authors found that in 2018 an estimated 13 million of all older adults in the United States were not ready for video visits, predominantly owing to inexperience with technology.[6] The authors defined "unreadiness" as meeting any of the following criteria for disabilities or inexperience with technology: (1) difficulty hearing well enough to use a telephone, (2) problems speaking or making oneself understood, (3) possible or probable dementia, (4) difficulty seeing well enough, (5) owning no internet-enabled devices or being unaware of how to use them, or (6) no use of email, texting, or internet.[7] In policy H-480.937, Addressing Equity in Telehealth, our AMA supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities. Telehealth must address a broad spectrum of patients with both physical and mental disabilities, of all ages and backgrounds. To help ensure equitable access including appointment scheduling, patients who are without technological proficiency or access may require a method other than electronic communication.

Electronic Advanced Care Planning

In emergent situations, the patient's EHR information may be the only means of getting physicians and the care team advanced care planning (ACP) information in the event the patient is incapacitated or when there is no family or caregiver to ensure that the patient's wishes are respected in an imminent situation. Relying on a system where ACP documentation standards are low may expose physicians to unnecessary liability with the risk of incomplete or inaccurate forms that purport to officially represent patient's preferences when in fact the information may be inaccurate or out of date.[8] One challenging aspect of ACP documentation is the non-standardized nature of documentation methods. However, there is a movement to promote structured advance care planning (S-ACP)

documentation within the EHR that better facilitates the transition of most medical documentation to the EHR and allows for ACP documentation to be rapidly disseminated across diverse ambulatory settings.[9] S-ACP may provide important advantages to free-text ACP documentation, including standardization, ease-of-access, lower provider-level variability, and auditability; recognizing that it is of value to maintain a level of flexibility to capture unique, patient-centered details.[10]

CONCLUSION

The Board of Trustees (Board) recognizes that the need for accessibility considerations for health IT tools is critically important to achieve equity among aging populations, as well as underserved, marginalized, and disabled populations. The Board shares the goal of supporting efforts aimed at addressing telehealth and equity, as well as associated barriers to patients being able to fully realize the potential of technology that can increase access to care and promote better health outcomes. Resolution 213-I-23 provides an example of one population, namely the aging population, that can benefit from stronger considerations being given to developers of health IT. As discussed above, the AMA has existing policy that more broadly addresses the issue of equity and telehealth but welcomes the opportunity to further refine and enhance existing policy to be aligned with the spirit of this resolution. The Board recognizes the importance of ensuring safeguards for those who are without technological access or access. The Board, therefore, recommends amending existing policy H-480.937 in lieu of Resolution 213-I-23.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 213-I-23, and the remainder of the report be filed.:

That our American Medical Association amend Policy H-480-937 by addition and the title be changed by addition.

Policy H-480-937, ADDRESSING EQUITY IN TELEHEALTH AND HEALTH TECHNOLOGY

1. Our American Medical Association recognizes access to broadband internet as a social determinant of health.
2. Our AMA encourages initiatives to measure and strengthen digital literacy, with appropriate education programs, and with an emphasis on programs designed with and for historically marginalized and minoritized populations.
3. Our AMA encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations.
4. Our AMA supports efforts to design and to improve the usability of existing electronic health record (EHR) and telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with other mental or physical disabilities.
5. Our AMA encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth.
6. Our AMA supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations.
7. Our AMA supports efforts to ensure payers allow all contracted physicians to provide care via telehealth.
8. Our AMA opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians.
9. Our AMA will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.
10. Our AMA encourages the development of improved solutions to incorporate structured advance care planning (ACP) documentation standards that best meet the requisite needs for patients and physicians to easily store and

access in the EHR complete and accurate ACP documentation that maintains the flexibility to capture unique, patient-centered details.

11. Our AMA encourages hospitals, health systems, and physician practices to provide a method other than electronic communication for patients who are without technological proficiency or access.

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7. REEVALUATION OF SCORING CRITERIA FOR RURAL COMMUNITIES IN THE NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENT PROGRAM

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: **ADOPTED**
IN LIEU OF RESOLUTION 307-I-23
REMAINDER OF THE REPORT FILED
See Policies D-200.980, H-200.972, H-200.99, H-305.925, H-465.974, H-465.988 and H-465.997

INTRODUCTION

Resolution 307-I-23, submitted by the Idaho Delegation, asked that the AMA "advocate, in partnership with other major medical associations at the federal level, for a comprehensive reevaluation and assessment of the effectiveness and equity of the Health Professional Shortage Area scoring criteria employed by the National Health Service Corps Loan Repayment Program with appropriate revisions to meet the physician workforce needs for the neediest rural communities and underserved areas." (Directive to Take Action)

Testimony was supportive of this item and cited concerns about bias in scoring as well as the need for a comprehensive reevaluation and assessment of the effectiveness and equity of the Health Professional Shortage Area (HPSA) scoring criteria. Testimony noted there is a Shortage Designation Modernization Project underway by the federal government. The resolution was referred.

BACKGROUND

The National Health Service Corps (NHSC) is a "federal government program administered by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Bureau of Health

Workforce, and created to address a growing primary care workforce shortage. Since 1972, the National Health Service Corps has been building healthy communities, ensuring access to health care, preventing disease and illness, and caring for the most vulnerable populations who may otherwise go without care. National Health Service Corps programs provide scholarships and student loan repayment to health care professionals in exchange for a service commitment to practice in designated HPSAs."[1] NHSC has granted scholarships and operated loan repayment programs for over 50 years to support about 75,000 primary care physicians, dentists, and behavioral health providers who supply health care services, regardless of a patient's ability to pay, in communities with significant health professional shortages.[2]

Loan Repayment Program

For physicians, the NHSC Loan Repayment Program has traditionally provided primary care specialists (as well as dentists and mental and behavioral health care clinicians) with up to $50,000 toward student loans in exchange for their service in an underserved community.[3] In 2024, NHSC "increased the award amount for physicians, nurse practitioners, certified nurse midwives, and physician assistants who provide primary care services in high-need communities (located in a primary care HPSA) to address the critical shortages of these practitioners" such that primary care awardees can receive up to $75,000 for a full-time, two-year commitment or up to $37,500 for a half-time, two-year commitment. Further, they will provide a one-time enhancement award of $5,000 for those awardees with Spanish-language proficiency (for a total of up to $80,000/ $42,500) if they can pass a Spanish-language competency assessment. Non-primary care participants are also eligible but at a lower amount of up to $55,000/$30,000.

To determine eligibility for the loan repayment program, an individual must be:

- "A United States citizen (U.S. born or naturalized) or a United States national.
- A provider (or eligible to participate as a provider) in the Medicare, Medicaid, and the State Children's Health Insurance Program, as appropriate.
- Fully trained and licensed to practice in the NHSC-eligible discipline and state in which you are applying to serve. [The HRSA website] lists eligible disciplines and specialties for primary care, dental care, mental/behavioral health care, and maternity care.
- A health professional in an eligible discipline with qualified student loan debt for education that led to your degree.
- Working at an NHSC-approved site."[4]

To apply to the loan repayment program, an MD or DO must be board certified in family medicine, general internal medicine, general pediatrics, obstetrics/gynecology, psychiatry, or geriatrics and willing to serve at least two years at an NHSC-approved site in a HPSA.[5] The NHSC website provides additional information regarding the sections of the online application, required supporting documentation, and additional supplemental documentation if applicable. Applicants can access the Bureau of Health Workforce Customer Service Portal to view their application status. The NHSC loan repayment program Fiscal Year 2024 Application and Program Guidance document provides detailed information to applicants. Also, the NHSC provides several links to resources for applicants on their website https://nhsc.hrsa.gov/loan-repayment/selection-factors.

Health Professional Shortage Areas

Definition and Governance

A HPSA is defined in the Public Health Service Act as being "any of the following which the Secretary determines has a shortage of health professional(s):

1. An urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services);
2. a population group; or
3. a public or nonprofit private medical facility."[6]

The statue that governs this program is 42 U.S. Code 254e "Health Professional Shortage Areas."[11] [7] Additional information about HPSAs can be found at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation. HRSA provides a search tool of current HPSA sites and related data at https://data.hrsa.gov/tools/shortage-area/hpsa-find.

Scoring Criteria

Applications for shortage designations are received from state primary care offices. Once an area is designated, NHSC calculates a score using the Shortage Designation Management System (SDMS), which contains standard national data sets. Supplemental data is provided by state primary care offices and facilities. HPSA scores are calculated based on methodology that includes three disciplines: primary care, dental health, and mental health. Common across all HPSA disciplines are three scoring criteria: population-to-provider ratio, percent of the population with incomes below 100% of the Federal Poverty Level (FPL), and travel time to the nearest source of care (NSC) outside the HPSA designation area. The scoring details for each element are listed in Appendix A. According to HRSA, the scores range from 0 to 25 "where the higher the score, the greater the priority."[8] In sum, the scoring calculation reads as follows:

(Image reprinted with permission from the Shortage Designation Branch, HRSA.)

According to the notice "Criteria for Determining Priorities Among Health Professional Shortage Areas" in the Federal Register, "a scale is developed for scoring each factor. The scale generally includes five scoring levels, and reflects different patient utilization patterns for primary care, dental, and mental health services. Relative weights for the various factors are established, based on the significance of the factors in determining a shortage. Each HPSA is scored on each factor. The factor scores are weighted and summed for each HPSA. The total scores for each HPSA are ranked from highest to lowest for each HPSA category. A level is selected annually to identify the boundary between the HPSAs of greatest shortage and all other HPSAs. Those HPSAs with total scores equal to or greater than the selected boundary level within each category are identified as the HPSAs of greatest shortage."[9] HRSA publishes, before July 1 of each year, the minimum HPSA score for NHSC scholars who are in their final year of training. NHSC approved sites must meet this score by class year (CY). For primary care, the scores are as follows: CY 2021= 20; CY 2022 = 20; CY 2023 = 18; CY 2024 = 19; and CY 2025 = 19.[10] Additional information about the HPSA score and NHSC Scholar requirements can be found at https://nhsc.hrsa.gov/scholarships/ requirements-compliance/jobs-and-site-search.

HRSA Shortage Designation Modernization Project

HRSA first launched the Shortage Designation Modernization Project in 2013 with the goal of creating efficiencies. In Phase I, the SDMS was established. This tool allowed state primary care offices to manage their health workforce data, apply for HPSA and Medically Underserved Areas/Populations designation, and request automatic (auto-)HPSA rescores. The SDMS was also used to review shortage designation applications, communicate with state primary care offices, and review auto-HPSA rescore requests. Phase II in 2017 saw the completion of the first National Shortage Designation Update of geographic, population, and facility HPSA designations (not including those automatically-designated). In Phase III in 2019, HRSA completed the first National Shortage Designation Update of auto-HPSAs.

During Phase IV, HRSA hosted a webinar in March 2021 entitled "National Shortage Designation 2.0" to provide updated information. Also, HRSA gathered public comment regarding the HPSA scoring criteria and Maternity Care Target Areas, and the SDMS was updated. Also, the due date for Statewide Rational Service Areas plans was moved to March 31, 2024, while addressing how these plans will be submitted and reviewed in the SDMS. The responses to the public comment were reviewed and the Shortage Designation Branch of HRSA is determining the optimal way to share the results, which will inform HRSA's options and next steps in modernizing the current HPSA scoring methodology. The AMA contacted HRSA in June 2024 and was told Phase IV is ongoing.

NHSC Sites

To become an NHSC-approved site, NHSC provides a Site Reference Guide and makes available their eligibility requirements. NHSC-approved sites provide outpatient, comprehensive primary health care services to people in HPSAs. "Eligible sites providing comprehensive primary care must become NHSC-approved BEFORE recruiting participants or supporting loan repayment applications from their existing clinician staff."[1] Once approved, sites may be able to recruit individuals into not only the scholarship program and loan repayment program discussed previously, but also the NHSC Students to Service Loan Repayment Program, Substance Use Disorder Workforce Loan Repayment Program, and Rural Community Loan Repayment Program.

Where Physicians Serve

HRSA provides data on those who serve in their programs. Their Field Strength Dashboard allows users to search and filter by specific subsets of data such as year, program, region, state, site type, rural status, provider type, site HPSA score, clinical discipline, ethnicity, race, and gender. Data is presented as of September 30 of a given fiscal year. For example, when filtering by "2023," "rural," "primary care," and "physician," results show a total of 680 participants across the country in such programs. The top five states with the most participating primary care physicians were Missouri (60), Michigan (50), Alaska (36), New York (31), and Arizona (30). Comparatively, the five states and U.S. territories with the lowest numbers were North Dakota (4), Pennsylvania (3), South Dakota (3), Delaware (1), and Guam (1).[11]

To aid interested and involved physicians and non-physician providers, HRSA provides the Health Workforce Connector database to identify NHSC sites as well as employment and training opportunities. Also, the NHSC Empowerment Initiative provides a curriculum intended to "equip NHSC participants with the information they need to succeed as they enter the workforce and begin caring for patients with complex medical needs and barriers to care and guide NHSC-approved sites in their efforts to support clinician well-being and develop organizational resilience."[10]

DISCUSSION

Resolution Author Concern

The original author of Resolution 307-I-23 cited concerns about the lack of NHSC approved HPSAs in Idaho, particularly as it relates to rural health and an applicant's ability to serve in Idaho pending the HPSA scores. According to the dashboard cited above, Idaho had only 12 primary care physicians serving in rural sites in 2023.[11] A search of all counties in Idaho on the HPSA Find tool indicated the following (most of which were listed as having "rural" or "partially rural" status):

- 12 geographic HPSAs (with one labeled as "high need")
- 2 low-income migrant farmworker population HPSAs
- 30 low-income population HPSAs
- 15 federally qualified health centers (FQHCs)
- 7 Indian Health Service, Tribal Health, and Urban Indian Health Organizations
- 31 rural health clinics
- 4 correctional facilities.[8]

Among these 101 HPSAs, only 26% of them scored 16 or higher. The HRSA website indicates that a level is selected annually to identify the boundary between the HPSAs of greatest shortage and all other HPSAs but does not provide the annual determination. Therefore, the cut-off score is unclear from year to year. This lack of transparency may further fuel frustrations.

Concerns From Others

Entities have raised concerns about the HPSA scoring criteria. For example, the National Organization of State Offices of Rural Health (NOSORH) conducted an analysis in 2020 of HPSA scoring for Primary Medical Care HPSAs to provide comments on the HRSA/Bureau of Health Workforce request for information on the HPSA scoring criteria. The analysis "focused on the number and percentage of Primary Medical Care HPSAs which

received a score of 16 or higher – the effective cutoff point for potential assignment of NHSC personnel."[12] It found that:

- few geographic Primary Medical Care HPSAs scored above 16;
- fewer than half of rural Primary Medical Care Population HPSAs and Rural Health Clinic HSPAs received NHSC-qualifying scores; and
- there is a low percentage of NHSC-qualifying rural Primary Medical Care FQHC HPSAs (compared to non-rural).[12]

Related listening sessions with member SORHs noted:

- Difficulties for geographic and low-income population HPSAs in rural areas to achieve NHSC-qualifying scores,
- Rural Health Clinic HPSAs and Indian Health Service/Tribal facility HPSAs as well as small rural population, remote rural, and frontier HPSAs do not receive scores which accurately reflect their needs.
- Current health indicators used in HPSA-scoring do not adequately measure HPSA health status,
- SDMS data are insufficient in many areas, and
- States have differential abilities to correct and supplement the SDMS dataset.[12]

As a result, NOSORH recommended that HRSA modify their scoring mechanism to more accurately reflect the severity of need within rural and frontier areas (for primary medical care, mental health, and dental health HPSAs as well as geographic, population and auto-scored facility HPSAs). NOSORH recommended further changes such as:

- Scoring measures
    - Add a factor to the scoring process that reflects the rurality of a HPSA's location.
    - Revise the factors used to measure population health status and health disparities and that a planning group be convened to identify and select such factors.
    - Revise the factors used in the measurement of distance/travel time, led by a planning group charged with identifying and selecting an appropriate redefinition.
    - Revise the factors used in the measurement of low-income population such that it be adjusted to include the low-income population with incomes below 200% of the Federal Poverty Level, as well as consideration for the uninsured population.
    - Revise the formula used to calculate facility HPSA scores for FQHCs, RHCs, and Indian Health Service-Tribal Facilities and use standardized approaches to service area definition, service population calculation, and calculation of low-income population.
- Scoring scales and factor weighting
    - Revise scoring scales to rule out bias against small rural and frontier HPSAs.
    - Revise the weighting of scoring so that the weights given to measure components are standardized, led by a planning group charged with creating revised scoring formulae for all HPSA disciplines.
- Scoring process
    - Establish a distinct scoring process just for small rural and frontier HPSAs.
    - Allow service areas to be designated as both geographic and population HPSAs.
    - Develop a more accurate national dataset for designation, recognizing the limits of the SDMS national provider dataset.
    - Increase investment in state capacity to assess HPSAs.[12]

Details related to these recommended changes can be found on the NOSORH website.

AMA EFFORTS

The Council on Medical Education issued a report on Rural Health Physician Workforce Disparities that was adopted at the Special November 2021 meeting. In March 2023, the AMA sent a letter to Senators Bernie Sanders and Bill Cassidy of the Committee on Health, Education, Labor and Pensions. Specific to this topic, the letter asked that:

- additional funding be provided to bolster the scholarship aspect of the NHSC program,
- NHSC program provide intensive and frequent counseling to NHSC scholars as they enter and then proceed through the NHSC program, and
- NHSC be expanded to include more scholarships, greater loan forgiveness, and the inclusion of all medical specialties in need.

RELEVANT AMA POLICIES

The AMA has policy in support of the National Health Service Corps (NHSC) and their Loan Repayment Program as well as physician workforce related to the needs of rural communities and underserved areas. While policy does address Health Professional Shortage Areas, it does not specifically denote scoring criteria. Full policies are listed in Appendix B and in the Policy Finder.

- Effectiveness of Strategies to Promote Physician Practice in Underserved Areas D-200.980
- Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925
- Educational Strategies for Meeting Rural Health Physician Shortage H-465.988
- Difficulties in the Fulfillment of National Health Service Corps Contractual Obligations H-200.991
- Access to and Quality of Rural Health Care H-465.997
- Primary Care Physicians in Underserved Areas H-200.972

Additional policies include:

- Access to Physician Services in Rural Health Clinics H-465.984
- Rural Health Physician Workforce Disparities D-465.997
- Improving Rural Health H-465.994
- Diversity in the Physician Workforce and Access to Care D-200.982
- Enhancing Rural Physician Practices H-465.981
- Teleconsultations And Medicare Reimbursement D-480.997

SUMMARY AND RECOMMENDATIONS

HPSAs serve a critical function in determining areas of greatest need. Such determinations impact the resources and NHSC scholars deployed to said areas. The HRSA Shortage Designation Modernization Project has been underway for over a decade, but next steps have not yet been made clear. Reevaluation of the scoring criteria as well as greater clarity and transparency are recommended to better inform all interested parties.

The analysis by NOSORH illuminated inequities in the process, whereby many HPSAs do not seem to receive scores that reflect their actual need and health indicators do not adequately measure health status. These problems can lead to significant negative impacts on underserved populations. The actionable changes, such as those recommendations by NOSORH, can lead the way to better outcomes.

Therefore, the Board of Trustees recommends that the following recommendations be adopted and the remainder of the report be filed:

1. Our AMA supports the efforts of the Health Resources and Services Administration (HRSA) to conduct a comprehensive reevaluation and assessment of the effectiveness and equity of the Health Professional Shortage Area scoring criteria in order to meet the physician workforce needs of rural communities and underserved areas.
2. Our AMA urges increased federal and state resources to improve the accuracy of the Shortage Designation Management System (SDMS) data used to determine Health Professional Shortage Area (HPSA) scoring.
3. AMA policies D-200.980, H-305.925, H-465.988, and H-200.991, which support funding for NHSC and loan repayment programs, be reaffirmed.
4. AMA policy H-465.997, which supports efforts to place NHSC physicians in underserved areas, be reaffirmed.
5. AMA policy H-200.972, which supports efforts to increase recruitment and retention of physicians to practice in HPSAs, be reaffirmed.

APPENDIX A – HPSA scoring criteria:

Score for population-to-full-time-equivalent primary care physician (PCP) ratio:

- Ratio > 10,000:1, or no PCPs and population greater than or equal to (GE) 2500 = 5 points
- 10,000:1 > Ratio GE 5,000:1, or no PCPs and population GE 2000 = 4 points;
- 5,000:1 > Ratio GE 4,000:1, or no PCPs and population GE 1500 = 3 points;
- 4,000:1 > Ratio GE 3,500:1, or no PCPs and population GE 1000 = 2 points;
- 3,500:1 > Ratio GE > 3,000:1, or no PCPs and population GE 500 = 1 point.[9]

Score for percent of population with incomes below poverty level (P):

- P GE 50% = 5 points;
- 50% > P GE 40% = 4 points;
- 40% > P GE 30% = 3 points;
- 30% > P GE 20% = 2 points;
- 20% > P GE 15% = 1 point;
- P GE < 15% = 0 points.[9]

Score for travel distance/time to nearest source of accessible care outside the HPSA:
Nearest source of care is defined as the closest location where the residents of the area or population can access comprehensive primary care services.

- Time GE 60 minutes or distance GE 50 miles = 5 points;
- 60 min > time GE 50 min or 50 mi > distance GE 40 mi = 4 points;
- 50 min > time GE 40 min or 40 mi > distance GE 30 mi = 3 points;
- 40 min > time GE 30 min or 30 mi > distance GE 20 mi = 2 points;
- 30 min > time GE 20 min or 20 mi > distance GE 10 mi = 1 point;
- Time < 20 min or distance < 10 mi = 0 points.[9]

For primary care, the scoring also includes the Infant Health Index, which evaluates both the infant mortality rate (IMR) and low birth weight (LBW) rate and awards points based on the one with the higher score.

- IMR GE 20 or LBW GE 13 = 5 points;
- 20>IMR>18 OR 13>LBW>11 = 4 points;
- 18>IMR>15 or 11>LBW>10 = 3 points;
- 15>IMR>12 or 10>LBW>9 = 2 points;
- 12>IMR>10 or 9>LBW>7 = 1 point;
- IMR<10 or LBW<7 = 0 points.[9]

Source: https://www.federalregister.gov/documents/2003/05/30/03-13478/criteria-for-determining-priorities-among-health-professional-shortage-areas

APPENDIX B – RELEVANT AMA POLICIES:

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

1. Our American Medical Association, in collaboration with relevant medical specialty societies, will continue to advocate for the following:
   a. Continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations.
   b. Permanent reauthorization and expansion of the Conrad State 30 J-1 visa waiver program.
   c. Adequate funding (up to at least FY 2005 levels) for programs under Title VII of the Health Professions Education Assistance Act that support educational experiences for medical students and resident physicians in underserved areas.
2. Our AMA encourages medical schools and their associated teaching hospitals, as well as state medical societies and other private sector groups, to develop or enhance loan repayment or scholarship programs for medical students or physicians who agree to practice in underserved areas or with underserved populations.
3. Our AMA will advocate to states in support of the introduction or expansion of tax credits and other practice-related financial incentive programs aimed at encouraging physician practice in underserved areas.
4. Our AMA will advocate for the creation of a national repository of innovations and experiments, both successful and unsuccessful, in improving access to and distribution of physician services to government-insured patients (National Access Toolbox).
5. Our AMA supports elimination of the tax liability when employers provide the funds to repay student loans for physicians who agree to work in an underserved area.

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

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

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit:

a. inclusion of all medical specialties in need, and
b. service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.

5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to:
    a. study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education;
    b. engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs;
    c. cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students;
    d. allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students;
    e. counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation;
    f. inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen;
    g. ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees;
    h. use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies;

i. work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals:
    a. Eliminating the single holder rule.
    b. Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training.
    c. Retaining the option of loan forbearance for residents ineligible for loan deferment.
    d. Including, explicitly, dependent care expenses in the definition of the "cost of attendance."
    e. Including room and board expenses in the definition of tax-exempt scholarship income.
    f. Continuing the federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs.
    g. Adding the ability to refinance Federal Consolidation Loans.
    h. Eliminating the cap on the student loan interest deduction.
    i. Increasing the income limits for taking the interest deduction.
    j. Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001.
    k. Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating.
    l. Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to:

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

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. Our AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will:
    a. Advocate that all resident/fellow physicians have access to PSLF during their training years.
    b. Advocate against a monetary cap on PSLF and other federal loan forgiveness programs.
    c. Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed.
    d. Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note.
    e. Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status.
    f. Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility,
    g. Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed.

h. Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas.
i. Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
j. Monitor the denial rates for physician applicants to the PSLF.
k. Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program.
l. Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner.
m. Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
23. Continue to monitor opportunities to reduce additional expense burden upon medical students including reduced-cost or free programs for residency applications, virtual or hybrid interviews, and other cost-reduction initiatives aimed at reducing non-educational debt.
24. Encourage medical students, residents, fellows and physicians in practice to take advantage of available loan forgiveness programs and grants and scholarships that have been historically underutilized, as well as financial information and resources available through the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine, as required by the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation, and resources available at the federal, state and local levels.
25. Support federal efforts to forgive debt incurred during medical school and other higher education by physicians and medical students, including educational and cost of attendance debt.
26. Support that residency and fellowship application services grant fee assistance to applicants who previously received fee assistance from medical school application services or are determined to have financial need through another formal mechanism.

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988

1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, our American Medical Association recommends that:
   a. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.
   b. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
   c. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.
   d. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.
   e. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.

f. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.
g. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.
h. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.
i. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.
j. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
k. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
l. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.
3. Our AMA will:
   a. work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and
   b. work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.
   4. Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas.
   5. Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs.

Difficulties in the Fulfillment of National Health Service Corps Contractual Obligations H-200.991

1. The AMA strongly urges the NHSC to provide intensive and frequent counseling to NHSC scholars as they enter and then proceed through the NHSC program. Through such briefings, as well as frequent written communications, the NHSC Administration should emphasize: (a) the dynamic nature of the HMSA Placement Opportunity List and the possibility of changes in placement options at any time; (b) the extent of any financial commitments that a scholar may have to incur to develop a Private Practice Option opportunity; and (c) the future possibilities of obtaining a Private Practice Option and/or a federal placement.
2. The AMA urges the NHSC to make particular effort to minimize, to the degree possible, the imposition of changes in assignment options during the last year of the obligee's education, so as to avoid disruption of personal and family plans.

Access to and Quality of Rural Health Care H-465.997

(1) Our AMA believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will also help to avoid and, if necessary, resolve existing duplication of health care resources. (2) In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued.

Primary Care Physicians in Underserved Areas H-200.972

1. Our American Medical Association should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:
   a. encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care;
   b. encourage the affiliation of these family health clinics with local medical schools and teaching hospitals;

c. advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies;
d. encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence;
e. urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations;
f. encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations and
g. urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.

2. Our AMA supports efforts to:
a. expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and
b. increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.

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8. INCREASING ACCESS TO MEDICAL CARE FOR PEOPLE SEEKING ASYLUM

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

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 007-I-23
REMAINDER OF THE REPORT FILED
See Policy H-350.957

INTRODUCTION

At the 2023 Interim Meeting of the American Medical Association (AMA) House of Delegates (HOD), the Medical Student Section submitted Resolution 007 "Improving Access to Forensic Medical Evaluations and Legal Representation for Asylum Seekers" that asked the AMA to:

> Support public funding of legal representation for people seeking legal asylum (New HOD Policy); and be it further
>
> Support efforts to train and recruit physicians to conduct medical and psychiatric forensic evaluations for all asylum seekers through existing training resources, including, but not limited to, the Asylum Medicine Training Initiative.

Testimony was mixed. Concerns were raised about the first resolve clause, noting it may be outside the purview of the AMA. Also, testimony suggested deletion of "Asylum Medicine Training Initiative" from the second resolve to avoid endorsement of a specific program. The resolution was referred.

BACKGROUND

2022 data from the World Health Organization states that more than 1 billion people globally — or one in seven people — are refugees, immigrants, and migrants (RIM).[1] Such RIM communities often experience economic, educational, social, and health inequities.[2] Many have also been victims of great harms.

Definition of asylum seeker

To better understand the issues raised in this resolution, we must first be clear on the definitions of key terms. The U.S. Citizen and Immigration Services (USCIS) of the U.S. Department of Homeland Security (DHS) and the International Rescue Committee (IRC) provide such definitions. Key terms are defined and compared in Appendix A. This report will focus on the term "asylum seeker" since it is the one written in the resolution. An "asylum seeker" (or asylee) is a person who is "an alien in the U.S. or at a port of entry who is unable or unwilling to return to his or her country of nationality, or to seek the protection of that country because of persecution or a well-founded fear of persecution. Persecution or the fear thereof must be based on religion, nationality, membership in a particular social group or political opinion."[1] They must arrive at or cross a border into the desired country and apply for protection. An asylum seeker's claim for refugee status has not yet been legally determined.[3]

According to the ICR, there were 6.9 million asylum seekers in 2023. The United States received the largest number of applications, followed by Germany. The most applications came from individuals departing Afghanistan, Colombia, Sudan, Syria, and Venezuela.[3] Many of these individuals, particularly women and children, report having fled their native country due to such atrocities as kidnappings, gender violence, forced gang recruitment, and even murder. Crossing an international border for asylum is legal, and the individual's case must be heard, per U.S. and international law.[3]

Applying for asylum

Asylum seekers must apply to the USCIS. To qualify, one must be physically present in the U.S. If one is eligible for asylum, then they may be permitted to remain in the U.S. Such persons must file a Form I-589 "Application for Asylum and for Withholding of Removal" within one year of arrival.[4] The DHS website provides further

information on the ways to obtain asylum. The information is available in English and Spanish; they also offer a Multilingual Resource Center to assist those who read/speak other languages.

Legal representation

The U.S. Department of Justice provides lists of pro bono (free) legal service providers per state to help asylum seekers navigate the process. States themselves also provide resources to asylum seekers who have recently arrived. One such example is the Illinois Department of Human Services, which offers a list of community service agencies that provide a variety of services including legal aid.[5] Some cities have even established funding mechanisms to support such individuals. The city of Chicago invests in its Legal Protection Fund in partnership with the National Immigrant Justice Center (NIJC) and The Resurrection Project "to provide community-based outreach, education, legal consultations and courtroom representation for thousands of immigrants each year."[6] Various organizations work to ensure access to justice and human rights protections for asylum seekers (as well as immigrants and refugees). As mentioned, the NIJC advocates for policy reform and systems change while also offering legal services for said individuals. Such direct services generally involve volunteer attorneys providing pro bono services. The NIJC serves more than 10,000 asylum seekers each year with a 90 percent success rate in obtaining asylum.[7]

Medical evaluation

The Centers for Disease Control and Prevention (CDC), United States Public Health Service , is responsible for ensuring that noncitizens entering the U.S. do not pose a risk to the health of U.S. citizens and U.S. legal residents. Thus, each person is required to receive a medical (physical and mental) examination when applying for entry. Detailed information about the medical examination performed by designated physicians can be found on the CDC website. The Department of Health and Human Services (HHS) Office of Refugee Settlement also promotes the health, well-being, and stability of refugees, unaccompanied children, and other eligible individuals and families. For children, this office operates the Unaccompanied Refugee Minors Program and the Unaccompanied Children Program that provide health, dental, and mental health care.[8]

As mentioned, many asylum seekers claim to have undergone harms in their native country or may undergo harms if deported. A forensic medical evaluation is a specialized exam to document the physical or psychological consequences of such harms. Research indicates that "forensic medical evaluations can provide scientific evidence that a person has suffered persecution and harm, improving the likelihood that those who seek refuge in the United States will be granted asylum or other forms of life-saving immigration relief."[9]

Training for physicians

The CDC provides technical instructions for "panel physicians" who are medically trained, licensed, and experienced physicians practicing overseas and designated by the local U.S. consulate or embassy. These physicians "must follow specific identification procedures, prescribed by the U.S. Department of State, to ensure that the person appearing for the medical examination is the person who is actually applying. The panel physician is responsible for the entire examination, including the required chest radiograph and any necessary laboratory procedures. The panel physician is also responsible for reporting the results of all required tests and consultations on the prescribed forms and for ensuring that the completed medical report forms are sent directly to the consular officer. The panel physician is not responsible for determining whether an applicant is actually eligible to apply to enter the United States; that determination is made by the consular officer after reviewing all records, including the report of the medical examination."[10] Likewise, the CDC provides technical instructions for designated "civil surgeons" who perform such medical examinations inside the U.S. The CDC also provides Overseas Refugee Health Guidance to physicians to help promote healthy resettlement.[10]

Medical education

Standard 7 of the Liaison Committee on Medical Education (LCME), the organization that accredits medical schools, addresses "Curricular Content." Specifically, 7.1 addresses "Societal Problems" and 7.2 addresses "Structural Competence, Cultural Competence, and Health Inequities." However, LCME does not dictate how medical schools will interpret these standards nor if they will include information on the needs of asylum seekers. Likewise, the Accreditation Council on Graduate Medical Education's Common Program Requirement IV.A. on "Educational Components" states that training be "consistent with the sponsoring institution's mission, the needs of

the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, residents, and faculty members" (but does not specify asylum seekers who may be part of the community).[11]

DISCUSSION

A study of U.S. medical students published in 2022 concluded that "medical students at schools with affiliated asylum clinics desire to care for asylum seeker patients but feel unprepared to do so, highlighting an unmet need for formal asylum education in U.S. medical schools."[12] This point was echoed in a 2024 study that assessed the current state of medical school curricula worldwide.[13]

Another study evaluated student-run clinics for asylum seekers, revealing "the burgeoning capability of student-run asylum clinics to provide evaluations, a trend that underscores medical students' ability to significantly impact human rights issues. Student-run asylum clinics are poised to fill an increasingly important role in supporting victims of torture and persecution."[14] These findings highlight the essential role of human rights and social justice in medical education.

Similarly, education is imperative for physicians to assist asylum seekers. A variety of resources and trainings are available for physician and non-physician health care professionals. For example,

- Physicians for Human Rights has galvanized an Asylum Network of physicians to provide forensic medical and psychological evaluations to support asylum seekers; training is required, and aids are available.
- Center for Health Care Strategies offers education on trauma-informed care.
- Center for Victims of Torture provides information about trauma-informed and culturally competent care and clinical interventions.
- Asylum Medicine Training Initiative prepares health care professionals in the forensic medical evaluation of persons seeking asylum in the U.S.

While payment for the provision of legal representation for asylum seekers is outside the scope of a physician, and therefore the AMA, the AMA is supportive of medical-legal partnerships (MLPs) and understands the large role that social resources have in health outcomes for patients. Policy H-265.986 is of relevance. The AMA Code of Medical Ethics does not provide a direct perspective on physician participation in MLPs, but recognizes they can help physicians carry out the responsibilities and principles articulated in Opinions 1.1.8, 8.5, 10.8, and 11.1.4. The AMA Journal of Ethics released information on this topic in August 2024.[15] Newly established immigration medical-legal partnerships are being implemented in some states to address the complex needs of asylum seekers; the results of the partnerships would be informative.

AMA efforts

AMA's Advocacy unit has been actively involved in communicating with the highest levels of government in support of the health and well-being of immigrants, refugees, and asylum seekers. In the last four years alone, letters to the following offices have been drafted and submitted (both alone and in collaboration with other organizations):

- March 28, 2024, letter to Centers for Medicare & Medicaid Services (CMS) asking to remove barriers to Medicaid and Children's Health Insurance Program (CHIP) coverage for immigrants.
- June 23, 2024, letter to HHS and CMS with comments on the proposed clarifications to eligibility criteria for Qualified Health Plans (QHP) through an Exchange, state-based Basic Health Programs (BHPs), and CHIP as well as some insurance affordability programs.
- March 16, 2023, letter to President of the United States and U.S. Department of Homeland Security (DHS) to raise concerns about the consideration of a harmful immigration policy — the reinstating of detention of immigrant families.
- October 10, 2022, letter to DHS and HHS to increase research and patient-centered mental health treatment for refugee and migrant populations and provide for safer medical practices and protections for migrant women.
- July 12, 2022, letter to U.S. Department of the Treasury and HHS with comment in support of Washington State's Section 1332 Waiver application to cover the uninsured and improve health insurance affordability.
- April 22, 2022 letter to DHS with comment on the Public Charge Ground of Inadmissibility proposed rule, opposing any regulations or policy that would deter immigrants and/or their dependents from utilizing non-

cash public benefits, including but not limited to Medicaid, CHIP, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and Supplemental Nutrition Assistance Program (SNAP).

- February 2, 2022 letter to the Department of Justice and DHS in opposition to Docket Number USCIS 2020-0013 (Interim Final Rule) on the grounds that it will place asylum seekers in even greater peril and provide DHS and border patrol agents with unwarranted and heightened authority that represents an ineffective way to protect public health while reducing barriers for noncitizens seeking protection in the U.S.
- January 13, 2022 letter to the Secretary of State with comment on "Visas: Ineligibility Based on Public Charge Grounds" Docket DOS-2021-0034 and RIN 1400-AE87.1 The AMA strongly opposed any rules, regulations, or policies that would deter immigrants, nonimmigrants, and their dependents from seeking visas or from utilizing noncash public benefits including, but not limited to, Medicaid, SNAP, and housing assistance.
- November 29, 2021, letter to DHS with comment on the USCIS proposed rule regarding Deferred Action for Childhood Arrivals (DACA) [DHS Docket No. USCIS–2021–0006]
- October 14, 2021, letter to DHS to provide information regarding the Public Charge Ground of Inadmissibility, as the AMA strongly opposed any rules, regulations, or policies that would deter immigrants/nonimmigrants seeking visas and/or their dependents from utilizing non-cash public benefits such as, but not limited to, Medicaid, SNAP, and housing assistance.
- September 23, 2021, letter to DHS urging them to ensure the health and well-being of all individuals and their families seeking asylum in the U.S., including the Haitian refugees that were at the U.S. southern border.
- September 23, 2020, letter to DHS urging DHS and the Office of the Inspector General (OIG) to thoroughly investigate complaints about detained immigrants' substandard living conditions and improper health care, including allegations of inadequate informed consent practices.
- September 22, 2020, letter to Customs and Border Protection to raise concerns regarding their expiring contract for medical services.
- July 16, 2020, letter to DHS to urge U.S. Immigration and Customs Enforcement (ICE) to release all children together with their parents and caregivers from ICE-run Family Residential Centers.

RELEVANT AMA POLICIES

AMA Policy H-350.957 "Addressing Immigrant Health Disparities" calls for:

1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

Additional policies that address asylum seekers are listed here and located in Appendix B:

- Opposition to Discriminatory Treatment of Haitian Asylum Seekers H-350.951
- Oppose Mandatory DNA Collection of Migrants H-65.955
- Care of Women and Children in Family Immigration Detention H-350.955

The AMA has many other policies regarding refugees and immigrants such as:

- Increasing Mental Health Screenings by Refugee Resettlement Agencies and Improving Mental Health Outcomes for Refugee Women D-345.982
- Increasing Access to Healthcare Insurance for Refugee Populations H-350.956
- Retraining Refugee Physicians H-200.950
- Immigration Status is a Public Health Issue D-350.975

- Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927
- Support of Health Care to Legal Immigrants H-290.983
- Medical Needs of Unaccompanied, Undocumented Immigrant Children D-65.992
- Improving Medical Care in Immigrant Detention Centers D-350.983
- Care of Women and Children in Family Immigration Detention H-350.955

CONCLUSION

The AMA recognizes that there are many facets to the legal U.S. immigration system, including medical evaluation. Asylum seekers are in need of care and assistance, and medical students, trainees, and physicians should play a role in this medical care. The AMA supports opportunities for interested physicians to gain further education and training to care for these patients.

The Board of Trustees therefore recommends that the following recommendations be adopted and the remainder of this report be filed.

That Policy H-350.957 be amended by addition and deletion to read as follows:

3. Our AMA ~~will~~ calls for asylum seekers to receive medically-appropriate care, including vaccinations, in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.
4. Our AMA supports efforts to train physicians to conduct medical and psychiatric forensic evaluations for asylum seekers.
5. Our AMA supports medical education that addresses the challenges of life-altering events experienced by asylum seekers.
6. Our AMA urges physicians to provide medically-appropriate care for asylum seekers.
7. Our AMA encourages physicians to seek out organizations or agencies in need of physicians to provide these services.
8. Our AMA encourages provision of resources to assist people seeking asylum, including social and legal services.

APPENDIX A: GLOSSARY (in alphabetical order)

Alien/Non-citizen/Foreign National
A person who is "not a citizen or national of the United States as the term 'alien' is defined in section 101(a)(3) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(3))." An alien is subject to the host country's law pertaining to non-citizens.[1]

Asylum Seeker/Asylee
A person who is "an alien in the U.S. or at a port of entry who is unable or unwilling to return to his or her country of nationality, or to seek the protection of that country because of persecution or a well-founded fear of persecution. Persecution or the fear thereof must be based on religion, nationality, membership in a particular social group or political opinion."[1] They must arrive at or cross a border into the desired country and apply for protection.[2] An asylum seeker's claim for refugee status has not yet been legally determined.

Immigrant
A person who "chooses to leave their home country and move to a foreign one to settle there."[2] While a "legal immigrant" is foreign-born and legally admitted to the U.S., an "undocumented immigrant" (also called an "illegal alien") is a foreign-born person who does not possess a valid visa or other immigration documentation.[2]

Migrant
A person who "is moving from place to place (within his or her country or across borders), usually for economic reasons such as seasonal work"[2]. Like immigrants, they are seeking better opportunities but were not forced to leave their native countries (due to persecution or violence).

Refugee
A person "outside his or her country of nationality who is unable or unwilling to return to that country because of persecution or a well-founded fear of persecution based on the person's race, religion, nationality, membership in a particular social group, or political opinion. For a legal definition of refugee, see section 101(a)(42) of the Immigration and Nationality Act." According to the International Rescue Committee (IRC), a government or the United Nations Refugee Agency determines whether a person seeking international protection meets the definition of a refugee. If one is granted refugee status, they are given protections under international laws and conventions and lifesaving support from aid agencies, including the IRC. Refugees in the U.S. also have the opportunity to become lawful permanent residents and eventually citizens.[2]

APPENDIX B: RELEVANT AMA POLICIES

Addressing Immigrant Health Disparities H-350.957
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

Opposition to Discriminatory Treatment of Haitian Asylum Seekers H-350.951
Our American Medical Association opposes discrimination against Haitian asylum seekers which denies them the same opportunity to attain asylum status as individuals from other nations.

Oppose Mandatory DNA Collection of Migrants H-65.955
Our American Medical Association opposes the collection and storage of the DNA of refugees, asylum seekers, and undocumented immigrants for nonviolent immigration-related crimes without non-coercive informed consent.

Care of Women and Children in Family Immigration Detention H-350.955
1. Our American Medical Association recognizes the negative health consequences of the detention of families seeking safe haven.
2. Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States.
3. Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.
4. Our AMA will advocate for access to health care for women and children in immigration detention.
5. Our AMA will advocate for the preferential use of alternatives to detention programs that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies.

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9. CORPORATE PRACTICE OF MEDICINE PROHIBITION

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 233-I-23 REMAINDER OF REPORT FILED**
See Policy H-215.981

INTRODUCTION

This American Medical Association (AMA) Board of Trustees report arises from Resolution 233"Corporate Practice of Medicine Prohibition", introduced at the 2023 Interim Meeting by the Private Practice Physicians Section (PPPS) and the Organized Medical Staff Section (OMSS). The AMA House of Delegates (HOD) referred the following amendments to existing policy:

> RESOLVED, That our American Medical Association amend policy H-215.981, Corporate Practice of Medicine, by deletion and substitution to read as follows:
>
> 1. Our AMA ~~vigorously opposes any effort to pass~~ will seek federal legislation to ~~preempting state laws~~ prohibit~~ing~~ the corporate practice of medicine by limiting ownership and corporate control of physician medical practices to physicians or physician-owned groups only and ensure private equity/non-medical groups do not have a controlling interest.
>
> 2. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical

staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.

3. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues. (Directive to Take Action).

Testimony was largely supportive of the resolution's underlying objectives to: (1) strengthen corporate practice of medicine prohibitions and (2) limit the controlling influence of corporate investors in health care. Much of the debate centered on the appropriateness of federal legislation to achieve this goal, in part because corporate practice of medicine (CPOM) prohibitions is governed at the state level.

BACKGROUND

The health care sector has become attractive to corporate investors. Private equity (PE) and other corporate investors are well-positioned to capitalize on the vulnerability of independent physician practices. At the same time, an array of factors related to the complexity of care delivery—including changes in payment and delivery models, physician payment challenges, and increased administrative and regulatory burdens, health care consolidation, etc. (all of which contribute to physician practice instability and physician burnout)—drive some physicians toward corporate investment to remain independent. For many, the only other option is employment with a hospital, health insurer, etc.

Physicians are on Both Sides of this Issue

Reasons Why Physicians May Value Corporate Investment in Medical Practices

Physicians may find value in corporate investment for several reasons. Some physicians consider corporate investment as the only way to stay independent. A corporate investor may be able to manage the financial and administrative aspects of practice operations, leaving more time for physicians to focus on patient care. Other benefits may include financially attractive deals for physicians looking to exit ownership of their practices; access to capital for practice expenses or expansions; potentially reduced medical liability costs; and centralized resources for certain functions such as information technology, marketing, or human resources. To this end, some physician practices have invited corporate investors into their practices.

Reasons Why Physicians May Oppose Corporate Investment in Medical Practices

On the other hand, some physicians oppose corporate investment in physician practices because in some cases corporate investors have taken control over physician practices and exerted undue influence over clinical matters that should be reserved exclusively to the physicians. Furthermore, some investors employ a short-term business model whereby once they invest in and/or start managing a practice, they make drastic cost-cutting changes to both the practice's business operations and clinical operations. Examples of these changes include hiring non-physician practitioners to replace physicians, altering physician working conditions for the worse, and forcing physicians to do more with less. Moreover, it is not unusual for physicians to be bound by physician noncompete agreements that hinder their ability to leave the practice. There are also instances where, after the investor has extracted all profits that it can from the practice, the investor may exit and leave the practice in debt if not bankruptcy. All of this has the potential to create uncertainties for non-owner early- and mid-career physicians, placing physicians under inordinate stress and further contributing to physician burnout.

Purpose of the CPOM

To date, CPOM prohibitions have been governed at the state level—as states use their police power to protect the health and welfare of their citizens by preventing the commercialization of medicine. One of the common ways states have tried to limit lay control over physicians is by restricting lay entity or non-physician ownership in physician practices, a strategy recognized by Resolution 233. The majority of states take this approach.

For example, some of these states prohibit lay entities or non-physician practitioners from having any ownership in a practice, meaning that the practice must be wholly owned by physicians. Other states allow lay entities or

individuals to own part of the practice but require that physicians must have a majority interest in the practice. In California, for example, at least 51 percent of the shares of a physician practice must be owned by a licensed physician or surgeon.

From what has been stated, it is clear that some states do not prohibit corporate investors from owning a physician practice. It is important to note, however, that these states often have in place other requirements that are designed to prohibit those investors from controlling the practice of medicine, e.g., actively enforcing fee-splitting prohibitions.

In states that prohibit or limit corporate investors from owning physician practices (in whole or in part), the only corporations that are permitted to practice medicine are physician-owned legal entities, typically known as a professional corporation or professional medical corporation (PC). States have specific requirements regarding how a PC can be structured, including but not limited to, who can serve as shareholders or owners and the composition of the board of directors.

Use of the "Friendly PC" or "Friendly Physician" Model in States that Prohibit or Limit Non-Physician Ownership in a PC

In the states that do not permit corporate investors from having a controlling interest in a PC, investors typically use an arrangement often referred to as the "friendly physician" model to invest indirectly in the practice. This is done through forming a corporation often referred to as a "management services organization" (MSO). Here the PC is frequently consolidated into one (or a small number) of the designated physician owners, some of whom will serve as "friendly physicians," i.e., sympathetic to the MSO (such that they will effectively control the PC entity on the MSO's behalf). The MSO may designate a "friendly physician" owner with whom it has a prior relationship, and who may be totally unknown to the PC's current owner physicians. Further, the MSO may have the right to replace the physician owners either at will or based upon the occurrence of a variety of events (e.g., incurrence of additional debt, initiating bankruptcy proceedings, etc.). Finally, the PC pays the MSO for providing administrative services and oftentimes, the MSO buys the practice's nonclinical assets, e.g., the office building, real estate, furniture, computers and other IT—and then leases those back to the practice. Unfortunately, as noted by the California Medical Association in an amicus brief submitted in a lawsuit filed by the American Academy of Emergency Medicine Physician Group (*American Academy of Emergency Medicine Physician Group (AAEMPG) v. Envision Healthcare Corp.*),

> Such "friendly" medical corporation arrangements are common, and in many cases can be desirable because they enable medical corporations to access and take advantage of needed capital and market resources. However, in some instances the "friendly" alignment between a lay entity and a medical corporation can cross over into prohibited territory, wherein the lay entity gains undue influence or control over the medical corporation.

Notably, the American College of Emergency Physicians also filed an amicus brief in this case.

Recent State Legislative Activity

While it is widely recognized that in many states the CPOM has been underenforced, the situation is rapidly changing. States are very aware of the harm that some PE and corporate investors have wrought in health care. State legislatures are closely scrutinizing the role of corporate interests in health care and considering diverse legislative proposals to limit the control that corporate investors have with respect to the practice of medicine, hospitals, and health care generally. What follows is a brief description, for illustrative purposes, of three state legislative strategies from 2024— strategies that other states are considering, including but not limited to strengthening the CPOM doctrine.

California AB 3129, which is currently being considered by the state senate (as of the writing of this report), would require a PE group or a hedge fund to notify and obtain the consent of the California attorney general before a transaction between the PE group or hedge fund and a health care facility, provider, or provider group, and any of those entities under common control or affiliated with a payer, can be completed. (AB 3129 amends a current prenotification law to include PE groups and hedge funds.) These notice and consent requirements, combined with a description of specific practices over which corporate interests may not intrude, may bolster the CPOM ban in California. Specifically, they call attention to transactions that may pose a threat to independent practice of medicine

by physicians and provide a clearer basis for a stronger exercise of state enforcement authority. At least 10 states have enacted similar prior notice laws.

Further, per AB 3129, a PE group or hedge fund would be prohibited from interfering with the professional judgment of physicians in making health care decisions, including but not limited to: (1) determining what diagnostic tests are appropriate for a particular condition; (2) determining the need for referrals to, or consultation with, another physician; (3) being responsible for the ultimate overall care of the patient, including treatment options available to the patient; and (4) determining how many patients a physician shall see in a given period of time or how many hours a physician shall work.

Massachusetts has also been considering different bills that would help the state impose greater scrutiny and control over PE and corporate investors in the state, e.g., H 4620. As of the writing of this report, among many other provisions, H 4620, like California AB 3129, would impose notice and reporting requirements for PE acquisitions, including the size and market share of any significant equity investor in a physician practice. It also would authorize the state attorney general to collect information from PE groups and MSOs (the bill has other requirements specific to MSOs). Finally, H 4620 would also require practices to provide notice of "significant transfers of assets including, but not limited to, real estate sale lease-back arrangements," and would ban the future leasing of land from real estate investment trusts for the operation of a hospital's in-patient facilities. It would also require increased disclosure of other lease arrangements.

Finally, Oregon considered HB 4130. HB 4130 attracted much attention, and refiling is expected next session. HB 4130 would prohibit a shareholder, director or officer of a PC from participating in managing the PC or having voting shares in the corporate action that bears on the ownership, management, or governance of the PC, if the shareholder, etc., is simultaneously a shareholder, director, member, officer or employee of an MSO serving the PC. HB 4130 provides that a PC cannot remove a director or an officer by means other than majority vote of directors or officers, as appropriate, who are licensed Oregon physicians. Physician noncompete clauses would be banned except in limited circumstances by enactment of HB 4130. Further, the bill prohibits an MSO from disciplining a physician for violating a non-competition, non-disclosure, or non-disparagement agreement or for disclosing or reporting information that the physician in good faith believes is a violation of federal or state law, rules, or regulations.

As stated, while the CPOM doctrine may have historically been unenforced in many states, things are rapidly changing. State legislatures are greatly concerned about the negative impact that some corporate investors have caused in health care markets, and there is a revived interest in enforcing existing CPOM prohibitions, strengthening prohibitions, and utilizing other legislative strategies to increase corporate oversight and scrutiny of corporate investors. The AMA's state Advocacy Resource Center is closely monitoring this legislative activity and is working closely with interested state medical associations and national medical specialty societies on addressing their concerns, as they arise.

Prospects for Federal Legislation

Resolution 233 raises the issue of AMA advocating for federal legislation to prohibit CPOM. There are several concerns about "federalizing" this issue.

As noted above, historically, CPOM has been a state issue—with state legislatures working on solutions that reflect their unique health care environments. For example, while some states mandate that PCs be wholly physician owned or restrict non-physician ownership to not more than 49 percent, other states have determined that it is best not to prohibit corporate investors from owning physician practices and instead place appropriate requirements and limitations on said models. A concern with advocating for federal legislation any time there are existing variations at the state level is that the new federal legislation that is passed may supersede an existing state protection that is stronger. Thus, depending on the nature of the federal legislation, some physicians may oppose weaker federal legislation, and unfortunately the federal legislative and subsequent regulatory processes leave no guarantee as to the strength of the final version of the federal legislation.

With respect to authority over practice operations, i.e., how a practice is "run," as was just mentioned above, the Board recommends that AMA policy distinguish between corporate investment, corporate ownership, and corporate control in physician practices. A corporate entity may invest in a practice but not have ownership nor operational control of the practice. Thus, a corporate investor may offer financing without physician practices giving up clinical

autonomy or operational authority. On the other hand, a corporate entity may not technically own a practice but effectively exercises corporate control of the physician practice. The previous discussion concerning the "friendly physician" model illustrates this point—under that model the desire for corporate profits may interfere with clinical decision-making and physician autonomy even though technically corporate investors' ownership interests are limited or prohibited outright. To clarify, retaining operation authority does not stop a practice from outsourcing or delegating its management or even day-to-day operations. However, management would be a contracted service or some other structure in which, if there is a conflict, the physician or designated physician partners have the final authority. Importantly, most of the time a controlling interest by a corporate entity will confer operational authority of a practice either directly or indirectly.

Obviously, while lay entities must not—under any circumstances—control the practice of medicine, the Board believes that decisions made by a corporate investor on matters often characterized as operational or administrative may in some cases intrude on clinical decision-making and physician autonomy, as well as affect quality of care and patient outcomes. This is not simply in cases where the difference may be blurred—even matters that may be typically characterized as operational, e.g., coding, billing and collections, administration and non-clinical management; risk managements, etc., may themselves be implemented in ways that interfere with clinical decision-making and physician autonomy and/or expose physicians to liability. Thus, the Board also believes that regardless of a physician practice's ownership structure, physician clinical autonomy and operational authority must be preserved and protected. The Board further recognizes that beyond patient care and physician autonomy at the practice level, allowing the corporatization of medicine has led to further consolidation of healthcare, increased costs, and siphoning of health care dollars to shareholders and non-health care entities in the larger health care system. Notably, allowing the corporate ownership of a medical practice also has implication for scope of practice issues—both in the supervision of non-physician practitioners (NPP) in the practice, as well as the potential conflict if an NPP has an ownership in the practice.

While the Board does not recommend developing federal legislation called for by Resolution 233 given the potential pitfall of initiating federal legislation as discussed above, the Board does believe that the AMA should be heavily engaged in fighting the negative influence that PE and other corporate investors are having on the practice of medicine. The Board also believes that the AMA must vigorously oppose any removal or weakening of existing state laws prohibiting the corporate practice of medicine legislation or regulation. This advocacy should include closely monitoring federal legislative proposals and engaging where appropriate, as well as continuing to work closely with state medical associations and national medical specialty societies in the state advocacy arena.

In this regard, it must be noted that at the AMA 2024 Annual Meeting, the HOD amended AMA Policy H-215.981 "Corporate Practice of Medicine," that directs AMA Advocacy as follows: "Our AMA will work with the state and federal government and other interested parties to develop and advocate for regulations pertaining to corporate control of practices in the health care sector such that physician autonomy in clinical care is preserved and protected." Importantly, the AMA was already engaged in federal advocacy, as well as advocacy at the state level—as directed by Resolution 710 (A-24). For example, prior to the AMA 2024 Annual Meeting on June 5, 2024, the AMA sent an extensive letter to the Federal Trade Commission (FTC), U.S. Department of Justice (DOJ), and the U.S. Department of Health and Human Services, expressing its concerns about PE, its impact on physicians, and how PE is exacerbating consolidation in health care markets generally. Given the current political environment, the Board believes that continued federal regulatory advocacy is much more likely to be successful (as compared to federal legislative advocacy). Both the FTC and DOJ are subjecting PE in health care to unprecedented scrutiny, including "strip and flip" tactics. The Board supports the preservation of the restrictions of ownership and operational authority of physician medical practices to physicians or physician owned groups. and expects AMA Advocacy to seek every opportunity to advocate consistent with our HOD policy at the federal level, as well as in the states.

With regard to AMA state level advocacy, the Board strongly recommends that the AMA's state government affairs team, the Advocacy Resource Center, develop a comprehensive corporate investor state legislative template modeled after the Advocacy Resource Center's "Legislative Template: Covenants not-to-Compete in Physician Contracts"—to advance AMA engagement at the state level on CPOM issues. State medical associations and national medical specialty societies interested in seeing how the corporate investor template will be structured can view the Advocacy Resource Center's covenant not-to-compete template here.

Notably, the AMA has also developed a number of excellent resources to help physicians understand and negotiate contracts with PE and venture capital firms, including, but not limited to, sample contract language. Finally, the Board would like to note that during its 2024 Annual Meeting, the HOD amended existing AMA Policy D-215.982 entitled, "The Corporate Practice of Medicine, Revisited" which calls on the AMA to create a new report that will study and report back by AMA 2025 Annual Meeting with recommendations on how to increase competition, increase transparency, support physicians and physician autonomy, protect patients, and control costs in already consolidated health care markets. This report is just one example of continuing studies that the AMA is conducting regarding the negative impact that corporate interests are having on the practice of medicine, and the Board expects that AMA Advocacy will take full advantage of new findings to prohibit corporate investors' intrusion into the practice of medicine, in its federal and state level work.

AMA POLICY

The following AMA policy is relevant to this Board Report:
Policy D-160-904 entitled, "The Regulation of Private Equity in the Healthcare Sector," which states that: Our American Medical Association will propose appropriate guidelines for the use of private equity in healthcare, ensuring that physician autonomy and operational authority in clinical care is preserved and protected.

Policy H-160.891 entitled, "Corporate Investors," which states that:
(1) Our American Medical Association encourages physicians who are contemplating corporate investor partnerships to consider the following guidelines:
(a) Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor.
(b) Due diligence should be conducted that includes, at minimum, review of the corporate investor's business model, strategic plan, leadership and governance, and culture.
(c) External legal, accounting and/or business council should be obtained to advise during the exploration and negotiation of corporate investor transactions.
(d) Retaining negotiators to advocate for the best interests of the practice and its employees should be considered.
(e) Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
(f) Physicians should consider the potential impact of corporate investor partnerships on physicians and practice employee satisfaction and future physician recruitment.
(g) Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.
(h) Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
(i) Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships.
(j) Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non- physician practitioners.
(k) Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.
(l) Our AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices.
(m) Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty.
(n) Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine.

AMA Policy H-160.887 entitled "Corporate Practice of Medicine"
(1) Our American Medical Association acknowledges that the corporate practice of medicine:
(a) has the potential to erode the patient-physician relationship.
(b) may create a conflict of interest between profit and best practices in residency and fellowship training.

Policy H-215.981 entitled. "Corporate Practice of Medicine," which states that:
(1) Our American Medical Association vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine.
(2) At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.
(3) Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues.
(4) Our AMA will work with state and federal government and other interested parties to develop and advocate for regulations pertaining to corporate control of practices in the healthcare sector such that physician autonomy in clinical care is preserved and protected.

Policy D-215.982 entitled, "The Corporate Practice of Medicine, Revisited" which states that:
Our American Medical Association will revisit the concept of restrictions on the corporate practice of medicine, including, but not limited to, private equities, hedge funds and similar entities, review existing state laws and study needed revisions and qualifications of such restrictions and/or allowances, in a new report that will study and report back by Annual 2025 with recommendations on how to increase competition, increase transparency, support physicians and physician autonomy, protect patients, and control costs in already consolidated health care markets; and to inform advocacy to protect the autonomy of physician-directed care, patient protections, medical staff employment and contract conflicts, and access of the public to quality health care, while containing health care costs.

Policy H-310.904 entitled, "Graduate Medical Education and the Corporate Practice of Medicine," which states that:
(1) Our American Medical Association recognizes and supports that the environment for education of residents and fellows must be free of the conflict of interest created between a training site's fiduciary responsibility to shareholders and the educational mission of residency or fellowship training programs.
(2) Our AMA encourages the Accreditation Council for Graduate Medical Education (ACGME) to update its "Principles to Guide the Relationship between Graduate Medical Education, Industry, and Other Funding Sources for Programs and Sponsoring Institutions Accredited by the ACGME" to include corporate-owned lay entity funding sources.
(3) Our AMA will continue to monitor issues, including waiver of due process requirements, created by corporate control of graduate medical education sites.

RECOMMENDATIONS:

The Board of Trustees recommends that in lieu of Resolution 233-I-23, existing AMA Policy H-215.981 entitled, "Corporate Practice of Medicine," be amended by addition and the remainder of the report be filed:

1. Our American Medical Association vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine.
2. Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state laws prohibiting the corporate practice of medicine.
3. Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups.
4. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.
5. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues.
6. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the healthcare sector such that physician clinical autonomy ~~in clinical care~~ and operational authority ~~is~~ are preserved and protected.
7. Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician

practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices.

10. AMA EFFORTS ON MEDICARE PAYMENT REFORM

Informational report; no reference committee hearing

HOD ACTION: FILED

BACKGROUND

At the 2023 American Medical Association (AMA) Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy – D-385.945, "Advocacy and Action for a Sustainable Medical Care System" and amended Policy D-390.922, "Physician Payment Reform and Equity." Together, they declare Medicare physician payment reform as an urgent advocacy and legislative priority, call on the AMA to implement a comprehensive advocacy campaign, and for the Board of Trustees (the Board) to report back to the HOD at each Annual and Interim meeting highlighting the progress of our AMA in achieving Medicare payment reform until a predictable, sustainable, fair physician payment system is achieved. The Board has prepared the following report to provide an update on AMA activities for the year to date. (Note: This report was prepared in mid-August based on approval deadlines, so more recent developments may not be reflected in it.)

AMA ACTIVITIES ON MEDICARE PHYSICIAN PAYMENT REFORM

The AMA's Medicare physician payment reform efforts were initiated early in 2022, following the development of a set of principles outlining the "Characteristics of a Rational Medicare Payment System" that was endorsed by 124 state medical associations and national medical specialty societies. These principles identified strategies and goals to: (1) ensure financial stability and predictability for physician practices; (2) promote value-based care; and (3) safeguard access to high quality care.

Subsequently, the AMA worked with Federation organizations to identify four general strategies to reform the Medicare payment system, including:

- Automatic annual payment updates based on the Medicare Economic Index (MEI);
- Updated policies governing when and how budget neutrality adjustments are made;
- Simplified and clinically relevant policies under the Merit-based Incentive Payment System (MIPS); and
- Greater opportunities for physician practices wanting to transition to advanced alternative payment models (APMs).

At the heart of the AMA's unwavering commitment to reforming the Medicare physician payment system lie four central pillars that underscore our strategic approach: legislative advocacy, regulatory advocacy, federation engagement, and grassroots, media, and outreach initiatives. Grounded in principles endorsed by a unified medical community, our legislative efforts drive the advancement of policies that foster payment stability and promote value-based care. We actively champion reform through regulatory channels, tirelessly engaging with crucial agencies such as the Centers for Medicare & Medicaid Services (CMS) and the White House to address impending challenges and ensure fair payment policies. Our federation engagement fosters unity and consensus within the broader medical community, pooling resources and strategies to amplify our collective voice. Lastly, our continued grassroots, media, and outreach efforts bridge the gap between policymakers and the public, ensuring our mission is well-understood and supported from all quarters. Together, these pillars fortify our endeavors to achieve a more rational Medicare physician payment system that truly benefits all.

Legislative Advocacy

The AMA shares its members' long frustration over the continued cuts to Medicare payment. Congress did mitigate about half of the 2024 Medicare physician payment cuts initially implemented despite urgent calls from physicians about the impact that two decades of annual payment cuts are having on practice viability and patient access to care. Adding salt to the wound is the proposed 2025 Physician Payment Rule that includes a 2.8 percent cut. This would

be the fifth consecutive year that physicians face Medicare cuts. Meanwhile, the CMS predicts that the MEI will increase by 3.6 percent in 2025. The gap between what Medicare pays physicians and the cost of delivering quality care to patients continues to widen. Further, the fiscal stability of physician practices and long-term viability of the nation's entire health care system is at stake because Medicare physician payment rates have plummeted 29 percent from 2001 to 2024 (adjusted for inflation in practice costs).

Fixing our unsustainable Medicare payment system will remain AMA's top advocacy priority until meaningful reform is achieved. The need to stop the annual cycle of pay cuts and patches and enact permanent Medicare payment reforms could not be clearer. Because of Congress' failure to reverse these cuts, millions of seniors will find it more difficult to access high quality care and physicians will find it more difficult to accept new Medicare patients. The impact of sustained, year-over-year Medicare payment cuts will become noticeable first in rural and underserved areas and with small, independent physician practices which will be highly detrimental for some of our nation's most vulnerable patients.

Summary of Recent AMA Advocacy Efforts in the 118th Congress

As a result of the continued advocacy efforts of the AMA and larger physician community and direct engagement with Congress, a collection of influential Dear Colleague letters and commonsense legislative reforms have been introduced as well as key Committee hearings and white papers released that build upon "Characteristics of a Rational Medicare Physician Payment System" including:

On May 9, 2024, the bipartisan Senate Medicare Payment Reform Working Group led by Senators Cortez Masto (D-NV), Blackburn (R-TN), Thune (R-SD), Barrasso (R-WY), Stabenow (D-MI), and Warner (D-VA) held its first provider roundtable where the AMA was invited to speak and present its consensus proposals on Medicare payment reform. The primary goal of this working group is to explore the current problems with the MPFS, propose long-term solutions, and recommend necessary updates to the Medicare Access and Chip Reauthorization Act (MACRA), which sets physician payment policies in the Medicare program. The AMA has served as a resource to the Senate working group and remains engaged with the Members and has shared important advocacy documents and consensus proposals on Medicare payment reform.

AMA and its Medicare Reform Workgroup finalized legislative language to reform MIPS in May of 2024; it was socialized with the Federation and has been circulated and discussed among key Committee and rank-and-file staff. The proposals are being incorporated into our messaging.
The new "Medicare Physician Data-Driven Performance Payment System" would: (1) simplify MIPS reporting and improve its clinical relevance; (2) reduce the potential severity of penalties (currently as much as -nine percent) for those scoring poorly under MIPS; (3) provide support to smaller practices that tend to score lower under the program; and (4) provide timely and meaningful performance feedback to physicians and expand the use of clinical data registries.

On May 17, Chairman Wyden and Ranking Member Crapo of the Senate Finance Committee issued a white paper on the Medicare Physician Fee Schedule and its impact on chronic care management. The bipartisan paper outlines policy concepts related to reforming the way physicians are paid by Medicare and meeting the needs of those with chronic illness. It includes important steps toward potential policy reforms to streamline clinician payment systems and treat chronic diseases. As Chairman Wyden noted, "The way Medicare pays doctors for their work has not kept up with the times, and if it's not working for doctors, it's not working for the patients they help."

The paper outlines a number of areas of interest that the Finance Committee sees as an opportunity for reform, including:

- Creating sustainable payment updates to ensure clinicians can own and operate their practices
- Incentivizing alternative payment models that reward providing better care at a lower cost
- Rethinking how Medicare measures quality care
- Improving primary care
- Supporting chronic care benefits in Medicare fee-for-service
- Ensuring continued access to telehealth

The paper is the follow up to the Finance Committee's hearing in April regarding how to approach updating the Medicare physician payment system, and how to ensure the treatment and management of chronic conditions is at the center of the Medicare program. The AMA submitted a Statement for the Record (PDF) for that hearing.

The AMA has been working closely with the Committee and sees the paper as a very positive development that represents a bipartisan commitment from the Finance Committee to begin the process of reforming the Medicare physician payment system. The AMA's response (PDF) to the paper encouraged the Committee to advance MACRA reform legislation to establish a permanent MEI update, reform the budget neutrality process, reform MIPS, and to maintain the APM bonuses and threshold requirements as well as to develop a more robust APM pipeline.

On May 23, the House Ways and Means Health Subcommittee held a hearing on the interconnectedness of Congress passing legislation to reform the current Medicare payment system and the ability of private practice physicians to remain a viable option for patients. The hearing, which was entitled, "The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine," touched on a variety of key policy themes that will help preserve private practice, including:

- The need for Congress to pass legislation providing physicians with an annual inflationary update in Medicare tied to the Medicare Economic Index (MEI);
- Burden reduction and administrative reforms; and
- Overhauling the Merit-based Incentive Payment System (MIPS)

The AMA submitted a detailed statement for the record (PDF), which focused on many of the same policies that were discussed during the hearing, especially support for H.R. 2474, the Supporting Medicare for Patients and Providers Act, and H.R. 6371, the Provider Reimbursement Stability Act.

August Recess

In light of the upcoming August congressional recess and the July release of the CY 2025 proposed Medicare Physician Fee Schedule (MPFS) rule which proposes to cut Medicare physician payments by 2.8 percent, the AMA spearheaded a Federation letter (PDF) signed by all 50 state medical associations and 76 national medical specialty societies to congressional leadership.

The 2025 Medicare conversion factor is set to decrease for the fifth straight year by approximately 2.8 percent from $33.2875 to $32.3562. This cut is largely the result of the expiration of a 2.93 percent temporary update to the conversion factor at the end of 2024 and a zero percent baseline update for 2025 under MACRA. These cuts coincide with ongoing growth in the cost of practicing medicine as CMS projects the increase in the MEI for 2025 will be 3.6 percent.

The Federation letter warned that physician practices cannot continue to absorb increasing costs with ever-increasing inflation rates, while their payment rates dwindle year after year. Both the Medicare Payment Advisory Commission (MedPAC) and the Medicare Trustees (PDF) have issued warnings about access to care problems for America's seniors and persons with disabilities if the gap between what Medicare pays physicians and what it costs to provide high quality patient care continues to grow. Committees of jurisdiction have started conversations on reforming MACRA, and the Federation letter urged them to continue these negotiations in earnest given the cuts in the latest proposed rule and enact priority legislation.

The letter specifically urged leadership to act on bills or future legislation which reforms MACRA along four keys pillars:

1. Enacting an annual, permanent inflationary payment update in Medicare that is tied to the MEI (H.R. 2474);
2. Budget Neutrality reforms (H.R. 6371);
3. An overhaul of MACRA's Merit-based Incentive Payment System (MIPS); and
4. Modifications to Alternative Payment Models (APM) (H.R. 5013/S. 3503).

These are well vetted, consensus reforms within the physician community. In addition to the Federation letter on MACRA reform, AMA advocacy staff are continuing to meet with the House and Senate leadership and committee

staff to educate them on the importance of a permanent inflation-based update tied to the MEI, MIPs reform, Budget Neutrality reform, and the need for legislation modifying APMs in any end of year health care package.

AMA advocacy staff will continue to work with Members of Congress and staff during all recess periods to build support for including elements of our reform proposal in the expected end-of-year omnibus legislation.

Physician Call to Take Action

As Congress returns home for the annual August recess, physician advocates have unique opportunities to engage with their members of Congress "back home" in the district and urge them to reform Medicare's broken physician payment system. To make these interactions with legislators as impactful as possible, the AMA developed an online "Advocacy Hub" for the August Congressional recess that serves as one-stop shop for toolkits, legislative calls to action, and information on scheduling and preparing for legislative meetings and other in-district opportunities.

Additionally, the AMA held an informative webinar on August 1st reviewing the current state of federal legislation and ways in which physician advocates can engage Congress during August and beyond. There was also a discussion of August recess advocacy best practices to help prepare physicians for in-district legislative meetings, hosting members of Congress at site visits, and engaging with legislators online.

The AMA will continue to work with Congress to build bipartisan support in Congress for a proposal that will put an end to the annual cycle of Medicare cuts that threaten seniors' access to care. Bipartisan support for the aforementioned legislative proposals continues to grow among rank-and-file Members of Congress. However, the need for further advocacy remains to push the relevant Committees and Congressional leadership to make Medicare physician payment reform a top priority.

Grassroots, Media, and Outreach

The AMA has maintained a continuous drumbeat of grassroots contacts through its Physicians Grassroots Network, Patients Advocacy Network, and its Very Influential Physicians program. Op eds have been placed in various publications from AMA leaders, as well as from "grasstops" contacts in local newspapers. Digital advertisements are running, targeted specifically to publications read on Capitol Hill, and media releases have been issued to highlight significant developments.

The AMA relaunched a dedicated Medicare payment reform web site, www.FixMedicareNow.org, which includes a range of AMA-developed advocacy resource material, updated payment graphics, and a new "Medicare basics" series of papers describing in plain language specific challenges
presented by current Medicare payment policies and recommendations for reform.

From a research perspective, the AMA has also launched the Physician Practice Information Survey to update physician practice cost data utilized in the Medicare Resource-Based Relative Value Scale and the MEI. More than 10,000 physician practices have been contacted to participate in the effort. Data from the effort will be summarized in late 2024 to share with CMS and to be used in AMA advocacy efforts.

Following up on public polling and focus groups held last year, additional polling was conducted this year of physicians and patients to further test our Medicare advocacy messaging and obtain more specific information about the impact of escalating practice costs and declining payments on patient access to care.

To support the Medicare legislation cited above, the AMA has been engaged in a major grassroots campaign to engage patients and physicians in our lobbying efforts. The following statistics result from the Fix Medicare Now campaign and engagement with the Physician Grassroots Network and Patients Action Network.

- 90.9MM+ Impressions
- 1.5MM+ Engagements
- 2,000+ #FixMedicareNow Social Media Mentions
- 397k messages sent to Congress
- 504k+ FixMedicareNow.org Pageviews
- 423k+ FixMedicareNow.org Site Users

1000+ earned media stories on Medicare, including more than 50 placements giving voice to physician leaders and third parties – making the case for reforming the system and stopping/reversing the cuts. These efforts have had an organic impact on thought leaders and policy analysts who are now beginning to express similar views independently.

A good example of the campaign is a promotional series that the AMA is running at the Politico site and other influential web properties.

Activities ramping-up in the summer will continue to intensify through the fall and in anticipation of a Congressional "lame duck" session that will tackle Medicare.

These include engaging both patient and physician audiences during Congress' month-long August Recess, helping them identify opportunities to contact and meet with their federal legislators, and staff equipped with 'action kits' (that include talking points, supportive charts/data, and feedback forms) that reinforce medicine's position. Other tactics include aggressive paid promotion that hit lawmakers in Washington, D.C. and their home states/districts with a battery of messaging online, in print, radio, and TV/streaming services ensuring the issue is top-of-mind for them and their constituents ahead of critical elections in November. Additionally, earned media efforts and physician grasstops and allied influencer engagement that bring together the most influential voices to put direct/public pressure on key legislators to act will be leveraged as well.

When Congress returns in the fall and throughout their lame duck session these activities will continue to ratchet-up in addition to other potential activities including coordinated social media and phone storms/blitzes as determined necessary at key times in anticipation of Congressional action.

We do not expect H.R. 2474 (MEI legislation) to advance during the lame duck session given its potential to cost $300 billion over a ten-year period. The current national debt of $35 trillion and CBO's projections that the federal budget deficit in fiscal year 2024 will be $1.9 trillion makes it extremely difficult to advance costly legislation. The current Congress remains deeply divided and achieving consensus on spending and budgetary matters has been very challenging, often resulting in gridlock.

Despite these hurdles, significant progress has been made to advance Medicare physician payment reform as highlighted in this report. During the lame duck session, the AMA will continue to aggressively advocate for replacing the proposed 2.8 percent Medicare physician payment cut on January 1st with a payment update that reflects practice costs as well as for reforms to the budget neutrality process, MIPS program, and modifications to APMs. Passage of these incremental reforms will serve to build the foundation for more comprehensive MACRA reform in the 119th Congress.

The AMA and Federation are working to maintain and grow our coalition in support of MACRA reforms, including the allied professions community who are also negatively impacted by the broken Medicare payment system as well as the patient community concerned about continued access to care.

Finally, a key element of our MACRA reform strategy involves the continuous engagement of physicians with their legislators in the months ahead. Individual physicians back home in the state and district have the unique ability to influence their Member of Congress by developing a relationship and sharing compelling stories as to why MACRA reform is urgently needed and will preserve their constituents access to care. The AMA will continue to reach out to the physician community in the days ahead through various channels, including the Physicians Grassroots Network, requesting their timely engagement with Congress.

CONCLUSION

The AMA will continue to engage the Federation and press Congress to develop long-term solutions to the systematic problems with the Medicare physician payment system and preserve patient access to quality care. Despite the aforementioned challenges, the continued engagement of the physician community is crucial. It is vital to continue advocating for reform, engaging with legislators, and highlighting the real-world impacts of the current, broken system on patient care and physician practices.

Please follow Advocacy Update, join the Physicians Grassroots Network, visit www.FixMedicareNow often for updated material and alerts, and follow other AMA communications vehicles to stay up to date and engaged on this topic.

11. CARBON PRICING TO ADDRESS CLIMATE CHANGE

Reference committee hearing: see report of Reference Committee K.

HOUSE ACTION: ADOPTED
IN LIEU OF RESOLUTION 601-I-23
REMAINDER OF THE REPORT FILED
See Policy D-135.966

INTRODUCTION

Resolution 601-I-23, introduced by the Medical Student Section, proposed modifying current HOD policy D-135.966, "Declaring Climate Change a Public Health Crisis," to include the following language:

> 6. Our AMA will advocate for federal and state carbon pricing systems and for US support of international carbon pricing.
>
> 7. Our AMA will work with the World Medical Association and interested countries' medical associations on international carbon pricing and other ways to address climate change.

The resolution was referred for study to gain a better understanding of the benefits and pitfalls of carbon pricing, including the possible consequences of our AMA endorsing a specific climate-saving alternative.

BACKGROUND

According to the Intergovernmental Panel on Climate Change (IPCC), global surface temperatures from 2011-2020 are approximately 1.1 degrees Celsius higher on average than in the period between 1850-1900.[1] Further, the U.S. Fifth National Climate Assessment states, "the evidence for warming across multiple aspects of the Earth system is incontrovertible, and the science is unequivocal that increases in atmospheric greenhouse gases (GHG) are driving many observed trends and changes."[13] Anthropogenic (i.e., human caused) increases in global GHG emissions are primarily a result of the burning of fossil fuels for electricity generation and transportation, deforestation, and unsustainable agricultural practices.[1,2,13] Recent research has demonstrated that human activities are responsible for 92 percent of observed warming.[14] Atmospheric concentrations of several GHG are at historically high levels within human history; with carbon dioxide (CO_2) concentrations at 419 parts per million, higher than at any time in at least two million years.[14] Additionally, concentrations of methane are at 1,923 parts per billion, and nitrous oxide are at 337 parts per billion, higher than at any time in at least 800,000 years.[1,14] The year 2023 was the planet's hottest calendar year on record, surpassing the 1.5 degree Celsius threshold set by the Paris Agreement and 2024 is on track to be as hot or hotter than 2023, with 1,400 heat records broken by June 2024.[15,16]

As concern over anthropogenic climate change has increased over the past few decades, several international agreements have been established to address the issue. The United Nations (UN) Framework Convention of Climate Change, adopted in 1992, was the first international treaty to explicitly address climate change and was ratified by 197 countries, including the U.S.[17] A key component of this framework was the establishment of an annual forum known as the Conference of the Parties, or COP, aimed at facilitating international discussions on establishing the concentration of GHG in the atmosphere.

Five years later, the Kyoto Protocol was adopted, establishing the first legally binding climate treaty aimed at reducing signatory country emissions by an average of five percent below 1990 levels as well as a system to monitor process.[17] While adopted in 1997, the treaty went into effect in 2005. While the U.S. signed the agreement, it was never ratified, and the U.S. later withdrew its signature. In 2015, the Paris Accord agreement was adopted, requiring all signatory countries to set emission-reduction pledges with the goal of preventing global average temperatures from rising two degrees Celsius above preindustrial levels but with the real aim of keeping temperature increases

below 1.5 degrees Celsius.[17] The U.S. withdrew from the accord under former President Donald Trump although President Biden reentered the U.S. into agreement upon entering office. As part of the Paris Agreement, National Determined Contributions (NDCs) are supposed to be submitted. NDCs form the basis for how countries are supposed to achieve the objectives of the Paris agreement and include information on targets, mitigation policies, and measures for reducing emissions.[18] "Mitigation" refers to efforts that aim to reduce emissions directly or reduce the current concentration of GHG in the atmosphere by enhancing carbon dioxide sinks (e.g. increasing the area of forests, which absorb carbon dioxide).[19] The U.S. NDC target is an economy-wide reduction of GHG emissions by 50-52 percent below 2005 levels by 2030.[20]

At the COP 2023 UN Climate Summit in Dubai, it was concluded that governments are not doing enough to prevent the global average temperature from rising by 1.5 degrees Celsius.[21] The significance of this global temperature target is that scientists warn that with consistent warming above 1.5 degrees Celsius, the Earth will experience catastrophic environmental consequences with dire impacts for human health and settlements as well as mass animal and plant species loss. While a recent analysis found U.S. GHG emission reductions have accelerated in the past few years, primarily due to the passage of the Inflation Reduction Act and Infrastructure Investment and Jobs Act, the adoption of a suite of federal regulations aimed at driving down emissions, and ambitious state action, it is still not enough to achieve the Paris Agreement climate commitment of a 50-52 percent reduction by 2030.[22]

There are many potential mitigation policies countries can adopt to address GHG emissions from multiple sectors. One policy solution that has gained popularity is carbon pricing. The following report describes what carbon pricing is, examines the economic logic behind it and summarizes available evidence of how effective existing programs are in terms of reducing GHG emissions. Lastly, the report reviews the challenges and benefits of carbon pricing, with a specific focus on potential health benefits, and outlines alternative policies for reducing GHG emissions.

METHODS

English-language reports were selected from a PubMed and Google Scholar search of the literature using the search terms "carbon pricing" or "carbon tax" or "carbon pricing policy" in combination with "evaluation," "benefits," "challenges," and "health impacts." Additionally, the websites of relevant organizations and agencies, such as the Environmental Protection Agency, the United Nations, the Intergovernmental Panel on Climate Change, the World Bank, and the Center for Climate and Energy Solutions were reviewed for applicable resources and information.

DISCUSSION

What is carbon pricing?

In the broadest sense, carbon pricing places a specific price on emitting carbon dioxide and passes the cost of emitting carbon emissions to the emitters.[3] The two primary mechanisms employed are through a tax on carbon, in which a fee is charged for the amount of carbon emitted wherever fossil fuels enter the economy, or through an emission trading scheme (ETS).[4,5] Within ETS, a limit is set for total emissions allowed and companies can buy or sell carbon emission allotments. For example, companies that produce less carbon emissions can sell shares of their carbon allotment to other companies that are higher carbon emitters.[5] ETS – also known as cap and trade - limits the total GHG permitted within a specific region and can help facilitate gradual emission decreases and keep total emissions within a designated amount.[5,23] As gains are made in terms of improved energy efficiency and technologies, the cap can continue to be lowered over time.

Carbon taxes, however, do not predetermine the total amount of allowable emissions, but rather, are focused on establishing a set price for carbon. In either form of carbon pricing, the policy follows a basic economic argument and logic – "faced with a price on carbon, economic agents will avail themselves to opportunities to abate emissions that are cheaper than paying the price."[7] Less well-known carbon pricing instruments include crediting mechanisms, a results-based climate finance framework, and internal carbon pricing schemes.[3] (See Table 1) There are also several indirect methods of pricing carbon, including fuel taxes, the removal of fossil fuel subsidies, and regulations that incorporate a social cost of carbon, which is intended to reflect the cost of effects created by generating one or more ton of emissions at any given period.[5,24]

As a policy solution, carbon pricing is not without historical precedent. For example, the sulfur dioxide cap and trade program for power plants in the U.S. was established under Title IV of the 1990 Clean Air Act Amendments;

the world's first large-scale pollutant cap-and-trade system, in response to widespread environmental concern over acid rain.[25] Despite industry opposition to the policy, this program was immensely successful at lowering sulfur dioxide levels and it led to such rapid technological advancements in controlling sulfur dioxide emissions that the marginal abatement costs fell to less than half of what had been predicted.[7] To be effective, many proponents believe carbon pricing should be implemented at a global scale and while this may seem unrealistic, successful international agreements on environmental action have been implemented and achieved their goals. For example, the Montreal Protocol, adopted in 1987, is an example of a successful international environmental agreement brought about by concern over the growing hole in our planet's ozone layer, which led to the phasing out of chlorofluorocarbons from industrial and pharmaceutical uses, and the ozone layer has since recovered.[26,27]

One of the most compelling reasons for carbon pricing, particularly a cap-and-trade model, is to guarantee emission targets are met.[7] Additionally, cap-and-trade programs provide economic incentives for reducing GHG emissions through the reinvestment of profits made through the program into renewable energy sources, changing consumption patterns, and improving energy efficiency.[7,23] Other considerations for a carbon tax versus a cap-and-trade model is the price elasticity of electricity generation.[7] Price elasticity is a term used to describe how responsive consumer demand is for a product based on its price. When something is price elastic, consumer demand is very sensitive to fluctuations in price (these tend to be pure commodities), versus price inelastic, meaning consumers will not change their usage much as price changes.[28] Energy and fuel consumption is generally a necessity versus a luxury, lending itself to being price inelastic. For many people, they will still power their homes, keep it at comfortable temperature, or drive their car no matter what the price of electricity or fuel, particularly those who do not have alternative methods of transportation. A main argument against a carbon tax is that it is regressive and will be passed down to consumers, with lower-income households being disproportionately impacted.[7,28] Proponents of ETS based carbon pricing policies argue that these systems are less likely to be subject to political intervention and pressure during periods of economic stress and are better able to respond to fluctuations in the economy overall.[23] Solutions to address these concerns are described further below.
Proponents of a carbon price argue the cap-and-trade approach requires additional bureaucracy to implement it and provides polluters with loopholes and options to buy their way out of penalties or regulation, versus implementing real change to reduce pollution.[4] A carbon tax is considered the most upstream approach to pricing carbon by defining a set price (versus a total limit) that is spread across all sectors of the economy that emit fossil fuels.[7,24] In essence, a carbon tax treats all fossil carbon equally, regardless of where it enters the system.[7] This approach greatly minimizes administrative burden and costs associated with a cap-and-trade model for carbon pricing.

Examples of carbon pricing programs and evidence of effectiveness

As of 2024, more than 70 carbon pricing schemes have been implemented globally and they vary widely.[5,6] The U.S. and Australia are currently the only countries with developed economies who do not have a nationwide carbon pricing system.[4] A recent systematic review and meta-analysis found consistent evidence that across the globe, carbon pricing policies (including both cap-and-trade and carbon tax policies) were effective at reducing GHG emissions between 5 to 21 percent.[6] As carbon ETS systems have been in effect for nearly twenty years and examples of their implementation exist in the U.S., a few of these programs are described in further detail below.

The European Union (EU) was the first to establish a cap-and-trade emissions system in 2005, and it remains the largest carbon market in the world.[29] The EU Emissions Trading System (EU ETS) primarily covers emissions created by the energy sector, manufacturing industry, as well as aircraft operators within the EU, which represents around 40 percent of the EU's emissions.[30] Based on a 2023 report by the European Commission, the EU ETS has thus far helped lower GHG emissions from the power and energy sectors by about 37 percent below 2005 levels.[31] Additionally, since the adoption of the EU ETS, there has been an increase in patent activity in low-carbon technologies.[7] In 2023, the EU developed a new separate emissions trading system (ETS2), which addresses the carbon dioxide emissions from fuel combustion in buildings, road transport and additional sectors (mainly small industry not covered by the existing ETS).[32] As this new trading scheme was recently established, there is no available data on its implementation and effectiveness.

While there is no nationwide carbon pricing policy, within the U.S., there are three active carbon ETS initiatives: (1) the Regional Greenhouse Gas Initiative (RGGI), which includes eleven participating states in the Northeast region of the U.S., (2) California, and (3) Washington. The RGGI was the first mandatory cap-and-trade program in the U.S. aimed at reducing carbon dioxide emissions from power plants within each participating state. Similar to the EU program, RGGI was established in 2005 and administered its first auction of carbon dioxide emissions

allowances in 2008.[33] As a result of this program, annual average carbon dioxide emissions from electric generation sources decreased by 48 percent within a ten-year period (from 2006-2008 to 2016-2018).[33] Between 2009-2018, participating RGGI states have seen a net economic benefit of $4.7 billion, which has been reinvested by states back into their participating communities and has included funding for clean energy programs, energy efficiency, and energy bill assistance programs to local business and communities.[33,34] Additional analyses of the program have found the RGGI has added 48,000 job-years (equivalent of one full-time job for the duration of one year) and contributed to positive health impacts in the form of avoided adverse child health outcomes from lower pollution levels.[9,35]

California's Cap-and-Trade program was initiated by the California legislature's approval of Assembly Bill 32 (AB 32) in 2006, which established the State's 2020 GHG reduction target and authorized the California Air Resources Board (CARB) to include a cap-and-trade program as one tool to help achieve the target.[36] After attempts to delay the implementation of the program, the defeat of a 2010 ballot initiative paved the way for the program to move forward and it began in 2013. A 2023 inventory report by the CARB indicates GHG emissions within the state have demonstrated a consistent decline between the years 2000 and 2021.[37]

Within the past five years, both Washington and Oregon passed legislation enabling the creation of carbon pricing initiatives. However, the Oregon Climate Protection Program was invalidated by the Oregon Court of Appeals in 2023 and a new regulatory process is underway to reestablish the program.[38–40] Washington state's cap-and-invest program was passed by the state legislature in 2021 under the Climate Commitment Act and the program officially started in January 2023.[41] The goal of this program, in addition to other clean energy initiatives in the state, is to reduce GHG emissions to 45 percent below 1990 levels by 2030, 70 percent below 1990 levels by 2040, and 95 percent below 1990 levels by 2050.[38] As Washington's program just started last year, there is no available data on its implementation and effectiveness.

As noted, there is no national carbon pricing scheme in place in the U.S. However, in 2023, legislation was introduced in the House of Representatives, H.R.5744 - Energy Innovation and Carbon Dividend Act of 2023, which would impose a fee on the carbon content of fuels, including crude oil, natural gas, coal, or any other product derived from those fuels and the revenue from those fees would be deposited into a Carbon Dividend Trust Fund and used for administrative expenses and dividend payments to U.S. citizens or lawful residents.[42] This proposed legislation is not likely to move forward this legislative session.

Implementation Challenges

There are several challenges with implementing carbon pricing schemes, which include carbon leakage (defined below), fairness and equity, public acceptance, competitiveness, market manipulation, and administrative burden. A well-designed carbon pricing mechanism should address carbon leakage - the phenomenon by which carbon-intensive industries or firms shift operations to lower-cost jurisdictions - resulting from geographically inconsistent policies and regulations. The lack of international agreement (or even national agreement within the U.S.) and/or implementation on carbon pricing has resulted in nonuniform pricing across the world resulting in the issue of carbon leakage. As one author noted, a uniform carbon pricing scheme across all global countries would be most ideal, to prevent certain "bad actors" simply moving their operations to an area of the world with less stringent environmental standards.[5] The Carbon Pricing Leadership Coalition – a group of leaders from government, private sector, academia, and civil society who aim to expand the use of carbon pricing policies – recommends that carbon pricing mechanisms be expanded and coordinated across countries to cover a higher proportion of global emissions.[3]

Another challenge for carbon pricing schemes is figuring out how generated revenue will be used and distributed. Critics of carbon pricing policies have argued that increased costs of fossil fuels will disproportionately impact low-income populations as well as fragile industries, who are more susceptible to energy price increases.[5,11] Customizing programs to be responsive to vulnerable populations who are most susceptible to energy price increases is crucial.[46] Strategies to reduce negative impacts on disadvantaged communities as well as address fairness and competitiveness concerns include targeting funds from carbon pricing to energy efficiency projects, supporting cleaner energy production technologies, carbon dividends, funding public transportation systems, and protecting or subsidizing energy costs for lower-income households.[5,8]

Carbon dividends, otherwise known as carbon cashback, is one potential strategy for reducing the economic burden of carbon pricing on households with low incomes that has gained popularity.[4,7,47] Carbon dividends is when a

proportion of revenues from a carbon tax are returned to households impacted by the policy, as opposed to transferring this money to firms (as in a cap-and-trade system with free permits) or to the government (as would happen if permit auction or carbon tax revenue goes to the treasury).[7,47] Multiple studies have projected that a carbon tax program implemented with a cashback option for U.S. citizens would provide an economic boost for many low-income households.[47] How revenues from carbon pricing are used also impact public acceptability and support for the policy, which has been a challenge. Carbon pricing policy has met considerable resistance in terms of general public acceptance, exemplified by the cancellation of a carbon pricing scheme in Australia after only two years and rejection of various ballot initiatives in the U.S.[7,48] A study on perceived fairness and public acceptability of carbon pricing found that the general population demonstrated little trust in the ability of governments to put the funds to good use but there were clear preferences for using funds to ensure fair outcomes and for environmental projects of various kinds.[48]

Another major challenge in developing and implementing carbon pricing policy is opposition from influential stakeholders whom the policy may negatively impact, such as fossil fuel companies and the energy sector more broadly.[5,36] Industry stakeholders have pushed back on carbon pricing policies citing potential impacts to competitiveness and predicting that it would hinder economic growth and job creation.[49] However, as cited above, the RGGI and EU ETS have generated net economic benefit of billions of dollars, have spurred job creation in the green energy sector, and prompted research and development funding into new green technologies leading to an increase in new patents in this area, calling into question the economic logic behind industry fears.[5,35]

Other challenges with cap-and-trade programs have been market manipulation and speculation, lack of transparency, and the possibility of being overly bureaucratic and administratively burdensome. Similar to other trading systems and capital markets, the ability to manipulate the market in your favor is a risk.[50] A way to avoid this issue is by creating a transparent, secure registry to track transactions and prevent manipulative tactics.[51] The issue of "greenwashing," the process of conveying false or misleading impression intended to deceive consumers into believing that a product or service is environmentally friendly or preferable to alternatives, has been raised as a concern with California's cap-and-trade program.[52] In response, California recently passed AB 1305, which went into effect in January 2024, requiring businesses marketing or selling voluntary carbon offsets (VCOs) or marketing products as having significantly reduced emissions within California to disclose on their website certain information concerning the projects that generated the VCOs and emission reductions.[53] This law represents California's attempt to hold businesses accountable for claims concerning GHG emission reductions and intensify transparency within the VCOs market.

Other potential solutions to minimize issues of market manipulation and lack of transparency include using technology to monitor and report emissions efficiently, establishing clear and transparent guidelines, and involving impacted stakeholders and citizen groups early in the formation process.[5] A 2018 review of existing ETS carbon pricing systems also found that more recently implemented programs demonstrated significant institutional learning from previous systems (like the EU ETS), thus making the administrative and regulatory structures easier to establish as the new programs are implemented.[54] Therefore, administrative hurdles may become less of a challenge as more programs are established. Lastly, these challenges are primarily of concern with a cap-and-trade mechanism of carbon pricing, thus could be reduced with the use of a broader carbon tax mechanism.

Another key consideration of any carbon pricing policy is how to define a reasonable and effective price for carbon. The Carbon Pricing Leadership Coalition noted in their most recent report that "Carbon prices must … be high enough to provide effective signals to society, which will drive the level of investment and technological changes necessary to reach net-zero and be taken in conjunction with complementary policy actions to make carbon pricing relevant across company value chains."[55] One strategy to define a reasonable and effective price for carbon is to calculate the social cost of carbon (SCC).[5] The SCC is an "economic metric intended to provide a comprehensive estimate of the net damages - that is, the monetized value of the net impacts, both negative and positive - from the global climate change that results from a small (1-metric ton) increase in carbon-dioxide emissions."[56] In the U.S., existing Executive Orders requiring the use of the SCC to determine regulatory impact have been in place since 2008.[56] Methods for estimating the SCC using integrated assessment models have been developed by an Interagency Working Group on the Social Cost of Carbon, set up in 2010, and continues to be refined as new data becomes available and models are updated.[56] However, there are still many challenges in calculating total risk and associated costs from carbon and SCC estimates have varied depending on political leadership at the federal level, ranging from $3-5 to $190 as determined by the U.S. Environmental Protection Agency in 2022.[5,7]

Potential Benefits

Despite the challenges, there are many benefits to carbon pricing policies, particularly health benefits. Overall, fossil fuel extraction and consumption have many negative environmental consequences that also lead to poor health outcomes, including contamination of drinking and recreational water sources, pipeline leaks or spills, gas leaks leading to explosions, and air pollution.[11,57,58] These health impacts do not include those that are directly or indirectly related to climate change. Direct health impacts from climate change include heatwaves and other extreme weather events such as hurricanes, forest fires, floods, or droughts. Indirect impacts are those mediated through the effects of climate change on ecosystems, such as agricultural losses and changing patterns of disease, economies, and social structures (such as displacement and conflict).[59] Additionally, climate change also poses risks to health care infrastructure, which threatens community health and the financial viability of health care organizations.[60] Climate change impacts are also already causing billions of dollars in economic losses.[61] To provide one example, economic losses from extreme weather events increased by 23 percent from 2010-14 to 2018-22, equaling $254 billion in 2022 alone.[62] For more detailed information on climate change and its health impacts, see AMA's Council on Science and Public Health report on climate change and health, written and adopted in 2022.[63] In short, the adverse health impacts and health care costs from climate change are already staggering and are only predicted to get worse.[62]

One of the most direct ways that carbon pricing can improve health is through improvements in air quality through lower air pollution. For example, based on evaluations of the RGGI, the program is estimated to have avoided several adverse child health outcomes, including 537 asthma cases, 112 preterm births, 98 cases of autism spectrum disorder, and 56 cases of term low birth weight.[9] These avoided adverse health outcomes are associated with an avoided cost estimated at $191 to $350 million. A study on a proposed carbon fee in Massachusetts estimated the program would yield nearly $3 billion in health benefits.[11,64] A report by CalEPA's Office of Environmental Health Hazard Assessment notes that reductions in co-pollutant emissions from California's carbon cap-and-trade program has resulted in major health benefits, including a reduction in premature pollution-related deaths, particularly in communities of color and disadvantaged communities.[12] Additionally, a 2021 study of potential impacts based on different mitigation scenarios in the U.S. found that nationwide health benefits from cleaner air-quality could be realized very rapidly from emission reductions and the cost savings from these benefits would exceed the costs of implementation within the first decade after going into effect.[65]

Higher fuel prices and funding from carbon pricing programs could also encourage and support alternative, active transportations options, such as walking, bicycling and public transportation. The use of active transportation modes, versus automobiles, is associated with greater levels of daily physical activity and lower air pollution.[59,66] Increased daily physical activity is associated with many health benefits, including reduced high blood pressure and risk of heart disease and stroke, reduced risk of type 2 diabetes, reduced risk of osteoporosis and falls, reduced symptoms of depression and anxiety, and improved sleep quality.[10]

Another potential impact from carbon pricing is the price of food, with carbon pricing most likely making the cost of some foods more expensive, namely red meat. Livestock production, and particularly cattle, is a major contributor to methane gas emissions, contributing almost 80 percent of agricultural GHG emissions.[67] It has been estimated that animal products with even the lowest environmental impacts generally exceed the environmental impacts related to all vegetable substitutes.[68] In general, plant-based diets (for example, Mediterranean, pescatarian, vegetarian, vegan) are associated with reduced disease risk compared with conventional Western diets and the widespread adoption of a healthy diet that emphasizes plants foods over red meat and dairy has been projected to prevent globally an estimated 10.8 million to 11.6 million deaths annually.[69,70] Carbon pricing could incentivize a transition to more plant-based diets, which would help reduce agricultural emissions, promote health, and generate financial savings.[69,71] One study in Australia estimated changes to food consumption habits and potential resulting health outcomes resulting from a carbon pricing scheme. The study estimated lower consumption of red and processed meats, with an increase in fruit consumption, resulting in lower body weight and decreased overweight and obesity prevalence.[71] The study concluded that carbon pricing on food commodities in Australia could have overall public health benefits.

Lastly, carbon pricing has the potential to improve health equity in several ways.[11] First, climate change impacts on health are disproportionately experienced by the most vulnerable and disadvantaged communities, including ethnic and racial minorities, communities of low-income, children, women, migrants and displaced communities, people with disabilities and existing health conditions, and indigenous populations.[61,72] Therefore, mitigating the future

harmful impacts of climate change will most benefit these vulnerable communities. Additionally, the public health benefits of reduced air pollution that could be achieved by the phasing out of fossil fuels would be greatest for low-income communities of color that experience disproportionately high exposure to air pollution.[73,74] While there have been concerns raised that the California cap-and-trade program has worsened local air quality within environmental justice communities, several studies have found the opposite to be true. In communities of color, there have been improvements in local air pollution and a reduction in exposure to toxic air pollutants from facilities covered by the cap-and-trade program.[12,36]

Alternatives

There are several other available strategies to meaningfully reduce GHG emissions outside of carbon pricing policies. Stricter regulations on CO2 and other greenhouse gases from electricity generation facilities as well as higher fuel efficiency standards for cars and trucks are policy options which push industry to make meaningful emission reductions.[7,11] Within the past few years, the AMA has joined with organizational partners urging federal agencies to pass such policies.[75,76] Another strategy is to invest and promote more renewable and sustainable energy sources.[11] The Inflation Reduction Act, enacted in 2022, has done just that, leading to $110 billion in new clean energy manufacturing investments within just 12 months of the bill being signed into law.[77] Investing in public transportation infrastructure, as well as sidewalks and bike lanes, and promoting their use over automobiles is another critical strategy to shift a general overreliance on personal vehicles for everyday trips.[7] Ultimately, in order to achieve current GHG emission reduction targets, all of these policies should be pursued as part of a holistic approach to reducing carbon emissions.

EXISTING AMA POLICY

The AMA has several existing policies on climate change and health (D-135.966 and H-135.938). D-135.966 is most relevant in regard to carbon pricing in that it calls on AMA to advocate for policies that: "(a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens."[78] At the 2024 Annual Meeting, the Board of Trustee's Report 25 Environmental Sustainability of AMA National Meetings was adopted with the recommendations that AMA is committed to make progress towards net zero emissions for its business operations by 2030 and to work with appropriate entities to encourage the U.S. health care system to decrease emissions to half of 2010 levels by 2030, achieve net zero by 2050, and remain net zero or negative.[79]

POSITION OF OTHER HEALTH CARE ORGANIZATIONS

Carbon pricing has been supported by other organizations within the health care sector. In October 2021, 100 leaders from the National Academy of Medicine signed a petition stating their strong support for a carbon pollution fee.[80] Additionally, the 2015 Lancet Commission on Health and Climate Change recommended that governments establish a framework for an international carbon pricing mechanism as a key policy strategy to protect public health.[59]

CONCLUSIONS

The threat of catastrophic climate change is becoming increasingly likely if the global community does not enact aggressive measures to reduce GHG emissions. As stated by a recent article, "Human-induced warming has been increasing at a rate that is unprecedented in the instrumental record, reaching 0.26 [0.2–0.4] °C per decade over 2014–2023."[14] This increasing rate of warming is directly tied to persistently high global GHG emissions. Despite existing challenges and concerns with carbon pricing, it is imperative that all GHG reduction strategies be on the table to meet reduction targets established by the Paris Agreement. While carbon pricing initiatives can be challenging to implement and must be thoughtfully designed, existing programs have been found to be effective at reducing GHG emissions and generating money to fund clean energy programs, energy efficiency projects, and subsidizing energy costs for low-income households. Despite challenges, there are many potential health benefits of carbon pricing initiatives that could result from a decrease in the extraction, processing, and use of fossil fuels, which could also result in health care cost savings.

RECOMMENDATIONS

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

1. Amend current HOD policy, D-135.966: Declaring Climate Change a Public Health Crisis, by addition to read as follows:

   1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.
   2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.
   3. Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge and ~~or~~ making a ~~similar~~ commitment to lower its own greenhouse gas emissions.
   4. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050.
   5. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.
   6. Our AMA supports the use of international, federal, regional, and state carbon pricing systems as an important tool to reduce global greenhouse gas emissions and achieve net-zero targets. Our AMA recommends that carbon dividends or energy subsidies for low-income households be a key component of any established carbon pricing system, to reduce the potential economic burden on households with lower incomes.

TABLES AND FIGURES

Table 1: Different Carbon Pricing instruments[3]

Carbon tax	Creates a direct price on GHG emissions and requires economic actors to pay for every ton of carbon pollution emitted.
Emission Trading System (ETS)	Also known as a cap-and-trade system, this instrument sets a limit on total direct GHG emissions from specific sectors and sets up a market where the rights to emit (in the form of carbon permits or allowances) are traded.
Crediting Mechanism	Emissions reductions that occur from a project, either by a business, government, or policy, are assigned credits, which can then be bought or sold. Entities seeking to lower their emissions can buy the credits as a way to offset their actual emissions.
Results-based climate finance framework	Entities, such as businesses, receive funds when they meet pre-defined climate-related goals, such as emissions reductions.
Internal carbon pricing	Governments, firms, and other entities assign their own internal price to carbon use and factor this into their investment decisions. These internal prices generally take two forms: a shadow price or an internal carbon fee.

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12. ELIMINATING ELIGIBILITY CRITERIA FOR SPERM DONORS BASED ON SEXUAL ORIENTATION

Informational report; no reference committee hearing

HOD ACTION: FILED

INTRODUCTION

At the 2023 Interim Meeting of the House of Delegates, our AMA adopted policy D-420.988, "Eliminating Eligibility Criteria for Sperm Donors Based on Sexual Orientation," which asked our AMA to "work with other interested organizations to ask the US Food and Drug Administration (FDA) to eliminate its eligibility criteria for sperm donation based on sexual orientation, with a report back at I-24." This informational report serves as a summary of our AMA's efforts in this space to accomplish this request.

Policies on donor eligibility are primarily maintained by the FDA, with one set of regulations for blood donors, and another for human cell, tissue, and cellular tissue-based product (HCT/P) donors. HCT/P is a broad category that includes bone, heart valves, ligaments, corneas, skin, semen, dura matter, and hematopoietic progenitor cells from cord blood.

Current guidelines require men who have had sex with men (MSM) to defer HCT/Ps donation for five years since their last sexual contact with a man, describing MSM as a risk factor for human immunodeficiency virus (HIV) and hepatitis B.[1] These guidelines arose out of the HIV epidemic of the 1980s and 1990s in which MSM were at higher risk of HIV transmission, and HIV tests were lacking in accuracy and precision. Modern HIV testing, however, can detect the presence of HIV as early as 10 days post-infection using nucleic acid testing, with more readily accessible antibody tests available around 23 days post-exposure.[2] The deferral period for MSM donors is also not consistent with the guidelines for other groups of comparable or higher risk. For example, only a one-year deferral period is advised for individuals who have had sex with someone known to be HIV-positive. A similar one-year deferral period is required for an individual who has had a needle-stick injury with a needle known to be infected with HIV.

MSM deferrals are not currently required for blood donation, although they have been in the past. Historically, MSM were banned entirely from donating blood between 1985 and 2015.[3] In 2015, after our AMA opposed this ban, it was replaced with a 1-year deferral period, which was then reduced to a three-month deferral period in 2020 in response to the increased need for blood donations during the COVID-19 pandemic.[4] Similarly, the U.S. Public Health Service updated its HIV risk assessment for solid organ transplantation in 2020 from a 12-month period to three-months, although they continue to use MSM as a risk criteria.[5] Finally, in May 2023, the FDA finalized its rule to rescind the blanket MSM blood donation ban and instead moved towards a personalized risk-assessment questionnaire, which included questions such as "[in the last 3 months, have you] had sexual contact with a new partner?" or "[in the last three months, have you] had an accidental needle-stick?".[6] Critics have argued that the questionnaire may still discriminate against MSM due to the inclusion of pre-exposure prophylaxis (PrEP) as a disqualifying risk factor, although this is in response to higher false-negative HIV testing rates for individuals taking PrEP.[7]

EXISTING AMA POLICY

Currently, the AMA maintains policy pertinent to HCT/Ps donations. The first, H-50.973, "Blood and Tissue Donor Deferral Criteria," which states:

1. Our American Medical Association supports the use of rational, scientifically-based deferral periods for donation of blood, corneas, and other tissues that are fairly and consistently applied to donors according to their individual risk.
2. Our AMA opposes all policies on deferral of blood and tissue donations that are not based on evidence.
3. Our AMA supports a blood and tissue donation deferral period for those determined to be at risk for transmission of HIV that is representative of current HIV testing technology.
4. Our AMA supports research into individual risk assessment criteria for blood and tissue donation.
5. Our AMA will continue to lobby the United States Food and Drug Administration to use modern medical knowledge to revise its decades-old deferral criteria for MSM (men who have sex with men) donors of corneas and other tissues.

AMA ACTIONS

While the changes in FDA policy represent a significant step forward for *blood* donation, the policy has not been expanded to HCT/Ps donation. Due to the multiple opportunities to speak on the changes in blood donor policy, our AMA has done significant outreach both directly to the FDA and in the public sphere on the need for HCT/Ps guidelines to follow those for blood.

A summary of recent communications to the FDA and media reports directly calling for revision of exclusionary donation policy (links available in online version of this report) is as follows:

- April 2nd, 2020 AMA press release on revised guidelines, urging "the FDA to take future steps to remove the categorical restrictions."
- October 20th, 2021 letter to FDA Acting Commissioner, requesting FDA "re-evaluate policy requiring a five year deferral period for [MSM] with regards to donating [HCT/Ps]."
- January, 26th, 2022 AMA Leadership Viewpoint, calling on the FDA to "evaluate all donors equally", particularly amidst an ongoing shortage.
- January 23rd, 2023 letter to FDA Director of Center for Biologics Evaluation and Research, stating "FDA's MSM [sperm donor] deferral policy is inconsistent with current evidence-based science."
- January 27th, 2023 statement to Medscape, "the current three-month deferral period singles out and bans blood donors based on their inherent attributes rather than the risk factors they present."
- March 23rd, 2023 letter to FDA Commissioner, applauding the lifting of restrictions on blood donation and "encourages expansion of these efforts to policies regarding the donation of [HCT/Ps]."
- May 11th, 2023 AMA press release on FDA removing restrictions for MSM blood donation, and calling for "the FDA to expand their work by reevaluating its donation deferral policies for [HCT/Ps] based on the latest scientific evidence."
- May 12th, 2023 video interview with MSNBC, stating "there are other deferral criteria around tissue-based products, corneas, human cells. We need to make sure those restrictions are fair."

- June 23rd, 2023 AMA news story, "Blood-donation changes bring equity. Next step: tissue rules.", which highlights AMA communications with the FDA.
- August 7th, 2023 AMA statement to NBC News, calling MSM deferral criteria "outdated categorical restrictions."
- August 8th, 2023 AMA statement to ABC News, quoting AMA policy and FDA communications.
- September 17th, 2023 coverage in USA Today, stating "it's hurtful when you should be able to do something so selfless and so important and you can't because of a bad policy decision that is based in old evidence, stigma and discrimination."
- June 27th, 2024 interview with NBC News (beginning at 34:33 of linked video), describing the FDA updates to MSM deferral periods.

CONCLUSION

While the FDA has yet to take action to align HCT/Ps donor eligibility with those of blood, there are reports suggesting that there is an FDA proposed rule in development to expand HCT/Ps donor eligibility, however it has not been made public at the time of this report's writing.[8] Given AMA policy and previous involvement on the issue, our AMA will continue to actively monitor this issue and would expect to comment if any such rule is proposed.

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13. AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 821-I-23
See Policies D-400.983, H-400.943, H-400.959, and H-400.969

At the 2023 Interim Meeting, the House of Delegates (HOD) referred Resolution 821. Introduced by the American College of Physicians, the American Academy of Family Physicians, and the Florida Medical Association, the resolution calls on the American Medical Association (AMA) to:

Encourage the AMA/Specialty Society Relative Value Scale (RVS) Update Committee (RUC) to modernize the RUC's processes and implement the following principles:

Data-Driven Decision Making: Enhance the data used in making recommendations by shifting from almost exclusive reliance on surveys of physicians and others who perform services to broader use of evidence-based data and metadata (e.g., procedure time from operating logs, hospital length of stay data, and other extant data sources) that permit assessment of resource use and the relative value of physician and other qualified healthcare professional services comprehensively. This can ensure that data is reliable, verifiable, and can be accurately compared to or integrated with other important databases.

Collaboration and Transparency: Seek collaboration with healthcare data experts, stakeholders, and relevant organizations to maintain transparent data collection and analysis methodologies.

Continuous Review and Adaptation: Expand and enhance its system for continuous review and adaptation of relative value determinations beyond its Relativity Assessment Workgroup (RAW) and other current strategies (e.g., New Technology/New Services list) to stay aligned with evolving healthcare practices and technologies.

Equity and Access: Work with the Current Procedural Terminology (CPT®) Editorial Panel and others, as appropriate, to identify the impact that factors related to healthcare equity and access have on the resources used to provide the services of physicians and other qualified healthcare professionals and how to account for those resources in the description and subsequent valuation of those services.

Broader Engagement: Actively engage with other parties to gather input and ensure that relative value determinations align with the broader healthcare community's goals and values.

Education and Training: Invest in the education and training of its members, AMA and specialty society staff, and other participants (e.g., specialty society RUC advisors) to build expertise in evidence-based data analysis and metadata utilization.

Timely Implementation: Invest the necessary resources and establish a clear timeline for the implementation of these modernization efforts, with regular progress self-assessment.

Testimony ranged from those who perceived that datasets of physician time are readily available and should be used to replace national medical specialty society surveys and clinical input to those who did not support the resolution and explained that specialty society information is currently the most available and reliable data. Many delegates supported referral as the RUC process may not be widely understood and a report would provide a greater understanding of its important work.

This report explains the RUC process, its relationship to the AMA, national medical specialty societies and the Centers for Medicare & Medicaid Services (CMS), and the data and methodology utilized to ensure that the Resource-Based Relative Value Scale (RBRVS) remains accurate.

BACKGROUND

In 1992, Medicare significantly changed the way it pays for physician services, based on statutory requirements from the Omnibus Budget Reconciliation Act of 1989. Instead of basing payments on charges, the federal government established a standardized physician payment schedule based on the RBRVS. In the RBRVS system, payments for services are determined by the resource costs needed to provide them. The cost of providing each service is divided into three components: physician work, practice expense, and professional liability insurance. Payments are calculated by multiplying the combined costs of a service by a conversion factor (a monetary amount that is determined by Congress and CMS). Payments are also adjusted for geographical differences.

The physician work component currently accounts for 50.9 percent of the total relative values units (RVUs) in the RBRVS system. The initial physician work relative values were based on the results of a Harvard School of Public Health study. The factors used to determine physician work, defined by statute and regulation, include the time it takes to perform the service; the technical skill and physical effort; the required mental effort and judgment; and stress due to the potential risk to the patient. The physician work relative values are updated each year to account for changes in medical practice described by new CPT codes. Practice expense accounts for 44.8 percent of the total relative values in the RBRVS system and represents the direct costs (e.g., clinical staff, medical supplies, medical

equipment) and indirect costs associated with the individual service. Professional liability insurance accounts for 4.3 percent of the total relative values in the RBRVS system.

THE RUC PROCESS

The RUC has served the physician community for more than 30 years, by most importantly ensuring that all physician specialties have an equal opportunity to represent their members and patients in a consistent, standardized, and fair process. Using its First Amendment right to petition the federal government, the RUC submits recommendations to CMS on resources required to provide a physician service. The RUC's data collection, deliberations, and recommendations must reflect the policy requirements of the RBRVS as determined via statute and regulation.

Data Driven Decision Making
The RUC reviews new services in advance of implementation of new and revised CPT codes. National medical specialty societies and other health care professional organizations use a standardized and rigorous survey process, designed to conform to federal requirements, to collect information from a random sample of physicians and others on the time, intensity, and work to perform the service in relationship to other services commonly performed by their members. The median number of survey responses for individual CPT codes is 70 responses. For services with higher volume, more than 100 responses are expected. The Evaluation and Management (E/M) office visit survey yielded the highest number of responses in the history of the RUC process, with 1,700 physicians completing the survey. The E/M survey was the concerted effort of 51 specialty societies and other health care professional organizations who represent 95 percent of Medicare claims for office visits. The data collected from these surveys provided the underlying basis for CMS implementing substantial payment increases for E/M office visit services in 2021.
Finally, the RUC also convenes a process to identify potentially misvalued services and then reexamines these services. Since 2006, the RUC has identified, reviewed, and submitted recommendations on nearly 2,800 services, resulting in the deletion of CPT codes or decrease in valuation for 58 percent of these services. As a component of participating in the RUC process and having an opportunity to fairly represent their members, national medical specialty societies conduct surveys to update the data for these identified services. In addition, the RUC provides the opportunity for specialty societies to identify national databases that may be utilized to present extant data. The RUC considers these data sets utilizing an approved list of criteria (e.g., ability to track data over time). To date, the RUC has approved the following databases to be utilized in support of the specialty presentations: Society of Thoracic Surgeons (STS) National Database™; American College of Cardiology (ACC) CathPCI Registry®; ACC LAAO Registry™; ACC EP Device Implant Registry™; STS/ACC TVT Registry™; and American Speech Hearing Language Association National Outcomes Measurement System. All participants are invited to submit extant data sources for consideration.

The RUC utilizes Medicare claims data in its processes to determine the typical patient, site-of-service, specialty, diagnosis, and other information to both determine appropriate relative value recommendations and to determine if a service may be potentially misvalued.

Collaboration and Transparency
The RUC is a transparent process. All RUC meeting minutes, votes, and recommendations are available on the AMA website and in a public database. Anyone may attend a RUC meeting. Hundreds of physicians from national specialty societies and other health care professionals attend as RUC participants. CMS sends representatives to each RUC meeting. Other observers include Medicare carrier medical directors, international delegations, MedPAC staff, Congressional staff, and researchers (e.g., Stanford, RAND). Since its inception in 1991, the RUC has sought the advice of AMA economists and other consultants in reviewing methodological or data methods.

Continuous Review and Adaptation
Federal law requires that all relative values be open for public comment and reviewed at least every five years. After initial implementation of the RBRVS in 1992, these reviews occurred for 1997, 2002, and 2007 implementation. In 2006, the RUC created the Relativity Assessment Workgroup (RAW) to ensure that services are identified and reviewed on an annual basis. In addition, CMS provides an annual opportunity, via federal rulemaking, for any individual or organization to identify services for review. The RUC also identifies new technology and maintains a new technology/new services list, reviewed when sufficient claims data become available.

The RAW, and the RUC, have identified and reviewed 2,800 services since the process inception in 2006. Numerous objective screens (e.g., rapid growth in utilization, site-of-service changes) are utilized to identify potentially misvalued services. To date, the RUC has reviewed services that comprise, in total allowed charges, 95 percent of the Medicare Physician Payment Schedule. More than $5 billion of annual spending has been redistributed, resulting from this process. To ensure a fair and consistent process, all participants in the RUC process may propose objective screens to identify such potential misvaluation. In addition, any member of the public may comment to CMS on individual services they believe to be misvalued. It should be noted that any increases in valuation must be supported by compelling evidence (e.g., that the service or patient population has substantially changed), a hurdle not only for RUC review, but also CMS consideration.

The RUC is further supported by an Administrative Subcommittee, Research Subcommittee, Practice Expense Subcommittee, Professional Liability Insurance Workgroup, and ad hoc workgroups to consider and adapt the RUC process and methodology. The CPT Editorial Panel and RUC often form joint workgroups to consider significant issues such as E/M services. The RUC and RUC process continuously evolve. The RUC's Administrative Subcommittee periodically studies the RUC composition. These reviews over the past two decades resulted in additional seats for neurology, geriatrics, physical medicine and rehabilitation, and primary care. The survey methodology is under constant review, including the Research Subcommittee review of customized surveys, such as for E/M office visits, to capture essential information. At each RUC meeting, RUC members, Advisors and other attendees are welcome to introduce new business items which typically relate to process improvements and are studied by these RUC Subcommittees.

Equity and Access
The RUC has actively worked with the CPT Editorial Panel to identify coding and valuation opportunities to address equity issues. For example, the CPT/RUC Workgroup on E/M was successful in changing the medical decision-making component to recognize that when a diagnosis or treatment is significantly limited by social determinants of health, a higher level of medical decision making for E/M coding may be warranted.

The RUC recently asked the American Urological Association and the American College of Obstetricians and Gynecologists to review services, performed by their members, which may be anatomically analogous but described by different CPT codes, such as hysterectomy vs. prostatectomy, to ensure gender equity in valuation. These specialty societies presented to the RUC that there were no overall inequities in the valuation of the services performed by these two specialties.[1] During that discussion, the RUC identified that the cost of providing a pelvic exam should be recognized to ensure equity in visit payments. The RUC referred the issue to CPT. CMS implemented RUC recommended RVUs for a new code on January 1, 2024.

RUC Composition/Broader Engagement
The RUC is comprised of 32 seats, 29 voting. The RUC requires a two-thirds majority approval to submit a recommendation to CMS. The RUC members do not advocate for their specialty and are strictly prohibited to speak to any code that their nominating specialty society members perform. The RUC must have the required clinical expertise to review the full range of physician services described in CPT and Healthcare Common Procedural Coding System codes. Primary care specialties are the top provider of only 184 of 7,392 CPT codes. The RUC does not review "specialties," but rather individual services described by CPT codes. For example, rather than discuss valuation of primary care, the RUC reviews specific CPT codes describing E/M services. Notably, 25 of the 29 voting members on the RUC are from specialties that receive 40 percent or more of their Medicare payment from E/M services. Therefore, nearly every voting member frequently perform and understand the resource costs required to perform E/M services described by individual CPT codes.

The AMA has one vote on the RUC. Every national medical specialty society in the AMA HOD may also appoint an Advisor, Alternate Advisor, and two staff to participate in the RUC process. In addition, the RUC has an active Health Care Professionals Advisory Committee to represent the non-MD/DOs who report their services based on the Medicare Physician Payment Schedule. RUC meetings are open, and observers are welcome to attend and provide feedback to the RUC.

Education and Training of RUC Participants
The RUC has an orientation process for its members, advisors, staff, and other participants. The RUC process is extremely technical, and it does require investment and time to become proficient in the rules and standards of the RBRVS methodology. The orientation includes participation in 12 webinars and annual in-person training sessions.

Most RUC members first serve for years as Advisors before being appointed to the RUC to fully be immersed into the RBRVS system.

Timely Improvements and Resources
The RUC has a continuous mechanism to ensure evolution and improvement in its methodology and processes. The RUC's Administrative Subcommittee, Research Subcommittee, and Practice Expense Subcommittee are all actively engaged in this effort. Collectively, the AMA and national medical specialty societies have devoted significant resources to the RUC process since its inception, spending millions of dollars each year for data collection, meetings, and travel. Hundreds of physician volunteers also spend countless hours preparing for and participating in RUC meetings.

AMA POLICY

The AMA has extensive, long-standing policy that supports the RUC process and the ability of physicians to provide clinical input into the refinement and improvement of the RBRVS (Policies D-400.983, D-400.986, D-400.988, D-400.999, H-70.952, H-70.980, H-400-956, H-400.957, H-400.959, H-400.962, H-400.969, H-400.972, H-400.973, H-400.990, H-400.991). Most relevant to the issues discussed in the report are the following AMA policies supporting the RUC and its ability to implement methodological improvements:

Policy D-400.983 states that the AMA, together with state medical associations and national medical specialty societies, will work to ensure that the resource-based relative value system and work values follow the statutory provisions that require the consideration of time and intensity.

Policy H-400.959 supports the RUC's efforts to improve the validity of the RBRVS through development of methodologies for assessing the relative work of new technologies and for assisting CMS in a more comprehensive review and refinement of the work component of the RBRVS.

Policy 400.969 states that the AMA continue to urge CMS to adopt the recommendations of the RUC for work relative values for new and revised CPT codes, and strongly supports the use of the RUC process as the principal method of refining and maintaining the Medicare RBRVS.

DISCUSSION

This report provides the opportunity to summarize the RUC process and the ongoing activities to offer improvements to the RBRVS. The RUC has successfully advocated on behalf of medicine and other health care professionals since 1991, with CMS often accepting more than 90 percent of the RUC's annual recommendations. The RUC also has engaged in the responsible, yet difficult, endeavor to identify potentially misvalued services. The national medical specialty societies are to be applauded for their ongoing effort to survey members and obtain clinical expertise to ensure that services are accurately and fairly evaluated, even when that review may lead to reduction in valuation for their services and a redistribution to other services.

The RUC has a long history of improving payment for primary care services, including increases to RVUs for preventive medicine, immunization administration, care management and E/M services in 1997, 2007 and 2021. Medical home recommendations were submitted to CMS in 2008.
The RUC has developed numerous standards within its review to ensure consistency and relativity using the national specialty society surveys and clinical expertise. Standards are used for physician pre-time evaluation, positioning and scrub, dress and wait times, and for post-time on the date of surgery. Numerous time standards are used for the tasks performed by clinical staff. These standards were developed with significant input by the national medical specialty societies, reviewed by the RUC, and ultimately published for public comment and review via CMS rulemaking. These standards, along with the national medical specialty society data, and the peer review by the RUC, lead to fair and consistent relative value recommendations to CMS.

The AMA supports the RUC's request for additional claims data from CMS, including updated Medicaid data and Medicare Advantage data. The AMA recently commented to CMS on a request for information on Medicare Advantage data and urged CMS to release these claims data in a manner similar to traditional Medicare claims data. The AMA also continues to investigate available claims data from commercial payers.

In addition, AMA staff have engaged in numerous meetings with staff from Epic and Oracle (which acquired Cerner in 2022) regarding the availability of any data within their electronic health systems that may be beneficial in reviewing physician time of individual services. To date, these systems do not collect meaningful physician time data that may be shared or utilized by the RUC. Ongoing discussions with Oracle on potential length of stay data will continue.

As previously noted, several national medical specialty societies have engaged in creating patient registries and some of these registries include time data. Cardiothoracic Surgery and Cardiology have each shared registry information with the RUC and these sources of extant data are approved for use in the valuation process. Other national medical specialties should be encouraged to share relevant extant databases with the RUC. The AMA, as well as the RUC's Research Subcommittee, will continue to investigate additional valid data sources to supplement specialty surveys, registries and claims databases that can enhance the overall RUC process.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 821-I-23, and the remainder of the report be filed.

1. That our American Medical Association (AMA) collaborate with relevant parties to support the AMA/Specialty Society RVS Update Committee (RUC) and RUC Research Subcommittee's study on how usable extant data, including electronic data, can be collected in order to compare the accuracy of a mixed methodology approach against the current survey methodology.
2. That our AMA reaffirm Policy D-400.983, which supports the RUC and its ability to implement methodological improvements.
3. That our AMA reaffirm Policy H-400.959, which supports the RUC's efforts to improve the validity of the RBRVS through development of methodologies for assessing the relative work of new technologies.
4. That our AMA reaffirm Policy H-400.969, which calls on the Centers for Medicare & Medicaid Services to adopt the recommendations of the RUC for work relative values for new and revised Current Procedural Terminology (CPT®) codes, and strongly supports the use of the RUC process as the principal method of refining and maintaining the Medicare RBRVS.

REFERENCES

[1]Hathaway, JK, Schuster MS, Richards KA, Turk TMT. Comparison of Work Relative Value Units Assigned to Urological and Gynecological Surgical Procedures. Urology Practice. 2024 July 1: 11 (4):654-60. Available at: https://www.auajournals.org/doi/10.1097/UPJ.0000000000000612

Board of Trustees Report -I-24
AMA/Specialty Society RVS Update Committee
Policy Appendix

Arbitrary Relative Value Decisions by CMS D-400.983
1. Our AMA, together with state medical associations and national medical specialty societies, will work to ensure that the resource-based relative value system and physician work values follow the statutory provisions that require the consideration of time and intensity. 2. Our AMA, working with state medical associations and national medical specialty societies, strongly advocates that the Centers for Medicare and Medicaid Services restore the Refinement Panel to serve as the appeals process that was appropriately in place from 1993-2010. Res. 107, A-16
The RUC: Recent Activities to Improve the Valuation of Primary Care Services D-400.986
Our AMA continues to advocate for the adoption of AMA/Specialty Society RVS Update Committee (RUC) recommendations, and separate payment for physician services that do not necessarily require face-to-face interaction with a patient. BOT Rep. 14, A-08 Reaffirmed: CMS Rep. 01, A-18

PLI-RVU Component of RBRVS Medicare Fee Schedule D-400.988
Our AMA will: (1) continue its current activities to seek correction of the inadequate professional liability insurance component in the Resource-Based Relative Value Scale Formula; (2) continue its current activities to seek action from the Centers for Medicare & Medicaid Services to update the Professional Liability Insurance Relative Value Units (PLI-RVU) component of the RBRVS to correctly account for the current relative cost of professional liability

insurance and its funding; and (3) support federal legislation to provide additional funds for this correction and update of the PLI-RVU component of the RBRVS, rather than simply making adjustments in a budget-neutral fashion. Res. 707, I-03 Reaffirmed: BOT Rep. 18, A-05 Modified: CCB/CLRPD Rep. 2, A-14

Non-Medicare Use of the RBRVS D-400.999
Our AMA will: (1) reaffirm Policy H-400.960 which advocates that annually updated and rigorously validated Resource Based Relative Value Scale (RBRVS) relative values could provide a basis for non-Medicare physician payment schedules, and that the AMA help to ensure that any potential non-Medicare use of an RBRVS reflects the most current and accurate data and implementation methods;.(2) reaffirm Policy H-400.969 which supports the use of the AMA/Specialty Society process as the principal method of refining and maintaining the Medicare relative value scale;(3) continue to identify the extent to which third party payers and other public programs modify, adopt, and implement Medicare RBRVS payment policies;(4) strongly oppose and protests the Centers for Medicare & Medicaid Services Medicare multiple surgery reduction policy which reduces payment for additional surgical procedures after the first procedure by more than 50 percent; and (5) encourage third party payers and other public programs to utilize the most current CPT codes updated by the first quarter of the calendar year, modifiers, and relative values to ensure an accurate implementation of the RBRVS. CMS Rep. 12, A-99 Reaffirmation I-03 Reaffirmation I-07 Modified: BOT Rep. 22, A-17

Medicare Guidelines for Evaluation and Management Codes H-70.952
Our AMA (1) seeks Federal regulatory changes to reduce the burden of documentation for evaluation and management services; (2) will use all available means, including development of new Federal legislation and/or legal measures, if necessary, to ensure appropriate safeguards for physicians, so that insufficient documentation or inadvertent errors in the patient record, that does not meet evaluation and management coding guidelines in and of itself, does not constitute fraud or abuse; (3) urges CMS to adequately fund Medicare Carrier distribution of any documentation guidelines and provide funding to Carriers to sponsor educational efforts for physicians; (4) will work to ensure that the additional expense and time involved in complying with documentation requirements be appropriately reflected in the Resource Based Relative Value Scale (RBRVS); (5) continues to advise and educate physicians about the guidelines, any revisions, and their implementation by CMS; and (6) AMA policy is that in medical documentation the inclusion of any items unrelated to the care provided (e.g., irrelevant negatives) not be required. Sub. Res. 801, I-97 Reaffirmation I-00 Reaffirmed: CMS Rep. 6, A-10 Modified: CMS Rep. 01, A-20

Bundling CPT Codes H-70.980
1. Our AMA, through its CPT Editorial Panel and Advisory Committee, will continue to work with CMS to provide physician expertise commenting on the medical appropriateness of code bundling initiatives for Medicare payment policies. 2. Our AMA strongly urges the Centers for Medicare & Medicaid Services (CMS) to not treat bundling of existing services into a common code as a new procedure and new code. 3. Our AMA will advocate for a phase-in of new values for codes where the cuts resulting from the identification of misvalued services cause a significant reduction from the value of the existing codes and work with CMS to achieve a smooth transition for such codes. 4. The RUC will take into consideration CMS's willingness or reluctance to transition large payment reductions as it schedules the review of relative values for bundled services or other codes that come before the RUC as a result of the identification of potentially misvalued services. 5. Our AMA strongly supports RUC recommendations and any cuts by CMS beyond the RUC recommendations will be strongly opposed by our AMA. Sub. Res. 801, I-91 Reaffirmed: Res. 814, A-00 Reaffirmed: CMS Rep. 6, A-10 Appended: Res. 118, A-10 Reaffirmation I-13 Reaffirmed: CMS Rep. 01, A-23

RBRVS Development H-400.956
That the AMA strongly advocate CMS adoption and implementation of all the RUC's recommendations for the five-year review; (2) That the AMA closely monitor all phases in the development of resource-based practice expense relative values to ensure that studies are methodologically sound and produce valid data, that practicing physicians and organized medicine have meaningful opportunities to participate, and that any implementation plans are consistent with AMA policies; (3) That the AMA work to ensure that the integrity of the physician work relative values is not compromised by annual budget neutrality or other adjustments that are unrelated to physician work; (4) That the AMA encourage payers using the relative work values of the Medicare RBRVS to also incorporate the key assumptions underlying these values, such as the Medicare global periods; and (5) That the AMA continue to pursue a favorable advisory opinion from the Federal Trade Commission regarding AMA provision of a valid RBRVS as developed by the RUC process to private payers and physicians. BOT Rep. 16, A-95 BOT Rep. 11, A-96

Reaffirmed: CMS Rep. 4, I-02 Reaffirmed: BOT Rep. 14, A-08 Reaffirmed: Sub. Res. 104, A-14 Reaffirmation A-15

Medicare Reimbursement of Office-Based Procedures H-400.957
Our AMA will: (1) encourage CMS to expand the extent and amount of reimbursement for procedures performed in the physician's office, to shift more procedures from the hospital to the office setting, which is more cost effective; (2) seek to have the RBRVS practice expense RVUs reflect the true cost of performing office procedures; and (3) work with CMS to develop consistent regulations to be followed by carriers that include reimbursement for the costs of disposable supplies and surgical tray fees incurred with office-based procedures and surgery. Sub. Res. 103, I-93 Reaffirmed by Rules & Credentials Cmt., A-96 Reaffirmation A-04 Reaffirmation I-04 Reaffirmed: CMS Rep. 1, A-14 Reaffirmed: CMS Rep. 3, A-14 Reaffirmed in lieu of Res. 216, I-14 Reaffirmed: CMS Rep. 04, I-18 Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19 Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19 Reaffirmation: A-22

Refining and Updating the Physician Work Component of the RBRVS H-400.959
The AMA: (1) supports the efforts of the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee's (RUC's) work with the American Academy of Pediatrics and other specialty societies to develop pediatric-specific CPT codes and physician work relative value units to incorporate children's services into the RBRVS; (2) supports the RUC's efforts to improve the validity of the RBRVS through development of methodologies for assessing the relative work of new technologies and for assisting CMS in a more comprehensive review and refinement of the work component of the RBRVS; and (3) continues to object to use of the relative values as a mechanism to preserve budget neutrality. BOT Rep. I-93-26 Reaffirmed by BOT Rep. 8-I-94 Res. 806, I-94 Reaffirmed: Sub. Res. 816, I-99 Reaffirmed: CMS Rep. 4, I-02 Reaffirmed: BOT Rep. 14, A-08 Reaffirmed: Sub. Res. 104, A-14 Reaffirmation A-15

The AMA/Specialty Society RVS Update Process H-400.962
Our AMA will strengthen its efforts to secure CMS adoption of the AMA/Specialty Society RVS Update Committee's (RUC) recommendations. BOT Rep. N, A-93 Reaffirmed: Sub. Res. 821, I-99 Reaffirmed: BOT Rep. 14, A-08 Reaffirmed: CMS Rep. 01, A-18

RVS Updating Status Report and Future Plans H-400.969
Status Report and Future Plans: The AMA/Specialty Society RVS Update Committee (RUC) represents an important opportunity for the medical profession to maintain professional control of the clinical practice of medicine. The AMA urges each and every organization represented in its House of Delegates to become an advocate for the RUC process in its interactions with the federal government and with its physician members. The AMA (1) will continue to urge CMS to adopt the recommendations of the AMA/Specialty Society RVS Update Committee for physician work relative values for new and revised CPT codes; (2) supports strongly use of this AMA/Specialty Society process as the principal method of refining and maintaining the Medicare RVS; (3) encourages CMS to rely upon this process as it considers new methodologies for addressing the practice expense components of the Medicare RVS and other RBRVS issues; (4) opposes changes in Relative Value Units that are in excess of those recommended by the AMA/Specialty Society Relative Value Scale Update Committee (RUC); and (5) supports the ongoing effort of members of the federation to analyze the valuation of CPT codes describing similar services by gender to ensure equitable valuation. BOT Rep. O, I-92 Reaffirmed by BOT Rep. 8-I-94 Reaffirmed by BOT Rep. 7, A-98 Reaffirmed: CMS Rep.12, A-99 Reaffirmed: CMS Rep. 4, I-02 Reaffirmed: BOT Rep. 14, A-08 Reaffirmation I-10 Appended: Res. 822, I-12 Reaffirmation I-13 Reaffirmed: Sub. Res. 104, A-14 Reaffirmed in lieu of Res. 216, I-14 Reaffirmation A-15 Appended: Res. 105, A-23

Physician Payment Reform H-400.972
It is the policy of the AMA to (1) take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to, (a) reduction of allowances for new physicians; (b) the non-payment of EKG interpretations; (c) defects in the Geographic Practice Cost Indices and area designations; (d) inappropriate Resource-Based Relative Value Units; (e) the deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system; (f) the need for restoration of the RBRVS conversion factor to levels consistent with the statutory requirement for budget neutrality; (g) the inadequacy of payment for services of assistant surgeons; and (h) the loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt., A-96); (2) seek an evaluation of (a) stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable

adjustments; and (b) descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients; (3) evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system; (4) seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors; (5) seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures; (6) seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992; (7) seek the elimination of regulations directing patients to points of service; (8) support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change; (9) take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs; (10) support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes; (11) request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations; (12) pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a "shadow" Medicare Economic Index; (13) continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform; and (14) take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements. Sub. Res. 109,
A-92 Reaffirmed: I-92 Reaffirmed by CMS Rep. 8, A-95 and Sub. Res. 124, A-95 Reaffirmation A-99 and Reaffirmed: Res. 127, A-99 Reaffirmation A-02 Reaffirmation A-06 Reaffirmation I-07 Reaffirmed: BOT Rep. 14, A-08 Reaffirmation A-09 Reaffirmed: CMS Rep. 01, A-19 Reaffirmed: Res. 212, I-21

Limited Licensed Practitioners and RBRVS H-400.973
It is the policy of the AMA to advocate that Medicare expenditure data clearly differentiate between the services of fully licensed physicians and those of limited licensed practitioners and of other Part B services. Sub. Res. 124, I-91 Reaffirmed: BOT Rep. DD, I-92 Modified: CMS Rep. 10, A-03 Modified: CMS Rep. 4, A-13 Reaffirmed: BOT Rep. 09, A-23

Refinement of Medicare Physician Payment System H-400.990
The AMA: (1) reaffirms its support for development and implementation of a Medicare indemnity payment schedule according to the policies established in Policy 400.991; (2) supports reasonable attempts to remedy geographic Medicare physician payment inequities that do not substantially interfere with the AMA's support for an RBRVS-based indemnity payment system; (3) supports continued efforts to ensure that implementation of an RBRVS-based Medicare payment schedule occurs upon the expansion, correction, and refinement of the Harvard RBRVS study and data as called for in Board Report AA (I-88), and upon AMA review and approval of the relevant proposed enabling legislation; and (4) continues to oppose any effort to link the acceptance of an RBRVS with any proposal that is counter to AMA policy, such as expenditure targets or mandatory assignment. BOT Rep. BBB, A-89 Reaffirmed: I-92 Reaffirmed and Modified: CMS Rep. 10,
A-03 Reaffirmation A-09 Reaffirmed: CMS Rep. 01, A-19 Reaffirmed: Res. 212, I-21

Guidelines for the Resource-Based Relative Value Scale H-400.991
(1) The AMA reaffirms its current policy in support of adoption of a fair and equitable Medicare indemnity payment schedule under which physicians would determine their own fees and Medicare would establish its payments for physician services using: (a) an appropriate RVS based on the resource costs of providing physician services; (b) an appropriate monetary conversion factor; and (c) an appropriate set of conversion factor multipliers. (2) The AMA

supports the position that the current Harvard RBRVS study and data, when sufficiently expanded, corrected, and refined, would provide an acceptable basis for a Medicare indemnity payment system. (3) The AMA reaffirms its strong support for physicians' right to decide on a claim-by-claim basis whether or not to accept Medicare assignment and its opposition to elimination of balance billing. (Reaffirmed: Sub. Res. 132, A-94) (4) The AMA reaffirms its opposition to the continuation of the Medicare maximum allowable actual charge (MAAC) limits. (5) The AMA promotes enhanced physician discussion of fees with patients as an explicit objective of a Medicare indemnity payment system. (6) The AMA supports expanding its activities in support of state and county medical society-initiated voluntary assignment programs for low-income Medicare beneficiaries. (7) The AMA reaffirms its current policy that payments under a Medicare indemnity payment system should reflect valid and demonstrable geographic differences in practice costs, including professional liability insurance premiums. In addition, as warranted and feasible, the costs of such premiums should be reflected in the payment system in a manner distinct from the treatment of other practice costs. (8) The AMA believes that payment localities should be determined based on principles of reasonableness, flexibility, and common sense (e.g., localities could consist of a combination of regions, states, and metropolitan and nonmetropolitan areas within states) based on the availability of high-quality data. (9) The AMA believes that, in addition to adjusting indemnity payments based on geographic practice cost differentials, a method of adjusting payments to effectively remedy demonstrable access problems in specific geographic areas should be developed and implemented. (10) Where specialty differentials exist, criteria for specialty designation should avoid sole dependence on rigid criteria, such as board certification or completion of residency training. Instead, a variety of general national criteria should be utilized, with carriers having sufficient flexibility to respond to local conditions. In addition to board certification or completion of a residency, such criteria could include, but not be limited to: (a) partial completion of a residency plus time in practice; (b) local peer recognition; and (c) carrier analysis of practice patterns. A provision should also be implemented to protect the patients of physicians who have practiced as specialists for a number of years. (11) The AMA strongly opposes any attempt to use the initial implementation or subsequent use of any new Medicare payment system to freeze or cut Medicare expenditures for physician services in order to produce federal budget savings. (12) The AMA believes that whatever process is selected to update the RVS and conversion factor, only the AMA has the resources, experience and umbrella structure necessary to represent the collective interests of medicine, and that it seek to do so with appropriate mechanisms for full participation from all of organized medicine, especially taking advantage of the unique contributions of national medical specialty societies. BOT Rep. AA, I-88 Reaffirmed: I-92 Reaffirmed and Modified: CMS Rep. 10, A-03 Reaffirmation A-06 Reaffirmed: CMS Rep. 01, A-16 Reaffirmed: Res 212 I-21

14. PRIVACY PROTECTION AND PREVENTION OF FURTHER TRAUMA FOR VICTIMS OF DISTRIBUTION OF INTIMATE VIDEOS AND IMAGES WITHOUT CONSENT

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

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF THE REPORT FILED
See Policy H-515.948

At the 2022 Annual Meeting, the House of Delegates (HOD) adopted Resolution 009, "Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent," which amended Policy H-515.967 as follows:

> Our American Medical Association opposes the publication or broadcast of sexual assault victims' names, addresses, images or likenesses without the explicit permission of the victim. The AMA additionally opposes the publication (including posting) or broadcast of videos, images, or recordings of any illicit activity of the assault. The AMA opposes the use of such video, images, or recordings for financial gain and/or any form of benefit by any entity.

And further asked our American Medical Association (AMA) to:

> Research issues related to the distribution of intimate videos and images without consent to find ways to protect these victims to prevent further harm to their mental health and overall well-being- (Policy D-515.975).

This report responds to the call for research.

BACKGROUND

The distribution of sexual or pornographic images and videos of individuals without their consent is a growing problem. Such acts include images taken without consent or images taken with consent but later distributed without consent, sometimes referred to as revenge porn, as well as sexually explicit deepfake images or videos of individuals created without their consent. The distribution of intimate videos and images without consent is known as image-based sexual abuse, which is also a form of gender-based violence, as it disproportionately affects women, and the impacts on victims often replicate those of sexual assault [1].

A 2020 report found that an estimated 1 in 12 adults in the U.S. have been victims of nonconsensual pornography, and that 1 in 20 adults in the U.S. have reported perpetuating such abuse [2]. Additionally, a 2016 report found that young people (ages 15 to 29), LGBTQ+ individuals, and those from low-income households are at greater risk of image-based sexual abuse [3]. Research published in 2020 also found that approximately 1 in 5 girls and 1 in 10 boys (ages 13 to 17) report sharing their own "nudes," and 1 in 3 underaged teens report having seen nonconsensual shared nudes of other minors, which legally qualifies as child pornography [4].

The development of generative AI has accelerated the proliferation of image-based sexual abuse. The creation of nonconsensual deepfake pornography of students by their peers has quickly become a nationwide crisis at schools across the country [5,6]. A 2023 report on the state of deepfakes found that 98 percent of all deepfake videos online were pornographic and that 99 percent of such videos were of women [7]. The same report also found a 550 percent rise in the prevalence of deepfakes from 2019 to 2023 and that "[i]t now takes less than 25 minutes and costs $0 to create a 60-second deepfake pornographic video of anyone using just one clear face image" [7].

ETHICAL CONCERNS

The nonconsensual creation and/or distribution of explicit images of a person is a form of sexual violence and is inherently unethical. Sexual violence, which disproportionately affects women and younger people (ages 18 to 34), can have lasting negative health impacts, including increased risk of Post Traumatic Stress Disorder (PTSD), substance abuse, and suicide [8]. In addition to the physical and mental harms, those who experience image-based sexual abuse may also suffer from social, emotional, and existential harms, such as social rupture, isolation, and constrained liberty [9,10]. In addition to the harms such acts of abuse may cause, they also constitute wrongs that violate individuals' rights to dignity, privacy, autonomy, and freedom of sexual expression [10].

DISCUSSION

Confidentiality laws, which protect individuals' choices about sharing information, and privilege laws, which prohibit the sharing of private information without an individual's consent, vary from state to state. As of May 2024, only 20 states have enacted laws addressing nonconsensual sexual deepfakes [11]. There is currently no federal law against image-based sexual abuse.

There is currently a lack of accountability when it comes to the regulation of nonconsensual sexually explicit images. The federal 1996 Communications Decency Act that regulates pornography on the internet protects websites and service providers from liability for content posted by users with whom they are not co-creators. According to Section 230 of the Act, operators of internet services and websites, including social media, are not considered publishers of content their users post, and as such, have no legal obligation to remove nonconsensual pornography unless it otherwise violates copyright or federal criminal laws [12].

On May 23, 2024, the White House released "A Call to Action to Combat Image-Based Sexual Abuse," calling on Congress and the technology sector to work to manage the risks of AI and to strengthen protections for survivors and victims of image-based sexual abuse, including those generated by AI [13]. One proposed approach to strengthen protections has been to craft an amendment to the Violence Against Women Act, which protects survivors of sexual assault and domestic violence, to give victims the right to sue in civil court those who create, solicit, possess, and distribute nonconsensual AI-generated pornography [14].

Technology Safety, a national network to end domestic violence, has created a Confidentiality Toolkit with resources such as survivor confidentiality releases, information on federal confidentiality laws, and access to online coordinated care networks and referral systems [15]. The National Network to End Domestic Violence has also

created a series of educational tools and online toolkits that focus on the intersections of technology and domestic and sexual violence [16]. Similarly, Cyber Civil Rights Initiative (CCRI) is an online organization that provides support for revenge porn survivors, including resources such as attorney referrals, a crisis hotline, and a guide for helping remove photos from the internet [17]. The Digital Millennium Copyright Act website also can help with taking down images [18].

The recent White House "Call to Action" lists actions that the private sector should take, such as disrupting the monetization of image-based sexual abuse by curbing access to payment services for the sites or apps that host such images, as well as encouraging institutional requirements for app developers to work towards preventing their creation in the first place. A 2020 international report found that men and young people are more commonly perpetrators of image-based sexual abuse, which suggests that targeted public health educational initiatives may be an effective tool to reduce such abuse [19].

RELEVANT AMA POLICY

Our AMA has several relevant policies including AMA *Code of Medical Ethics* Opinion 8.10, "Preventing, Identifying and Treating Violence and Abuse." Among the directives of the opinion, physicians are told that they should become familiar with how to detect violence or abuse and the resources available for abused or vulnerable persons; routinely inquire about physical, sexual, and psychological abuse as part of the medical history; not allow diagnosis or treatment to be influenced by misconceptions about abuse; and treat the immediate symptoms and sequalae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise. The 2023 AMA article "You suspect a patient is being abused. What should you do?" provides physicians with information and links to relevant resources, including information on the importance of providing trauma-informed care and recognizing that not all patients may choose to disclose abuse, even when screened [20].

AMA policies that address sexual assault include H-515.953, "Sexual Assault Education and Prevention in Public Schools," H-515.956, "Addressing Sexual Assault on College Campuses," H-515.967, "Protection of the Privacy of Sexual Assault Victims," and D-515.976, "Advocacy on the US Department of Education's Spring 2022 Title IX Rules on Sexual Harassment and Assault in Education Programs." These policies tend to focus on sexual assault rather than sexual violence, which is a more encompassing, non-legal term that covers sexual assault, harassment, and abuse. Our AMA may want to consider adopting the broader term "sexual violence" in place of "sexual assault" in most cases.

CONCLUSION

Advances in digital technologies including generative AI have facilitated the distribution of intimate videos and images without consent, and thus sexual violence overall. Physicians should be familiar with how to identify signs of sexual violence, how to treat the immediate and long-term consequences of sexual violence, and how to prevent further harm to their patients' mental and overall health. In addition, more public and private sector efforts to address image-based sexual violence are needed.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) encourage the development of public and private sector initiatives to prevent and address image-based sexual violence or abuse.
2. That Policy D-515.975 be rescinded as having been accomplished by this report.

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15. PUBLISHED METRICS FOR HOSPITALS AND HOSPITAL SYSTEMS

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 715-A-23 REMAINDER OF THE REPORT FILED
See Policy D-215.979

INTRODUCTION

At the 2023 Annual Meeting of the House of Delegates (HOD), the American Association of Neurological Surgeons and Congress of Neurological Surgeons introduced Resolution 715-A-23, "Published Metrics for Hospitals and Hospital Systems". The resolution was referred for report back and directs the American Medical Association to

identify transparency metrics (e.g., physician retention and physician satisfaction) applicable to hospitals and hospital systems and report back with recommendations for implementing appropriate processes to require the development and public release of such metrics. The following Board of Trustees Report provides this update and will be provided to the HOD for review at the 2024 Interim Meeting.

BACKGROUND

Nearly 63 percent of physicians in the United States experience at least one symptom of burnout, according to recent research. A dramatic increase in burnout and decrease in job satisfaction occurred among U.S. physicians during the first two years of the COVID-19 pandemic, leading many physicians to consider a reduction in work effort or leaving their organization and the profession altogether.[1] Nearly one-quarter of all physicians noted an intent to leave their job, and a recent study also found that the annual rate of physician turnover in the United States increased between 2010 and 2018.[2,3] A Definitive Healthcare report found that an estimated 117,000 physicians left the workforce in 2021.[4] Similarly, a study using AMA-collected data from 2020-2021 found that clinician burnout and intent to leave gradually increased in the early days of the pandemic and rose sharply in late 2021. Work control, teamwork, and feeling valued were both mitigating and aggravating factors for clinician burnout and retention and could provide mechanisms for worker protection.[5]

Overall, these trends are alarming for the U.S. health care system. Nearly one billion dollars in excess patient costs are tied to physician turnover.[6] Physician burnout and turnover may also have a profound impact on patient access, especially for people living in rural areas and health systems caring for underserved communities. Physician burnout and turnover have myriad consequences for physicians, patients, and the overall health care system. While many hospitals and hospital systems have begun to address the underlying system-level issues that cause burnout and turnover, much work remains to be done to address the work environment of physicians to reduce physician burnout and turnover.

Currently, there are reporting mechanisms by which hospitals and hospital systems are held accountable to for the maintenance of quality and safety standards. These existing transparency metrics are largely focused on patient safety and quality of care. These standards have not traditionally focused on the physician experience (e.g., turnover and job satisfaction) but remain largely in place to provide the public (i.e., patients) with transparent information about the performance and safety of the hospital or hospital system. However, over the last ten years, more hospitals and hospitals systems are beginning to measure and track metrics related to the physician experience, including physician burnout and turnover. They have done so as a foundational strategy to address the underlying causes of these outcomes. While collection and reporting of these measures remains voluntary and are not tied to hospital accreditation, these measures can provide insights to help motivated health system leaders develop data-driven approaches to reduce burnout, improve job satisfaction, and increase retention—and thus, provide an enhanced working environment for their physicians, a better care environment for their patients, and improve overall value and costs. Metrics and reporting mechanisms for the physician experience vary widely by hospital systems. Most do not share these measures publicly, although many do share these measures with their physician staff for increased accountability and shared solution-building.

Physician burnout and turnover have myriad causes and addressing these issues to reduce physician burnout (and lessen physician turnover) is a key pillar of the AMA's "You Are Why We Fight" campaign. Central to these efforts are AMA's collaborations over the past five years with more than 300 hospitals or hospital systems in measuring physician burnout and turnover, and incentivizing health systems to improve the physician experience through the AMA's Joy in Medicine Health System Recognition Program.

In addition to further outlining existing transparency metrics for health systems in the United States, this report provides a more in-depth review of existing AMA resources for hospital systems and its leadership for the adoption of metrics to accurately assess the physician experience.

DISCUSSION

Existing public reporting, accreditation, and grading systems include the Leapfrog group, Joint Commission, and National Integrated Accreditation for Healthcare Organizations (NIAHO) accreditation program. The details of each

system are discussed below in addition to the opportunities and risks associated with mandatory reporting of transparency metrics.

Leapfrog Hospital Safety Grades

Overview
The Leapfrog group is an independent, national not-for-profit organization focused on measuring and publicly reporting hospital performance. Hospitals voluntarily participate free of charge.[7] Leapfrog Hospital Safety Grade uses up to 30 national performance measures from the Centers for Medicare & Medicaid Services (CMS) and other supplemental data sources. The goal of the Leapfrog Hospital Safety Grade is to publicly report patient safety and quality information for consumers, purchasers, and physicians to guide their decisions regarding where to seek care and direct patients. Leapfrog Hospital safety grades can be searched by anyone in the public via their website. This public reporting is largely focused on supporting patients in selecting a hospital and advocating for better hospital safety.[8] None of the Leapfrog metrics or related reporting focus on physician or clinician experiences, suggesting an opportunity for Leapfrog to enhance their portfolio of measures.
Some research has been done to assess Leapfrog's grading system. A 2017 analysis found that Leapfrog's measure skews toward positive self-report and bears little association with Medicare outcomes and penalties.[9] A 2023 examination of Leapfrog safety measures and Magnet designation found that Magnet-designated hospitals had higher Leapfrog grades for structural safety measures but not better infection rates.[14] There exists a paucity of literature that provides insights into whether Leapfrog transparency metrics result in behavior or choice modification (e.g., choosing a different hospital) by either patients or physicians. Therefore, the total impact of these measures in their transparent reporting is largely unknown or unattributed.

The Joint Commission

Overview
The Joint Commission is an independent, not-for-profit organization in the United States that accredits and certifies health care organizations and programs. It sets standards for health care quality and safety and conducts regular evaluations to ensure compliance. Hospitals, health care systems, nursing homes, clinics, and other health care facilities voluntarily seek Joint Commission accreditation to demonstrate their commitment to meeting high standards of patient care.

The Joint Commission does not have specific accreditation standards solely focused on physician burnout, turnover, or satisfaction. The Joint Commission touts that their accreditation may help attract and retain qualified personnel who prefer to serve in an accredited organization.[12] The Joint Commission includes reference to several physician well-being resources on its website, but workforce well-being is not explicitly a part of its accreditation standards.[13]

While having Joint Commission accreditation may signal to physicians that their institutions are prioritizing patient safety, quality care, and efficient processes, there has been little to no exploration on whether organizations that have Joint Commission accreditation have lower physician burnout or turnover. In fact, a 2023 study found that while half of Joint Commission-accredited hospitals and Federally Qualified Health Centers are taking steps to improve physician well-being, a small minority of them are measuring well-being and very few are taking a comprehensive approach to advancing well-being as an organizational priority.[14]

Existing Literature
There does not currently appear to be literature that provides insights into whether Joint Commission accreditation and their transparency metrics result in behavior or choice modification (e.g., choosing a different hospital) by either patients or physicians. Therefore, the total impact of these measures in their transparent reporting is largely unknown or unattributed.

DNV Healthcare – NIAHO® Hospital Accreditation

Overview
DNV GL Healthcare offers yet another hospital accreditation—the NIAHO accreditation program. Similar to the Joint Commission, this accreditation program also largely focuses on patient safety, quality of care, facility manager, and adherence to regulatory requirements. Further, this accreditation directly addresses CMS requirements, and standards vary by facility type.[15]

NIAHO measures do include evaluation of leadership and management, clinical excellence, and facility and environmental management. Although this may influence physicians' decisions about joining a hospital, measurements of physician turnover, job satisfaction or burnout are not part of the standard measures.[16]

The Pathway to Excellence Program®

The Pathway to Excellence Program is one accreditation program that can be used as a model for health care organizations interested in utilizing metrics to improve physician well-being. The program is the premier designation for health care organizations and long term care organizations that have achieved healthy practice environments for nurses. To qualify for designation, organizations are required to meet the six Pathway Standards that have been identified as essential for a positive practice environment for nurses. These standards are designed to support nurse satisfaction, high-quality nursing practice, and interprofessional collaboration, and impact an array of factors that in turn influence results such as employee turnover, job satisfaction and engagement, errors and safety events, and patient satisfaction.[17]

Public Reporting of Metrics in Health Care: Benefits and Potential Unintended Consequences

Public and transparent reporting of hospital metrics can have a positive impact but there may also be unintended consequences for physicians, patients, hospitals, and hospital systems that must be weighed against those benefits.

Some benefits of public reporting may include transparency and accountability, informed decision-making, quality improvement initiatives, and benchmarking and learning. Publicly reporting hospital metrics, such as quality of care, patient outcomes, infection rates, and readmission rates creates transparency. Hospitals are held accountable for their performance, encouraging them to strive for better outcomes and quality of care. Patients' and families' access to this information can enable them to make more informed decisions about where to seek care. When patients have access to data on hospital performance, they can choose facilities with better outcomes, which incentivizes hospitals to improve their services to attract patients. Additionally, public reporting can drive hospitals to implement quality improvement initiatives. Knowing that their performance is being publicly evaluated can motivate hospitals to identify areas for improvement and implement changes to enhance care quality and outcomes. Further, public reporting can facilitate hospitals' comparisons of their performance against others, allowing them to identify best practices and areas where improvement is needed. This benchmarking helps hospitals learn from each other and adopt successful strategies to improve care.

Also of importance to recognize is that public reporting of transparency metrics influences, at least to some degree, hospital and health system behavior. For instance, in a 2012 survey of hospital leaders from over 600 U.S. hospitals, participants reported that publicly reported measures impacted planning and improvement initiatives within their organization. Over 70 percent of respondents agreed that public reporting stimulated quality improvement activity at their institution; 89.7 percent reported that their organization's reputation was affected by patient experience measures; 87.1 percent indicated that performance on publicly reported measures was incorporated into their hospital's annual goals; and more than 90 percent reported regularly reviewing the results of publicly reported measures with hospital board of trustees members. However, hospital leadership also expressed concern about the clinical meaningfulness, unintended consequences, and current methods of public reporting.[18] Additionally, in a recent Becker's article, physician executives from four health systems shed light upon their views of national rankings and its use for quality improvement strategies. Many leaders saw greater value in national benchmarking data from private third-party organizations as opposed to rankings from platforms such as Leapfrog, CMS' Overall Hospital Star Ratings, and *U.S. News & World Report's* best hospitals since the latter sources are retrospective in nature.[19]

Importantly, public reporting is not a singular solution and there may be unintended consequences from public and transparent reporting that have implications for patients, physicians, hospitals, and hospitals systems. Much of the concern about publicly reporting hospital and hospital system metrics generally question the validity of these metrics and the potential for misuse. For instance, authors from a 2005 *JAMA* article argue that the value of publicly reporting quality information is largely undemonstrated.[20] Additionally, measures that have been validated for one purpose can be inappropriately used for another purpose. For instance, patient safety indicators from administrative data sources are helpful tools for case identification and tracking rates at a single organization but not useful for comparing rates across hospitals. Research has reported that when rates of postoperative infections were derived

from administrative data sources, over 50 percent of the variation in risk-adjusted postoperative infection rate observed across hospitals could be attributed to differences in coding practices rather than actual outcomes. [21]

Another major potential unintended consequence of publicly reporting transparency metrics is reduced access to – and even disparities in – care. For instance, hospitals in neighborhoods with greater social risk often care for patient populations with increased medical complexity and fewer resources than hospitals in other neighborhoods. This has been shown to unfairly and negatively impact hospital ratings, as well as reinforce disincentives to care for patient populations living in neighorhoods with greater social complexity. One study that examined the relationship between neighborhood social risk factors and hospital ratings in Medicare's Hospital Compare Program found that lower hospital summary scores were associated with caring for neighborhoods with higher social risk. This included a reduction in hospital score for every ten percent of residents who reported dual-eligibility for Medicare and Medicaid, lacking a high school diploma, unemployment, Black race, and high commute times to work.[22] Another study found that compared to other hospitals, total reimbursements for patient care at hospitals serving the most Black patients were on average 21.6 percent lower. Mean and median profits per patient day at Black-serving hospitals were also eight dollars and 17 dollars, respectively, while these values were $64 and $126 at other hospitals.[23] Taken together, these studies have implications for the public reporting of hospital metrics such as physician burnout, turnover, and job satisfaction rates and their impact on the care of some of America's most marginalized patient populations. For example, publicly reporting such metrics could potentially exacerbate inequities for patients that receive care at majority Black-serving hospitals, physicians that work at these organizations, and quality rankings appointed to these facilities.

Moreover, publicly reporting physician burnout, turnover, and job satisfaction rates could possibly lead to hospitals becoming risk-averse in their hiring practices to keep these metrics low similar to evidence demonstrating hospitals avoiding high-risk patients when subject to public reporting. For example, a study compared the percentages of white, Black, and Hispanic patients that received coronary artery bypass grafting (CABG), percutaneous transluminal coronary angioplasty, and cardiac catheterization prior to and following the availability of the New York State CABG public report. The study found that there was a greater racial disparity in the percentage of patients who received CABG in the periods after public reporting versus before. Additionally, the disparity was found to be greater in New York as opposed to the twelve comparison states assessed in the study that had not released CABG public reports.[24] This begs the question of whether publicly reporting hospital metrics could potentially lead to hospitals and hospital systems avoiding hiring marginalized and minoritized clinical staff with demonstrated disproportionate rates of burnout such as physicians of color, women physicians, and physicians who are caregivers for children, aging parents or other dependents rather than collaborating with physicians to actually and effectively improve burnout, turnover, and job satisfaction.[25,26]

Lastly, making these metrics publicly available bears the risk of patients and payers misinterpreting this information and incorrectly using it to make decisons about where to seek care and direct patients. Too much data, particularly when devoid of context, can overwhelm the public and fuel misinformation. Patients using this data to guide where to receive care is especially risky because poor performance in one area (e.g., physician burnout) does not mean that performance in another area is also poor (e.g., the percentage of patients that are able to receive a certain procedure).[24]

While transparent reporting of metrics, particularly those related to physician turnover, job satisfaction, or burnout, may increase accountability from hospital system leadership, it could also act as a detractor in establishing physician-organization collaboration and may feel more punitive than solution-seeking. Establishing a strong and collaborative relationship between physicians and their organizations is shown to reduce physician burnout and increase physician engagement.[27] Public and transparent reporting of burnout, satisfaction, and turnover metrics could have the unintended consequence of disrupting the establishment of a strong and collaborative relationship between physicians and their leadership, as hospital leadership could become hyper-focused on specific measures that do not completely capture the nuances and intricacies of the physician experience.

AMA POLICY

The AMA has several policies related to increased transparency of hospital and hospital system metrics that reflect the physician experience.

The AMA will study current tools and develop metrics to measure physician professional satisfaction (Policy D-405.985, "Physician Satisfaction").

The AMA will also foster the creation of quality measures and rating systems that incorporates the satisfaction and perspective of the medical staff regarding individual hospitals (Policy D-215.988, "Capturing Physician Sentiments of Hospital Quality").

Further, the AMA promotes physician-developed guidelines for evaluating patient and physician satisfaction with plans, accreditation standards, utilization, quality and cost policies (Policy H-450.962, "National Committee for Quality Assurance").

Moreover, the AMA supports that the "Triple Aim" be expanded to the Quadruple Aim, adding the goal of improving the work-life balance of physicians and other health care providers.
The AMA will also advocate that addressing physician satisfaction count as a Clinical Practice Improvement Activity under the Merit-Based Incentive Payment System (MIPS) (Policy H-405.955, "Support for the Quadruple Aim").

AMA SUPPORT FOR HEALTH SYSTEMS IN IMPROVING THE PHYSICIAN EXPERIENCE

Overview

The AMA has long supported hospitals and hospital system leadership in measuring the physician experience (i.e., burnout, satisfaction, stress, etc.) and in providing evidence-informed tools and resources to support health systems in comprehensively addressing the physician experience, including physician burnout. Addressing this issue is centered in the AMA's "You Are Why We Fight" campaign and there has been broad investment from the AMA in continuing to support health systems' work to improve the physician experience. The AMA has researched and developed metrics for measuring physician workload, burnout, and experience within their organizations. Notably, the AMA has worked with hundreds of health systems in providing organizational well-being assessments, evidence-informed resources, a comprehensive roadmap for change, and grants for ongoing research. AMA leaders have been publicly vocal in encouraging health systems to invest in their physician workforce, regularly measure physician burnout, and systemically address issues arising from regular measurement. Outlined below are several programs and initiatives that AMA has continued to undertake in support of health systems improving the physician experience.

The AMA Organizational Biopsy®

The Organizational Biopsy® is an assessment tool and a set of services to support organizations in holistically measuring and taking action to improve the health of their organization. The Organizational Biopsy provides a comprehensive assessment for health systems across four domains: organizational culture (leadership, teamwork, trust, etc.), practice efficiency (team structure, team stability, workflows, etc.), self-care (post-traumatic stress, post-traumatic growth, work-life balance, etc.), and retention (work intentions).[28] The survey is distributed to physicians and other clinicians within the organization and the data is collected by the AMA for analysis.

Following an assessment, organizations receive an executive summary of their key findings and access to the Organizational Biopsy data through an online reporting platform. This platform also includes national comparison data. Following the assessment, the AMA can provide ongoing guidance and communication on interventions, research, and convening opportunities in support of their ongoing improvement efforts. The Organizational Biopsy includes the validated Mini-Z burnout assessment.[29] There is also a separate tool that can be used by residency and fellowship programs to measure and address the trainee experience.[30]

Since 2018, the AMA has collaborated with more than 300 health systems in collecting and sharing organizational well-being assessment results and advising on solutions. A yearly national comparison report is also shared with participating health systems to see how they compare against other institutions. The majority of health systems that the AMA collaborates with complete measurement on an annual basis. The AMA encourages organizations to share their survey results internally with their physicians to allow for greater collaboration, strengthen the physician-organization relationship, support collaborative dialogue about the current state of organization well-being, and identify future solutions and realistic accountability for improvement.

The Joy in Medicine™ Health System Recognition Program

Launched in 2019, the Joy in Medicine Health System Recognition Program (otherwise known as the Recognition Program) incentivizes health systems to improve the physician experience by providing public national recognition for organizations that have met a set of evidence-informed criteria centered on addressing the primary system drivers of physician burnout and organizational well-being.[31]

The Recognition Program provides a comprehensive roadmap to guide organizations through the existing research and interventions to improve organizational well-being—and thus, the physician experience. Measurement of various outcomes and processes are foundational to the program, as AMA asserts that these data can and should be used to understand unique organizational drivers of physician burnout within an organization and to help focus system-specific solutions. Measures included in the Recognition Program criteria include: burnout (using a validated tool), intentions to leave or reduce work effort (via survey), teamwork assessments (via surveys), leadership skills assessments and their impact on direct team members (via surveys), and electronic health record audit log data to help illuminate the day-to-day experience of physicians and identify workload/workflow improvements. The Recognition Program includes required criteria for health systems to share these data internally with their physicians as well as their executive leadership teams for shared decision making and increased accountability.[32]

Organizational recognition is valid for two years. Since 2019, AMA has recognized more than 100 organizations for their efforts and this body of work continues to gain a national spotlight in the efforts to improve physician well-being.[33] Health system leaders have publicly noted the impact the Recognition Program has had on their efforts to improve conditions for their workforce and in providing them with a critical framework for addressing a complex issue.[34–37]

AMA STEPS Forward®

The program provides free access to a variety of resources to support health systems in implementing interventions. The AMA STEPS Forward program offers a collection of engaging and interactive educational toolkits, playbooks, podcast episodes, and success stories that are practical, actionable guides to transform and improve your practice. They address common practice challenges and offer solutions that aim to save two to three hours a day, reduce physician burnout and improve well-being, optimize team-based workflows, and enhance patient experiences.[38]

Each module provides practical steps to implementation, as well as real-world "success stories", downloadable tools and additional resources.[38] Clinicians, care team members, administrators, and organizational leaders can use these modules to help improve practice efficiency and ultimately enhance patient care, physician satisfaction, and practice sustainability.

Other Activities

The AMA also organizes conferences and provides interactive, hands-on learning opportunities for physicians and members of their care teams including boot camps, coaching, and learning collaboratives.

Alongside the Canadian Medical Association and British Medical Association, the AMA co-sponsors the International Conference on Physician Health™ (ICPH). ICPH is a biennial conference that promotes a healthier culture for physicians through evidence-based solutions, practice skills, and other resources. The theme of this year's conference is "improving well-being through the power of connections".[39] The American Conference on Physician Health (ACPH) is co-sponsored by the AMA, Stanford Medicine, and Mayo Clinic, and is held biennially. ACPH is designed to promote scientific research, discourse about health system infrastructure, and actionable steps that organizations can implement to improve physician well-being.[40]

Another of the offerings provided by the AMA are in-person boot camps wherein the AMA STEPS Forward Innovation Academy convenes attendees over the course of multiple days to equip them with tools and strategies to reform their organization and improve professional satisfaction. Topics discussed in past boot camps include EHR inbox optimization, team-based care practice fundamentals, and reducing barriers to taking paid time off.[41] Additionally, AMA physician faculty provide one to one coaching sessions to health system well-being leaders. These coaching sessions include direct feedback related to establishing strategic well-being initiatives and using data to guide a comprehensive approach to address institutional well-being needs.

Further, the AMA has learning collaboratives planned for this fall designed to transform care delivery. These collaboratives will leverage peer-to-peer learning, group discussions, and the sharing of results, as well as facilitate connections between health system leaders. Collaborative participants will receive support from physician facilitators and evidence-based resources such as content and education, in addition to benefiting from extra assistance and mentorship during "office hours".

STATEMENTS

AMA President, Dr. Jesse Ehrenfeld released a leadership viewpoint to spotlight the AMA's Joy in Medicine Health System Recognition Program and to encourage health systems and health system leadership to thoroughly examine their support for physician well-being and implement improvements that promote wellness across the entire workforce while strengthening the patient-physician relationship.[42]

Dr. Ehrenfeld also provided remarks at the National Press Club about the physician shortage, where he reaffirmed AMA's commitment to addressing physician burnout and turnover through both advocacy efforts—such as combatting prior authorization—and support for health systems directly through the Joy in Medicine Health System Recognition Program.[43]

CONCLUSION

Although several efforts are currently in place that publicly report hospital performance metrics, these metrics generally do not adequately capture the physician experience. Additionally, insufficient research exists to support that such metrics impact physicians' selection of a particular hospital or hospital system for employment or partnership. The AMA has made substantial efforts to address and improve physician burnout, professional satisfaction, and workforce turnover. Such efforts have included the adoption of a variety of policies, advocacy, partnerships with professional organizations, development and dissemination of tools, educational resources, and hands-on support for health systems to regularly assess the state of their physician workforce. The AMA actively champions and provides resources for the collection of measures related to the physician experience (e.g., burnout, retention, and satisfaction) by health systems to support the development of data-driven solutions. In addition, the Joy in Medicine Health System Recognition Program publicly recognizes organizations taking actionable steps along six domains to improve the work environment for their physicians.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 715-A-23 and the remainder of the report be filed.

1. That our AMA research and develop useful metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment in a manner accessible to physicians with report back to the House of Delegates no later than Annual 2026.

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16. AMA REIMBURSEMENT OF NECESSARY HOD BUSINESS MEETING EXPENSES FOR DELEGATES AND ALTERNATES

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTIONS 605 AND 609 REMAINDER OF THE REPORT FILED
See Policy D-600.951

At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD) Resolution 606, "AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates" was referred to the Board of Trustees for a report back to the HOD. The Reference Committee heard mixed testimony, including compelling testimony from the Board of Trustees regarding their fiduciary responsibility to our AMA and the need to allow sufficient time to identify and fully assess the impact on our AMA. An informational report was provided at the 2024 Annual Meeting.

Resolution 606-A-23 asked:

> That our American Medical Association develop a reimbursement policy consistent with established AMA travel policies for reasonable travel expenses that any state or national specialty society is eligible to receive reimbursement for its delegate's and alternate delegate's actual expenses directly related to the necessary business functions required of its AMA delegates and alternate delegates in service to the AMA at HOD meetings, including travel, lodging, and meals; and
>
> That each state or national specialty society requesting such reimbursement for its delegate's and alternate delegate's reasonable travel expenses will submit its own aggregated documentation to the AMA in whatever form is requested by the AMA.

BACKGROUND

Resolution 606-A-23 highlighted the significance of the AMA HOD as a policy-making body with diverse voices being represented through the delegations. The resolution focuses on the costs that are incurred by the organizations sending delegates and alternates to the meetings without discussing the costs of the meeting to the AMA. The resolution pointed out that several state and specialty medical societies are facing financial hardships due to several factors, including declining membership. As these organizations are looking to cut costs, not sending their full complement of delegates and alternate delegates to the AMA HOD meetings could be seen as a savings. In some instances, delegates pay their own expenses to attend AMA HOD meetings so they can be a part of the robust policy-making process.

Your AMA Board is acutely aware of the high cost to the Federation of attending AMA HOD meetings as the AMA is already spending approximately $12 million annually to host these meetings. If the AMA were to adopt this resolution, an estimated $8.1 million would be added to the cost for our governance meetings. An expenditure of this magnitude annually needs careful consideration including all factors that would contribute to this expenditure with feasible options for reducing the overall costs, while maintaining the fiduciary responsibility of the Board and protecting the governance of the association.

LISTENING SESSIONS

Following the 2024 Annual HOD meeting, the Board of Trustees hosted three listening sessions with members of the HOD and Federation staff. Over 100 state and specialty society delegates and executives participated. The purpose of the calls was to gather information and assess recommendations or other options for mitigating the costs of the HOD meetings.

It is understood that sending a delegation to an AMA HOD meeting can be seen as a financial burden for state and specialty societies that are experiencing financial strains. It was also expressed that certain societies have chosen to prioritize other activities or programs within their society over sending a full delegation to an AMA HOD meeting.

The decline in professional medical society membership can be attributed to several environmental factors, including a rapidly evolving health care landscape, shifts in professional priorities among younger physicians, and challenges in adapting to modern business models. Many medical societies rely on traditional membership-based revenue models, which may not align with the expectations of younger physicians who seek more immediate, tangible benefits from their affiliations, such as digital resources, networking opportunities, and career support or alternatively find most of their needs met through their employers. Additionally, younger physicians are often burdened with substantial student debt and face time constraints due to demanding work schedules, making them less willing to pay for memberships that do not provide clear value. Resistance to generational change within these societies can further exacerbate the decline, as established leaders may be hesitant to embrace new technologies, flexible engagement methods, and innovative services that appeal to younger members. Furthermore, the rise of online communities and free educational resources has diminished the perceived need for traditional society memberships, as physicians can access information and professional networks more conveniently and cost-effectively through digital platforms and their employers.

The following categories of costs associated with attending AMA HOD meetings and potential ways to mitigate their costs were raised during the listening sessions.

Costs associated with On-site Meetings

1) Travel-Associated Costs
   Cost mitigation strategies for hosting large medical conferences at hotels that focused on optimizing expenditures without compromising the quality and impact of the event.
   a. Negotiating contracts with venues to include discounts on food and beverage services, such as opting for buffet-style meals or selecting less expensive menu options that still cater to dietary needs and preferences. Since meeting venues negotiate an overall package, this may simply shift current discounts from one category to another.
   b. Choosing venues in less expensive cities or during off-peak seasons can also result in significant savings. This item was raised by multiple participants over all three days. It was recognized that current AMA policy G-630.140, Lodging, Meeting Venues, and Social Functions, limits options for venues and can only be changed through affirmative action of the House of Delegates.
   c. Utilizing convention centers, which may offer more flexible pricing and amenities tailored for large events, may help reduce venue costs compared to traditional hotel settings. However, these cost savings may be offset by losing discounts attained when meeting rooms and hotel sleeping rooms are reserved at the same facility and additional transportation costs to move between hotel and convention center. In addition, this option could impose challenges to those who have impaired mobility or other disabilities.
   d. Leveraging technology to provide virtual participation options can lower the need for physical space and associated expenses.
   e. Partnering with local vendors and suppliers can further decrease costs, while consolidating event components such as audiovisual services through bundled packages can lead to better pricing.

2) Time commitment
   In addition to the financial concerns, the time spent preparing and attending HOD meetings was given as an added challenge for delegates and alternates, particularly those in private practice. Extended time away from family and patients was a repeated concern. It was conveyed that not only are the costs of the meeting, but also the time spent preparing and attending the meeting are major concerns that the Board of Trustees must consider. Several delegates voiced support for shortening the meeting and revisiting the elimination and/or structure of the Interim meeting. The suggestions included changing one or both HOD meetings to a fully or partially virtual format or hybrid meeting, shortening the meetings, and eliminating one meeting a year. There is the potential for many delegates and alternates to benefit by attending shorter meetings and having less time away from their practices.

3) Corporate Sponsorship
   Medical specialty organizations employ a variety of strategies to finance their annual meetings and conferences, balancing income streams from corporate sponsorships, registration fees, and educational grants. Corporate sponsorships often represent a significant portion of funding, with companies in the pharmaceutical, medical device, and technology sectors contributing funds in exchange for opportunities to showcase their products and

services. These sponsorships can include exhibitor booths, branded sessions, or other promotional activities. Payment for educational sessions is another revenue stream, where attendees pay to participate in workshops, seminars, or continuing medical education activities. Organizations may also receive educational grants from industry partners, which are typically earmarked for specific educational content and must adhere to guidelines to maintain educational integrity and independence. Additional funds may come from advertising in conference materials and ancillary events like social gatherings or fundraising dinners. The strategic flow of these funds is carefully managed to cover the costs of venue rental, speaker fees, technology, and logistics, ensuring that the event provides value to both attendees and sponsors while aligning with the organization's mission and educational goals. However AMA policy G-630.040, Principles on Corporate Relationships, addresses situations where our AMA cannot utilize external funding and states "Funding core governance activities from corporate sponsors, i.e., the financial support for conduct of the House of Delegates…could make our AMA become dependent on external funding for its existence or could allow a supporter, or group of supporters, to have undue influence on the affairs of the AMA."

4) Financial Assistance
While listening session participants suggested a variety of approaches, overall financial assistance to support delegates and alternates attending the meetings was the most mentioned option, pointing to the resolution's original language as a "quick fix" to a complex situation, while recognizing that the complexity indicates a need for a multi-phase solution. Resolution 606-A-23 called for each state or national specialty society to request reimbursement for its delegates' and alternate delegates' reasonable travel expenses by submitting aggregated documentation to the AMA in whatever form is requested by the AMA. Alternatively, a grant program or request for support, was suggested as an option for those organizations who need assistance as a temporary support mechanism to maintain participation in the HOD.

Based on a financial analysis of 178 constituent and specialty societies, the AMA understands the financial landscape of the Federation. There appears to be an immediate need to provide support for some delegations if the AMA is to maintain the strong policy making process that is currently in place. At the same time, and before attempting to solve the problem, a deeper understanding of the issue needs to be obtained. There are extenuating factors that should be examined:(1) societies with a financial challenge who need to direct their resources internally; and (2) societies with resources available who are deciding not to fund AMA delegations. Without some understanding of each individual situation, it is difficult to determine a solution that is appropriate for all situations over the long term, while still maintaining AMA's fiduciary obligations. A temporary solution could solve the immediate need of delegations in societies facing financial pressure to maintain an active presence at AMA HOD meetings. Support for those delegations in need of additional assistance could provide emergency relief while providing time to find a long-term solution that supports the sustainability of the AMA HOD while also acting as a responsible fiduciary for the AMA. Your Board needs to examine all aspects of the current HOD meeting and find areas that can be refined to offer increased value and lower costs for all participants.

Implementation of newly adopted changes on Introducing Business to the AMA House, G-600.060, may also yield savings yet-to-be realized.

OTHER CONSIDERATIONS

Further considerations must be made about the financial implications of comprehensively implementing a policy such as Resolution 606-A-23 calls for, including the financial status of the AMA and the Federation organizations that would be impacted by such a policy. While funding delegate/alternate travel to AMA meetings would not immediately threaten the AMA's financial standing, it would adversely affect the AMA's efforts in other key areas that support physician practices. It is crucial to understand that AMA financial policy provides for ongoing sustainable operations and programmatic activities for both the short- and long-term. By policy, any expenditures above the current budget levels will require reducing expenses from other areas of the annual budget. Such expenditures would reduce financial allocations that support other programmatic activities such as advocacy, health equity, improving health outcomes, public health. If this resolution were adopted, that would result in an ongoing annual $8.1 million cost reduction in other programs, which at the current rate of inflation would cost almost $100 million over the next ten years.

Tax Implications

AMA's tax-exempt status and the regulations under which it operates to maintain that status is a key consideration when determining if or how to provide benefits or contributions to individuals or organizations. AMA's tax counsel has advised that generally the IRS has found that the provision of financial benefits to members in certain situations will constitute private inurement which will result in the loss of tax-exempt status. Counsel did advise that the IRS has consistently viewed paying the reasonable travel expenses of volunteers, particularly those who have a defined role in governance, as being acceptable and not treated as compensation which in this case would cover those attendees with an official role, delegates and alternate delegates, and thus led to the language of the resolution submitted to the HOD.

Further discussions with tax counsel have resulted in another potential alternative to direct reimbursement: providing travel grants to societies in the HOD to cover or partially cover direct out-of-pocket expenses for delegates and alternate delegates based on financial need of the organization they represent in the HOD. Under this alternative, counsel recommended the following criteria:1) the travel grants be limited to societies that demonstrate financial need; 2) the travel grants be specifically identified as grants to cover travel reimbursement only for voting delegates and alternate delegates who participate in the HOD meetings, enabling delegates to participate in discussions regarding important issues affecting AMA and the medical profession; 3) the grant agreement between AMA and the society require that the funds are for reimbursement of incurred travel expenses in a manner that is consistent with 501(c)(6) purposes; and 4) that AMA establish a cap on the amount that any one society can receive for reimbursement of travel expenses.

DISCUSSION

Your Board of Trustees has approached this report with two elements weighing heavily: (1) the fiduciary responsibility of the Board of Trustees to make sound, reasonable and prudent financial decisions and (2) the need to have a policy-making process that includes representatives from across the Federation. With myriad issues influencing AMA HOD participation, your Board of Trustees has determined that one report cannot address all the issues that are contributing to the current financial situation across the Federation that limit or threaten to limit participation in the policy-making process. However, the Board recognizes that there is an immediate need to provide relief to several societies to maintain a vibrant HOD and is committed to providing that relief in a temporary emergency assistance program. At the same time, your Board of Trustees also recognizes the need for further examination of the factors that are creating the current situation and will form an ad hoc work group of the Board to continue to look at ways to mitigate costs, explore solutions, and maintain participation in order to reduce the financial burden on all parties over the long term.

Emergency Assistance Program: In the near term, your Board of Trustees will establish an emergency assistance program that will be funded at no more than $1 million per year for two years, to be discontinued after I-26. The purpose of this temporary assistance program will be to offer financial relief to Federation organizations to support the funding of delegates and alternates to attend the AMA Annual and Interim HOD meetings. The funding will be made available as a grant to societies who are deemed to spend a greater percentage of their annual revenue to support their AMA delegation than the AMA spends on the Annual and Interim meetings (based on an average cost estimate per delegate for all societies and using the most recent Form 990 available). The AMA will provide the society $300 per day per delegate and alternate delegate that will be required to be used for expenses related to the AMA HOD meetings. This amount was based on Internal Revenue Service guidelines for allowable per diem amounts to eliminate the need for documentation of expenses and avoid any tax issues. Each society that is deemed eligible to receive assistance will need to provide a formal request to the AMA to receive funding. The funds will be paid directly to the society, not to the individual delegates and alternates, but will be limited to use for defraying the costs for delegates and alternate delegates to attend the AMA HOD meetings.

Shorter Meetings: Additionally, to defray costs, the AMA will compress the schedule of both the Annual and Interim Meetings by eliminating one day from each meeting, thereby ending each meeting a day earlier. This schedule will be implemented at the Annual 2025 meeting of the HOD. It is estimated that this will reduce the cost to societies by a minimum of $1.4 million per year and benefit many delegates and alternates by requiring less time away from their practices.

Ongoing Efforts to Mitigate Costs: Finally, the Board of Trustees will continue to examine all aspects of our policy-making process to determine efficiencies, which will result in cost mitigations for all who participate. As part of this examination, the Board ad hoc committee will evaluate meeting venues, locations, options for methods of participation, economies of scale related to food and beverage and audio-visual costs, and all other aspects that contribute to the cost of the meetings and report back at I-25 and I-26 at the conclusion of the program.

RECOMMENDATIONS

The AMA recognizes that engagement by the organizations who send representatives to our HOD meetings to participate in the policy-making process is essential to the strength of organized medicine. Your Board of Trustees is committed to supporting attendance at AMA HOD meetings, providing immediate financial relief on a short-term emergency basis, and developing a plan for long-term sustainable participation. Therefore, your Board of Trustees recommends that Resolution 606-A-23 not be adopted and the remainder of this report be filed.

1. That our AMA will issue a report at the 2025 Annual Meeting, and each meeting thereafter, identifying the number of delegates and alternate delegates supported by the grants and the total amount provided under our AMA House of Delegates Emergency Assistance Program.
2. That our AMA will provide the House of Delegates with reports on a regular cadence detailing ongoing work regarding House of Delegates meetings to mitigate costs, explore solutions, and maintain participation while reducing the financial burden on all parties over the long term.
3. That our AMA will not reduce by one day the 2025 Annual and Interim Meetings and will issue a report for consideration at the 2025 Annual Meeting outlining details for potential changes to the length and format of future House of Delegates meetings.

17. ENVIRONMENTAL SUSTAINABILITY OF AMA NATIONAL MEETINGS

Informational report; no reference committee hearing

HOD ACTION: FILED

At the 2024 Annual Meeting of the American Medical Association (AMA), Board of Trustee's Report 25 Environmental Sustainability of AMA National Meetings was adopted as amended to read:

1. Our AMA is committed to progression to net zero emissions for its business operations by 2030, by continuing and expanding energy efficiency upgrades, waste reduction initiatives, and the transition to renewable energy sources (New HOD Policy).
2. Our AMA will prioritize sustainable organizational practices to reduce emissions over purchasing carbon offsets (New HOD Policy).
3. Our AMA Board of Trustees will present a report at the 2024 Interim Meeting that details a timeline as to when and how to achieve our organizational carbon neutrality. (Directive to Take Action).
4. Our AMA will continue to prioritize collaboration within the health care community by sharing the learnings from our sustainability initiative to inspire our peer organizations to follow suit and adopt similar environmentally conscious practices (Directive to Take Action).
5. Our AMA will work with appropriate entities to encourage the United States health care system to decrease emissions to half of 2010 levels by 2030, achieve net zero by 2050, and remain net zero or negative (Directive to Take Action).

This report is in response to recommendation 3, that our Board present a report that details the timeline as to when and how to achieve carbon neutrality.

DISCUSSION

The AMA is committed to achieving carbon neutrality. The work to achieve net zero emissions involves not only the ongoing public health strategy per BOT Report 17-A-23 Update on Climate Change and Health – AMA Activities, but also the strategy of AMA's business operations. Below is an overview of ongoing, operational initiatives as well as the AMA's approach to this topic moving forward.

2022 to 2024 current and ongoing efforts: During and after the COVID-19 pandemic, the AMA made key infrastructure investments that mitigate carbon footprint in the following areas.

- Building Infrastructure
  - AMA headquarters updated HVAC systems and put in Merv-13 filtration on each floor, resulting in a 35 percent energy reduction.
  - Following the COVID-19 pandemic, AMA adjusted its physical footprint to align with occupancy rates, returning the 40th floor to the landlord in Q3 2023. This consolidation led to a 20 percent reduction in storage space. AMA also created space usage guidelines, with staff onsite fewer than one day per week using new hoteling stations.
  - Lighting retrofits, including adding LEDs and a daylight harvesting feature in the lobby to automatically dim the lights according to the amount of sunlight entering the building), produced a savings of two million kilowatt-hours per year, or 70 percent less energy.
  - Fifty percent of AMA Plaza's roof houses a green vegetable garden, which not only reduces carbon dioxide emissions but also slows the amount of rainfall runoff that goes to Chicago's sewer system. The roof at AMA Plaza is also home to a vegetable garden and bee program, which harvests honey twice a year.
  - The AMA has tenancy in three locations (Chicago, DC, and Greenville) that have implemented varying sustainability best practices including LEED Green Certification, light sensors, recycling, etc. within their building guidelines. The AMA also instituted a requirement to contract exclusively with LEED-certified conference centers for Annual and Interim meetings in 2030.
  - A re-landscaping project is on track for completion by August 2024. The project will use low-maintenance, synthetic plants, which are projected to reduce energy consumption from landscaping maintenance by 20%.
- Employee Commuter Benefits
  - AMA employees are encouraged to enroll in the commuter benefit program to use pre-tax payroll deductions towards public transit costs.
  - AMA's shuttlebus service, bike area, on-site Zipcars and scooter and hybrid vehicle parking reduced carbon emissions by nine metric tons. The shuttlebuses alone save an average of 65,000 pounds in carbon dioxide emissions per month.
- Building Operations and Amenities
  - AMA's HQ café sources local food and participates in the building's compost program, which repurposes 70 percent of waste.
  - AMA staff and visiting members/meeting attendees can charge their electronics using solar-powered benches in AMA plaza.
  - The AMA does not offer disposable hot cups in any of the breakrooms.
- AMA Events
  - Following COVID-19, AMA saw a surge in remote and hybrid meetings, prompting improvements in technology, workflows, vendor lists, licenses, guidelines, and training. Staff enhanced their skills in meeting accessibility and completed PCMA Event Accessibility certifications.
  - Catering practices:
    - AMA promotes the use of water stations vs plastic water bottles when catering.
    - AMA catering is equipped to compost waste from internal meetings.
    - AMA's top three vendors for catering all have a sustainability program.
  - The AMA instituted a requirement to contract exclusively with LEED-certified conference centers for

Annual and Interim meetings in 2030.

- AMA has committed to Hyatt Regency Chicago, a LEED-certified building, for AMA's Annual meeting through 2029.

- AMA's 2027, 2029 and 2031 Interim Meetings will be held at the Gaylord Pacific (currently under construction), designed to adhere to California's energy code Title 24, surpassing the standards set by LEED certified buildings.

Timeline of future efforts

To make the most of limited resources and a shortage of benchmark emissions data, the AMA will adopt a framework from the United States Environmental Protection Agency (EPA)[1] to perform a self-review of current operations within AMA properties and AMA events. The AMA will develop sustainability guidelines based on the review and work with key partners and stakeholders on improvements to meet these guidelines. Implementation will be done with consideration of existing resources and fiscal impacts. Below is an outline of planned efforts from 2025 to 2030.

1. **By end of 2025: Collect data on carbon footprint.** The AMA will conduct an inventory of sources and amounts of emissions from business operations within AMA properties and AMA-hosted events:
    a. The AMA will follow the United States Environmental Protection Agency's (EPA) Greenhouse Gas (GHG) inventory development process to determine the proper scopes of emissions inventorying relevant to AMA's business operations.

    b. The AMA will utilize the EPA's Simplified GHG emissions Calculator[2] to identify the sources of carbon emissions and calculate emission estimates. The results will set a benchmark, against which the AMA can assess improvements towards net zero emissions from operations. While the AMA is committed to a target of net zero by 2030, certain operations might require a further target year to achieve net zero based on the calculation. The AMA would then inform the Board of Trustees of such cases. Below is a non-exhaustive list of environmental areas to examine:
        i. Waste management
        ii. Transportation (i.e. business travel, event transport, commuting)
        iii. Energy consumption
        iv. Carbon offsets

2. **By end of 2025: Develop guidelines for operational sustainability.** Based on the self-review, the AMA will establish sustainability guidelines for AMA building operations and event operations. Such guidelines will account for ways in which employees and vendors the AMA contracts with can implement and improve emission reduction practices.

3. **2026 to 2030: Implement guidelines.** The AMA will work with necessary stakeholders and vendors to implement operational improvements and measure emissions reduction against the calculated benchmarks.

4. **2026 to 2030: Leading by example within the Health Sector**
    a. Beginning in 2026, the AMA will launch an internal awareness campaign to inform and train employees on the new sustainability guidelines and improved practices aimed at reducing emissions. The AMA will utilize the following channels:
        i. Employee communications via email, SharePoint, and physical signage
        ii. Programming via collaboration with Employee Resource Groups and local opportunities for volunteering with sustainability projects
        iii. A digital course to educate employees on the sustainability guidelines

    b. The AMA will continue to engage in the following consortiums and partnerships, not only to advance policies and interventions on climate change and health (BOT Report 17-A-23 Update on Climate Change and Health – AMA Activities) but also to share resources, information, and insights gained from the data collection, guideline development, implementation, and communication work above.
        i. Medical Society Consortium on Climate Health

ii. National Academy of Medicine Action Collaborative on Decarbonizing the U.S. Health Sector
iii. The American Lung Association's Healthy Air Partners campaign
iv. American Public Health Association (APHA) Advisory Board on Climate, Health, and Equity

CONCLUSION

The AMA is committed to continuing to execute against our current initiatives, and expanding upon them, to achieve environmental sustainability. These resolutions reflect our proactive stance in reducing carbon emissions and championing sustainability initiatives within our organization and the broader health care sector. Through our efforts, we demonstrate our dedication to mitigating the environmental impact of our business operations. Additionally, our commitment to limiting carbon emissions generated by AMA events and researching opportunities for attendees to offset their environmental impact, highlights our holistic approach to sustainability. Through these initiatives, the AMA reaffirms its commitment to environmental stewardship and welcomes the opportunity to drive meaningful change within the health care ecosystem and beyond.

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1 U.S. Environmental Protection Agency. (2024, April). Simplified Guide to Greenhouse Gas Management for Organizations. Retrieved from U.S. Environmental Protection Agency: https://www.epa.gov/system/files/documents/2022-09/Simplified_Guide_GHG_Management_Organizations.pdf

2 U.S. Environmental Protection Agency. (2024, May 15). Simplified GHG Emissions Calculator. Retrieved from U.S. Environmental Protection Agency: https://www.epa.gov/climateleadership/simplified-ghg-emissions-calculator

18. EXPANDING PROTECTIONS OF END-OF-LIFE CARE

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

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 722-A-23 REMAINDER OF THE REPORT FILED
See Policies D-295.969, H-70.915, H-295.875 and H-450.919

At the 2023 Annual Meeting, the House of Delegates (HOD) referred Resolution 722, "Expanding Protections of End-of-Life Care," authored by the New York Delegation which asks our American Medical Association (AMA):

(1) recognizes that health care, including end of life care like hospice, is a human right,

(2) supports the education of medical students, residents and physicians about the need for physicians who provide end of life health care services,

(3) supports the medical and public health importance of access to safe end of life health care services and the medical, ethical, legal and psychological principles associated with end-of-life care,

(4) supports education of physicians and lay people about the importance of offering medications to treat distressing symptoms associated with end of life including dyspnea, air hunger, and pain,

(5) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to end-of-life care,

(6) supports shared decision-making between patients and their physicians regarding end-of-life health care,

(7) opposes limitations on access to evidence-based end of life care services,

(8) opposes the imposition of criminal and civil penalties or other retaliatory efforts against physicians for receiving, assisting in, referring patients to, or providing end of life health care services.

This report provides relevant background, discussion, and recommendations.

BACKGROUND

The leading causes of death in the United States are associated with chronic illness in which the patient experiences long durations of symptom burden, medical treatments and interventions, and diminished quality of life [1]. As chronic illness progresses to serious and critical illness, death may be anticipated; however, patients and their families are often unprepared for the emotional burden of making life-sustaining and/or prolonging medical decisions during treatment of serious and critical illness [2]. As a result, many patients experience physical suffering and receive life-sustaining and/or prolonging medical treatments and interventions that are not in accordance with their preferences, values, and goals [3]. Additionally, patients and their families commonly experience emotional suffering including anxiety and depression [2]. The health care team plays a crucial role in alleviating the burden of physical and existential suffering during serious and critical illness and end-of-life through the delivery of palliative care.

Palliative care is the comprehensive management and coordination of care for pain and other distressing symptoms, including physical, psychological, intellectual, social, psychosocial, spiritual, and existential consequences of a serious illness, which improves the quality of life of patients and their families/caregivers. Additionally, palliative care evaluation and treatments are patient-centered, with a focus on the central role of the family unit in shared decision-making according to the needs, values, beliefs, and culture or cultures of the patient and their family [4]. Importantly, palliative care can be offered in all care settings through a collaborative team approach involving all disciplines (e.g., physicians, nurses, social workers, spiritual care providers, therapists, pharmacists), should be available at any stage of illness from birth to advanced age, and may be offered simultaneously with disease-modifying interventions, including attempts for cure or remission [5, 6]. However, palliative care is especially suited for persons who have incurable, progressive illness and are facing end-of-life. Hospice, which is a part of palliative care, is offered when a patient is eminently dying [7].

Palliative care can be delivered by any physician, in any specialty; however, specialty palliative care can be provided by consultants when the patient and/or their family's needs are more complex [6]. Integration of palliative care into the patient's care plan has many well studied benefits including, improved quality of life, decreased symptom burden, increased goal-concordant care, increased caregiver support, reduced anxiety, decreased hospital mortality, and reductions in unnecessary medical costs [8]. Additionally, early integration of palliative care reduces unnecessary medications and procedures that have the potential to elicit unwanted side effects or complications and, in some cases, lengthens survival while also decreasing suffering [9,10]. Although palliative care is especially suited for persons who have incurable, progressive illness and are facing end-of-life, it is imperative to distinguish the delivery and purpose of palliative care from any action that intentionally causes death, including physician assisted suicide and euthanasia. While palliative care provides pain and symptom management as well as assistance with making difficult medical decisions and emotional support to patients during end-of-life, palliative care interventions never intentionally cause death.

Numerous AMA policies (H-295.875, Palliative Care and End-of-Life Care; H-70.915 Good Palliative Care; D-295.969, Geriatric and Palliative Care Training for Physicians) support the provision of palliative care for patients and the education on palliative care for physicians. The AMA is not alone in its support of palliative care. The World Health Assembly (WHA) declared that providing palliative care should be considered an ethical duty for health organizations [11]. Additionally, the World Health Organization (WHO) declared that palliative care is an ethical duty of health professionals, and, in 2012, the United Nations Office of the High Commissioner for Human Rights recognized that the failure to provide palliative care and end-of-life care to older persons is a human rights violation [11,12]. Furthermore, in 2011, the World Medical Association (WMA) adopted the *Declaration on End-of-life Medical Care* which declared that "The objective of palliative care is to achieve the best possible quality of life through appropriate palliation of pain and other distressing physical symptoms, and attention to the social, psychological and spiritual needs of the patient" and is part of good medical care [13]. Three years later, the WMA further expanded their support of palliative care with the adoption of a resolution that called for the integration of palliative care in global disease control and health system plans. Additionally, major world religions also endorse palliative care [14].

The AMA recognizes the disparities in access to palliative care services, especially among racial, ethnic, and socioeconomically disadvantaged populations. Ensuring all patients, regardless of background or geography, receive equitable, culturally competent, and appropriate palliative care is essential.

DISCUSSION

Despite a strong evidence basis supporting the benefits of palliative care, and existing AMA and international medical policies supporting palliative care as an ethical and imperative part of high-quality medical care, millions of patients within the United States experience barriers to accessing palliative care due to misconceptions, misinformation, limited resource availability, and inaccurate stigma surrounding the definition of palliative care and its scope [5,11,15,16]. Additionally, due to these same misconceptions and stigma, physicians face barriers to receiving education and providing palliative care at all stages of the disease course [17,18].

While AMA Policy and the *Code of Medical Ethics* (Opinion 5.2: Advance Directives; Opinion 5.3: Withholding or Withdrawing Life-Sustaining Treatment) historically support addressing the palliative needs of patients and assert that clinicians have a duty to provide optimal palliative care to patients, our AMA has not provided specific guidance on the definition, delivery, and scope of high-quality palliative care.

First, although the concept of palliative care is referenced throughout AMA policy, it is often inaccurately labeled as end-of-life care and no specific definition is provided as to what the ethical provision of this care entails or the scope of this practice. Defining palliative care is essential given that palliative care is often misunderstood and misattributed. Second, expanding palliative care education and access is important for ensuring that patients are able to obtain these evidence-based health care interventions during any stage of their serious or critical illness, including end-of-life care. Palliative care should be offered concurrently with disease modifying interventions, including attempts for cure or remission. Thirdly, palliative care, which is an ethical duty, should be distinguished from other practices that are considered ethically questionable or unethical in the practice of medicine by the AMA *Code of Medical Ethics* (e.g., knowingly and intentionally hastening or causing death, physician assisted suicide, and euthanasia). Lastly, advocating for expanding access to palliative care, as well as legal protections for physicians who provide this essential component of high-quality patient care are important.

CONCLUSION

Palliative care is an evidence based, essential component of serious illness, critical illness, and end-of-life care that is often inaccurately defined, misrepresented, and neglected. As a result, patients and their families endure physical and existential suffering that could be mitigated or alleviated with palliative care intervention. Barriers to physicians providing, and patients receiving palliative care may be alleviated through reaffirming existing AMA policy on education and new AMA policy providing guidance on the definition, delivery, and scope of palliative care.

RECOMMENDATIONS

1. The Board of Trustees recommends that policies H-295.875, Palliative Care and End-of-Life Care; H-70.915, Good Palliative Care; D-295.969, Geriatric and Palliative Care Training for Physicians be reaffirmed.

2. The Board of Trustees recommends that alternate Resolution 722, be adopted in lieu of Resolution 722 and the remainder of this report be filed:

Our American Medical Association:

(1) recognizes that access to palliative care, including hospice, is a human right.
(2) recognizes that palliative care is the comprehensive management and coordination of care for pain and other distressing symptoms, including physical, psychological, intellectual, social, psychosocial, spiritual, and the existential consequences of a serious illness, which improves the quality of life of patients and their families/caregivers and that generalist and subspecialist palliative care evaluation and treatments are patient-centered and family-oriented, emphasizing shared decision-making according to the needs, values, beliefs, and culture or cultures of the patient and their family or chosen family.
(3) recognizes that palliative care can be offered in all care settings through a collaborative team approach involving all disciplines (e.g., physicians, nurses, social workers, spiritual care providers, therapists,

pharmacists) and should be available at any stage of a serious illness from birth to advanced age and may be offered simultaneously with disease modifying interventions.

(4) recognizes that palliative care can be offered alongside curative or life-prolonging treatments at any stage of illness, whereas hospice is a specific type of palliative care, typically reserved for individuals with a prognosis of six months or less.

(5) recognizes that palliative care differs from physician assisted suicide in that palliative care does not intentionally cause death. In fact, palliative treatments that relieve symptom distress have been shown in numerous studies to prolong life.

(6) will work with interested state medical societies and medical specialty societies and vigorously advocate for broad, equitable access to palliative care, including hospice, to ensure that all populations, particularly those from underserved or marginalized communities have access to these essential services.

(7) opposes the imposition of criminal and civil penalties or other retaliatory efforts against physicians for assisting in, referring patients to, or providing palliative care services, including hospice.

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19. UPDATE ON CLIMATE CHANGE AND HEALTH AMA ACTIVITIES

Informational report; no reference committee hearing

HOD ACTION: FILED

BACKGROUND

At the Interim Meeting of the American Medical Association (AMA) House of Delegates (HOD) Board of Trustees Report 3, "Update on Climate Change and Health AMA Activities," was referred by the HOD. BOT 3-I-23 was an informational report, in which the Board reiterated its plan to address the health effects of climate change and outlined the work the AMA had accomplished since the strategy was outlined in June of 2023.

Those who testified at the Reference Committee hearing indicated that what they were expecting was a plan similar to the AMA's strategic plan to advance health equity. It was noted that this report did not meet their expectations, and it was asked that the report be referred back to the Board.

It is important to note the Board of Trustees serves as the principal planning agent for the AMA. That involves decision-making over allocation of resources and strategy development. Any strategy put forth needs to set realistic goals that the organization can reasonably achieve.

The AMA's strategic arcs are removing obstacles that interfere with patient care, confronting chronic disease and eliminating health inequities, and driving the future of medicine by reimagining medical education and lifelong learning. Each arc is powered by the cross-cutting accelerators of advocacy, equity and innovation.

Climate change is not a strategic arc nor is it a cross-cutting accelerator, rather it fits within the AMA's public health strategy along with other public health crises impacting physicians, patients, and the public. These include preventing firearm injuries and deaths, preparing for emerging and reemerging infectious disease threats, and ending the nation's drug overdose epidemic. The AMA has multiple levers it can utilize to address these public crises including advocacy, education, and collaboration with other interested organizations.

DISCUSSION

The attached document, which will be made available on the AMA website, provides a summary of the current evidence on climate change and health as well as historical context for AMA's work on both climate change and environmental health more broadly. In Section II, organizational levers for combatting the health effects of climate change are described and four priorities are described. Lastly, in Section III, key accomplishments over the past two years and proposed actions for the future are outlined. The AMA's four priorities on climate change and health are:

1. Educate physicians and trainees on the health effects of climate change.
2. Identify and disseminate information to physicians on decarbonizing the health care sector, reducing greenhouse gas emissions, as well as improving adaptation and resilience efforts.
3. Elevate the voices of physician leaders on the issue of climate change and health.
4. Collaborate with stakeholders to advance policies and interventions with a unified voice.

CONCLUSION

The AMA will continue to provide updates on activities taken to address the climate crisis in the AMA's annual public health strategy report.

20. 2024 AMA ADVOCACY EFFORTS

Informational report; no reference committee hearing

HOD ACTION: FILED

BACKGROUND

Policy G-640.005, "AMA Advocacy Analysis," calls on the Board of Trustees (the Board) to provide a report to the House of Delegates (HOD) at each Interim Meeting highlighting the year's advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The Board has prepared the following report to provide an update on American Medical Association (AMA) advocacy activities for the year. (Note: This report was prepared in August based on approval deadlines, so more recent developments may not be reflected in it.)

DISCUSSION OF 2024 ADVOCACY EFFORTS

In 2024, our AMA fought forcefully on behalf of physicians and patients on the most critical health care issues:

- Reforming Medicare physician payment;
- Fixing prior authorization;
- Promoting physician-led team-based care;
- Improving physician wellness and reducing burnout; and
- Making technology work for physicians.

The AMA has prioritized these issues based on HOD-adopted policy, physician polling, their overarching nature, and the opportunity to affect change. Making progress on these issues is vital to establishing and maintaining thriving practices. The AMA is also seeking to advance AMA policy on a host of other health care issues under consideration at the federal and state levels. Updates on these additional efforts are also included in this report.

It is abundantly clear that physician practices are facing difficult headwinds on several fronts from payment cuts to administrative hurdles to government interference in the provision of care. Many physicians are highly frustrated with how policymakers are addressing or failing to address critical health care issues. AMA leadership including the Board, senior management, and frontline lobby staff share this high level of frustration and are committed to achieving meaningful progress to alleviate the untenable pressures facing physician practices.

As of August, the AMA has sent close to 150 letters to federal and state policymakers advocating for AMA policy. Many of these letters stem directly from HOD resolutions. Further, some were sign-on letters written in conjunction with the Federation of Medicine, and the AMA is grateful for the partnership. The AMA has also launched strong grassroots campaigns on several issues with more details included later in this report.

Medicare Payment Reform

The AMA shares its members' long frustration over the continued cuts to Medicare payment. Congress did mitigate about half of the 2024 Medicare physician payment cuts initially implemented despite urgent calls from physicians about the impact that two decades of annual payment cuts are having on practice viability and patient access to care. Adding salt to the wound is the proposed 2025 Physician Payment Rule that includes a 2.8 percent cut. Meanwhile, the Centers for Medicare & Medicaid Services (CMS) predicts that the Medicare Economic Index (MEI) will increase by 3.6 percent in 2025. Further, the fiscal stability of physician practices and long-term viability of the nation's entire health care system is at stake because Medicare physician payment rates have plummeted 29 percent from 2001 to 2024 (adjusted for inflation in practice costs).

Fixing our unsustainable Medicare payment system will remain AMA's top advocacy priority until meaningful reform is achieved, and the AMA has committed significant additional resources to this campaign in 2024.

The AMA has worked with the Federation to develop Medicare payment reform pillars and is advocating for legislation introduced at the behest of the AMA to address each of them.

Medicare Reform: Automatic Annual Inflation-based Updates
In response to AMA advocacy, Congress took an important first step last year toward Medicare reform with the introduction of H.R. 2474, "The Strengthening Medicare for Patients and Providers Act," a bipartisan bill that would provide automatic, annual payment updates to account for practice cost inflation as reflected in the MEI. Tying annual payment updates to the MEI has long been supported by the AMA because it would place physicians on equal ground with other health care providers.

Medicare Payment Reform: Budget Neutrality
A bill strongly supported by the AMA was introduced in the House by the co-chairs of the GOP Doctors Caucus (H.R. 6371) and is based on AMA recommendations to reform the budget neutrality policies that have been producing across-the-board payment cuts. The bill would require CMS to review actual claims data and correct flawed utilization projections that cause inappropriate conversion factor cuts or increases; raise the spending threshold that triggers a budget neutrality adjustment from $20 million to $53 million; and limit destabilizing swings in payment by limiting budget neutrality adjustments to 2.5 percent in any given year.

Medicare Payment Reform: Revising the Merit-based Incentive Payment System (MIPS)
Together with the Federation, the AMA has developed legislative language to improve the MIPS program. The draft would address steep penalties that are distributed unevenly and disproportionately impact small, rural, and independent practices; hold CMS accountable for providing physicians with timely and actionable data; and reform MIPS so that it is more clinically relevant and less burdensome.

Although the MIPS reform proposals were more recently introduced to policymakers, the AMA was successful in persuading the Senate Appropriations Committee to include relevant report language for its FY 2025 budget bill "urging CMS to improve timely access to MIPS feedback reports and claims data...consistent with current law." The Committee goes on to request an update from CMS next year on various issues related to national specialty society-developed quality measures and their use in clinical quality data registries.

In a further positive sign, a bipartisan coalition of U.S. Senators created a Medicare payment reform working group that has been examining proposals for long-term reforms to the physician fee schedule and updates to the Medicare Access and CHIP Reauthorization Act (MACRA). AMA has been engaging with this group and responded in detail to a physician payment reform white paper that they issued. Further, MedPAC and the Medicare Trustees have both acknowledged the unsustainability of the current system and the need for significant payment reform which is helpful as the AMA and Federation seek long-term improvements to the Medicare payment system.

The AMA has been meeting directly with key Congressional offices, particularly House and Senate leadership, committee members and staff, members of the Doctors Caucus, and other champions for medicine, as well as with CMS and MedPAC, to advocate for our reform proposals. Staff has also been instrumental this year in persuading members of Congress to circulate their own Dear Colleague sign-on letters to Congressional leadership expressing support for various reform elements, notably about the need for an annual inflation update. Bill cosponsorship campaigns have been successful, with 154 (as of early August) cosponsoring H.R. 2474, the annual MEI update legislation, despite the high cost of the proposal.

From a research perspective, the AMA has also launched the Physician Practice Information Survey to update physician practice cost data utilized in the Medicare Resource-Based Relative Value Scale and the MEI. More than 10,000 physician practices have been contacted to participate in the effort. Data from the effort will be summarized in late 2024 to share with CMS and to be used in AMA advocacy efforts.

Following up on public polling and focus groups held last year, the AMA conducted additional polling this year of physicians and patients to further test our Medicare advocacy messaging and obtain more specific information about the impact of escalating practice costs and declining payments on patient access to care.

To support the Medicare legislation cited above, the AMA has been engaged in a major grassroots campaign to engage patients and physicians in our lobbying efforts. The following statistics result from the Fix Medicare Now campaign and engagement with the Physician Grassroots Network and Patients Action Network.

- 90.9MM+ Impressions
- 1.5MM+ Engagements

- 2,000+ #FixMedicareNow Social Media Mentions
- 397k messages sent to Congress
- 504k+ FixMedicareNow.org Pageviews
- 423k+ FixMedicareNow.org Site Users
- 1000+ earned media stories on Medicare, including more than 50 placements giving voice to physician leaders and third parties – making the case for reforming the system and stopping/reversing the cuts. (These efforts have had an organic impact on thought leaders and policy analysts who are now beginning to express similar views independently.)

A good example of the campaign is a promotional series that the AMA is running at the Politico site and other influential web properties. Activities ramping-up in the summer will continue to intensify through the fall and in anticipation of a Congressional "lame duck" session that will tackle Medicare. These include engaging both patient and physician audiences during Congress' month-long August Recess, helping them identify opportunities to contact and meet with their federal legislators and staff equipped with 'action kits' (that include talking points, supportive charts/data, and feedback forms) that reinforce medicine's position. Other tactics include aggressive paid promotion that hit lawmakers in Washington, D.C. and their home states/districts with a battery of messaging online, in print, radio, and TV/streaming services ensuring the issue is top-of-mind for them and their constituents ahead of critical elections in November. Additionally, the AMA will leverage earned media efforts, physician grasstops, and allied influencer engagement that brings together the most influential voices to put direct/public pressure on key legislators.

When Congress returns in the fall and throughout their lame duck session, these activities will continue to ratchet-up in addition to other potential activities including coordinated social media and phone storms/blitzes as determined necessary at key times in anticipation of Congressional action.

Please see Board Report 22-A-24 for more details on AMA Medicare payment reform efforts.

Prior Authorization

Prior authorization is a remarkable frustration for physicians due to its excessive use by insurance companies to delay or deny patient care, and its use directly correlates with poorer health care outcomes. According to the most recent AMA research, overuse of prior authorization leads to:

- Patient Harm - Nearly one in four physicians (24 percent) reported that prior authorization has led to a serious adverse event for a patient in their care, including hospitalization, permanent impairment, or death.
- Bad Outcomes - More than nine in 10 physicians (93 percent) reported that prior authorization has a negative impact on patient clinical outcomes.
- Delayed Care - More than nine in 10 physicians (94 percent) reported that prior authorization delays access to necessary care.
- Disrupted Care - More than three-fourths of physicians (78 percent) reported that patients abandon treatment due to authorization struggles with health insurers.
- Lost Workforce Productivity - More than half of physicians (53 percent) who cared for patients in the workforce reported that prior authorizations had impeded a patient's job performance.

The AMA has led a grassroots campaign for several years focused on "fixing prior auth" which has contributed to much of the progress that has been made on this issue. The AMA secured an important victory for physicians in the CMS final rule that requires government-regulated health plans to reduce the timeframes for prior authorization decisions and to publicly report program metrics, which will reduce care delays and improve transparency. These plans will also be required to offer electronic prior authorization technology that directly integrates with EHRs, significantly reducing unnecessary burden for physicians, resulting in an estimated $15 billion in savings over 10 years according to the Department of Health and Human Services (HHS). These changes build on new regulatory requirements that went into effect in January that ensure validity of prior authorization clinical criteria and protections for care continuity in Medicare Advantage plans.

The AMA is also advocating for the "Improving Seniors' Timely Access to Care Act" in both the House and Senate to codify and expand on prior authorization reforms finalized by CMS. This bill is even more important and is

needed to memorialize the CMS rule in light of the *Loper Bright Enterprises v. Raimondo* ruling which may limit agency regulatory authority. The AMA successfully sought the reintroduction of the "Getting Over Lengthy Delays in Care as Required by Doctors (GOLD CARD) Act," which would exempt qualifying physicians from Medicare Advantage plans' prior authorization requirements.
The AMA continues to work to provide medical societies with legislative language, talking points, data, and other resources to push for important prior authorization reforms in state legislatures. The AMA is also lobbying national policymaking organizations (e.g., the National Association of Insurance Commissioners) on the importance of reform and working closely with coalitions of other impacted organizations to make the case for important patient protections from payers' utilization management requirements.

So far in 2024, 12 prior authorization reform bills have been enacted at the state level with AMA support. Broadly, state bills are aiming to decrease the growing volume of prior authorization requirements, reduce delays in patient care associated with prior authorization, improve the transparency of prior authorization rules, and increase reporting of prior authorization data.

For example, Vermont Governor Phil Scott recently signed a bill championed by the Vermont Medical Society that limits prior authorization requirements on primary care physicians and helps ensure that patients with chronic conditions will not have to continuously seek repeat approvals. The new law will also require that urgent prior authorization requests are responded to within 24 hours. Additionally, and uniquely, the law requires health plans and physicians and other health care providers to report to the legislature in coming years on the impact of the law. Additional prior authorization reform laws were enacted in California, Colorado, Illinois, Maine, Maryland, Minnesota, Mississippi, New Jersey, Oklahoma, Virginia, Wyoming, and the District of Columbia.

The AMA is also working on a host of other payer issues including continuing to address No Surprises Act implementation issues with the administration, Congress and in the courts as this issue continues to play out. Recent court decisions, initiated by the Texas Medical Association and supported by the AMA, have resulted in a fairer dispute resolution process. The AMA also assisted the state medical associations in California and North Carolina to prevent the implementation of harmful modifier 25 policies by Blue Cross Blue Shield plans in those states. Finally, the AMA is supporting bipartisan legislation to hold health plans responsible for inaccurate provider directories under Medicare Advantage.

Physician-Led Team-Based Care

The AMA strongly supports physician-led team-based care where all members of the team use their unique knowledge and valuable contributions to improve patient outcomes. Removing physicians from the care team results in higher costs and lower quality of care. Patients deserve access to a physician leading their care team.

The AMA Scope of Practice Partnership (SOPP), a coalition of 105 national, state and specialty medical associations, has been instrumental in defeating scope expansion bills across the U.S. The SOPP has awarded more than $4 million in grants to its members to fund advocacy tools and campaigns since 2007. The SOPP Steering Committee has awarded 10 grants for 2024 to the state medical associations in the following states: Alabama, Georgia, New York, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, and Utah, plus the District of Columbia. In addition, the Mississippi State Medical Association and South Dakota State Medical Association received grants in 2023 for the 2024 legislative sessions. These grants are instrumental in providing financial assistance for on-the-ground resources necessary to help defeat inappropriate scope expansion legislation. Further, to respond to increasing scope threats, the AMA substantially increased its financial support for the SOPP, raising its annual contribution from $50,000 to $300,000 in 2023.
So far in 2024, the AMA has worked with more than 35 state medical associations and national medical specialty societies on scope of practice, securing more than 50 wins and demonstrating the collective work of organized medicine. State medical associations deserve special gratitude since they are on the ground in the statehouses each day and serve as point on these campaigns.

- At least 12 states have defeated legislation that would remove physician supervision of or collaboration with nurse practitioners or advanced practice registered nurses (APRN), including two states, Oklahoma and Wisconsin, where the Governor vetoed APRN bills;
- Bills that would have allowed optometrists to perform surgery have been defeated in at least 10 states, including California, Idaho, Kansas, Minnesota, Missouri, Nebraska, New Hampshire, Utah, Vermont, and West Virginia;

- Nurse anesthetist bills have been defeated in at least eight states including: Florida, Georgia, Illinois, Kansas, Missouri, South Carolina, Utah, and Virginia;
- Arizona, California, Illinois, Mississippi, Oklahoma, South Carolina, and West Virginia stopped pharmacist test-to-treat legislation, while Washington State defeated a bill that would have given the Pharmacy Commission the authority to identify drugs and devices that a pharmacist could prescribe;
- Alaska, Colorado, Connecticut, Florida, Indiana, Kansas, Minnesota, Missouri, New Jersey, New York, and Washington defeated legislation that would have created a license for naturopaths, allowed naturopaths to prescribe medications and perform minor surgeries, or order and interpret diagnostic tests;
- Florida, Hawaii, New York, Oklahoma, and Washington defeated psychologist prescribing bills; and
- South Dakota State Medical Association achieved a "silent" victory as a physician assistant scope expansion bill was not introduced this year, likely because SDSMA defeated physician assistant scope bills three times in recent years. Unfortunately, however, two scope bills passed in South Dakota this year, an optometrist surgery bill and APRN Compact bill.

The AMA also sent 18 letters to state lawmakers expressing opposition to pending scope of practice legislation and testified before state legislative bodies on five occasions expressing our opposition to inappropriate scope expansions and the importance of preserving physician-led care.

At the federal level, the AMA organized two sign-on letters to the House Ways & Means and Energy & Commerce committees, expressing medicine's strong opposition to H.R. 2713, the "Improving Care and Access to Nurses Act," or the "I CAN Act." This legislation would endanger the quality of care that Medicare and Medicaid patients receive and is expected to be the primary advocacy focus of nonphysician practitioners in the current Congress. The AMA is also organizing opposition to the "Equitable Community Access to Pharmacist Services Act," which would permit pharmacists to perform services that would otherwise be covered if they had been furnished by a physician, test and treat patients for certain illnesses (including illnesses that address a public health need or relate to a public health emergency), and also expand Medicare payment for pharmacists in limited but significant ways. Further, the AMA continues to lead a coalition to oppose the Department of Veterans Affairs Supremacy Project, which aims to set national standards of practice for all health professionals that provide care in the VA system.

Physician Wellness

The AMA has made improving physician wellness/reducing physician burnout a cornerstone of its strategic work for more than a decade, working at the system-level to remove the common barriers that interfere with patient care and often lead to burnout and dissatisfaction. Following the passage of the "Dr. Lorna Breen Health Care Provider Act" in 2022, a bill the AMA strongly supported, the AMA continued to push for regulatory, legislative, and other solutions to direct more funding and resources to support the mental health needs of physicians. The AMA is also seeking reauthorization of the legislation in 2024.

AMA advocacy also has encompassed multiple efforts to ensure medical licensing, credentialing, and other applications do not stigmatize mental illness or substance use disorders and do not contain language mandating disclosure of past treatment or diagnosis of a mental illness or substance use disorder. In partnership with the Dr. Lorna Breen Heroes' Foundation and countless medical societies and other partners, the AMA has supported and secured multiple wins. As of July 2024, the following have removed stigmatizing language regarding physicians' mental health and wellbeing:

- 28 medicals boards: California, Connecticut, Georgia, Hawaii, Idaho, Illinois, Kansas, Louisiana, Massachusetts, Maine, Michigan, Minnesota, Missouri, Mississippi, Montana, Nebraska, New York, North Carolina, North Dakota, Ohio, Oregon, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, and Washington (the AMA is in the process of working directly with multiple other medical boards);
- More than 25 local, state and regional health systems, including Allegheny Health Network, Augusta Health, Bon Secours Mercy Health - Richmond, Centra Health, Envision, Children's Hospital of the King's Daughters, Geisinger Health, HCA Healthcare, Henry Ford Health System, Inova Health System, Mary Washington Health Care, Medstar Health, Northeastern Vermont Regional Hospital, Northwell Health, NYC Health + Hospitals, Sentara Health System, Sturdy Health, PacificSource Health Plans, UVA Health System, Valley Health System, Wooster Community Hospital, Wooster Community Hospital, Allina Health, and Fulton County Health Center. The AMA is working with more than 40 additional systems to audit and revise their credentialing applications;

- AMA advocacy efforts and partnerships also secured multiple organizations adopting policies and/or advocacy positions directly aligned with the AMA on these issues, including CDC/NIOSH, the National Association of Medical Staff Services, the Massachusetts Hospital Association, the American Dental Association, the American Society of Health System Pharmacists, and others;
- Minnesota and Virginia enacted legislation in 2024 restricting applications from having stigmatizing language and supporting "safe-haven" type programs; and
- AMA advocacy has led to the National Association of Medical Staff Services revising its Ideal Credentialing Standards to follow AMA policy. The AMA also successfully advocated for the National Center for Quality Assurance to align with AMA policy for credentialing applications to ask only about current impairment and not past diagnosis or treatment of a mental illness or substance use disorder.

The AMA has also opened a new legislative advocacy campaign to help the Federation advocate for laws protecting physicians from violence, including creating a comprehensive analysis of all state laws that protect physicians and health care practitioners from workplace violence. In addition, the AMA has also developed an extensive legislative template that the Federation can use to analyze and develop their own state legislation protecting physicians from violence in numerous settings—not simply the workplace.

Telehealth

The physician adoption rate of telehealth and digital health tools has accelerated as physicians grow increasingly optimistic about providing care virtually, which can increase access and break down barriers to care. Two years ago, the AMA won an important victory for physicians and patients with the passage of legislation extending pandemic-related Medicare telehealth flexibilities through 2024. Unless Congress acts by December 31, 2024, Medicare will no longer be able to cover and pay for most telehealth services starting January 1, 2025.

AMA strongly backs bipartisan measures to enact a permanent fix. Congress is expected to pass another extension through 2026. This is due to the cost associated with making the policy permanent. The Congressional Budget Office (CBO) is expected to score the cost of a two year extension at $2 billion per year, double the cost of the original two year extension. This is based on the CBO's current assumption that telehealth services have been additive, not substitutive to in person services, and therefore have increased Medicare utilization.

Telehealth legislation is currently making its way through the committees of jurisdiction. The House Ways and Means Committee unanimously passed H.R. 8261, the "Preserving Telehealth, Hospital and Ambulance Access Act," on May 8. The House Energy and Commerce Subcommittee on Health unanimously approved a modified version of H.R. 7625, the "Telehealth Modernization Act," on May 17. The bills are largely identical and would extend all key telehealth flexibilities through 2026 (2 years) including:

- An extension of the exemption of the geographic and originating site restrictions, plus allowing anyone to receive telehealth services both in the home and wherever they can access a telecommunications system;
- A continued moratorium on the requirement for an in-person visit within 6 months of the beneficiary receiving the first telemental health service;
- Authority to provide audio-only telehealth services; and
- An extension of the hospital at home flexibilities through 2029 (5 years).

In addition, the Energy and Commerce Committee bill would authorize:

- Medicare coverage and payment for cardiopulmonary rehabilitation services in the home through 2026; and
- Medicare coverage and payment of virtual Diabetes Prevention Program services.

The AMA was instrumental in making sure both bills were "clean" and did not include any new restrictions on coverage and payment of telehealth services such as in-person requirements. Both the House Energy and Commerce Committee and the Senate Finance Committee are expected to report out telehealth bills in September.

The AMA was also pleased with the Drug Enforcement Administration's decision to extend flexibility in prescribing of controlled substances based on telehealth patient visits through 2024 which was an AMA advocacy priority.

Further, in a final rule, CMS announced it will maintain the waiver of geographic and originating site restrictions related to telehealth through the end of 2024. The waiver, which began during the COVID-19 pandemic, allows Medicare beneficiaries to connect with physicians anywhere in the U.S. from home. This creates flexibility in patients' access to care. CMS also finalized extending payment for audio-only telehealth services, increasing remote patient monitoring capabilities.

Cybersecurity

The AMA is deeply concerned about cybersecurity breaches including the Change Healthcare breach that threatened the viability of medical practices and jeopardized access to care for potentially millions of patients. After the Change Healthcare cyberattack, the AMA called for immediate action by UnitedHealth Group and policymakers on specific items that could help practices to survive the event:

- Advance payments;
- Restoring practices' electronic systems;
- Suspension of all prior authorization, quality reporting and similar administrative requirements;
- Broader focus on restoring function for independent physician practices;
- Prohibiting retroactive denials based on eligibility or lack of utilization management approval;
- Waivers for timely filing deadlines for claims and appeals;
- More information on the scope and the impact on patients' data; and
- Clarification that the duty to inform patients about a breach of their personal health data resides with Change Healthcare and Optum and not with individual providers.

The AMA appreciated that HHS and CMS responded to the urgency of this incident and the unprecedented disruptions to medical practices and access to care. Following the AMA's urging, HHS and CMS announced initial steps in March to support physicians experiencing financial hardships as a result of this ransomware attack. CMS announced that physicians impacted by the Change Healthcare service disruption could apply for advance Medicare payments. CMS also extended the 2023 MIPS data submission deadline to April 15.

HHS further responded to concerns from the AMA regarding difficulties physicians face in securing information and assistance from commercial health insurers in the aftermath of the Change Healthcare cybersecurity attack by releasing a resource that collates information and contacts across many health plans. The AMA submitted multiple statements for the record for congressional hearings on the Change Healthcare cyberattack. In addition, a letter cosigned by over 100 Federation groups and other stakeholders was sent in May, asking that HHS and the Office of Civil Rights publicly clarify that breach notifications are the responsibility of UnitedHealth Group and not individual physicians, hospitals, and other providers. Following this sign-on letter, the HHS Office of Civil Rights released updated FAQs specifying that covered entities can delegate to Change Healthcare the tasks of making the required Health Insurance Portability and Accountability Act breach notifications on their behalf.

The AMA also sent a letter to the National Association of Insurance Commissioners (NAIC) asking that it urge its members to take immediate action to protect physician practices from the widespread impact of the Change Healthcare cybersecurity breach. NAIC disseminated the letter to states, which have responded with their own actions. NAIC has also formed a steering committee to address this issue and has been in touch with the AMA to assess the ongoing impact on physicians. The AMA also advocated to the National Association of Medicaid Directors (NAMD) asking that it urge its members to take immediate action to assist physician practices impacted by the Change breach, including taking advantage of flexibilities provided by CMS related to state plan amendments to provide advance payments to physicians under Medicaid. NAMD responded positively to the AMA outreach and welcomed ongoing discussions with the AMA on how the service disruption is interfering with care delivery.

The AMA has engaged with Congress, offering several recommendations to prevent or mitigate future cyber-attacks and the impact on physicians:

- Robust cybersecurity standards for health plans and health care clearinghouses;
- Federally funded cybersecurity support centers to assist physician offices and smaller health care providers with cybersecurity adoption, prevention, training, and education;

- Impacted payers and clearinghouses must provide emergency connection points to maintain business continuity with physicians' health IT systems; and
- Physicians should be explicitly exempt from any accountability, liability, or penalties if a breach of their patients' protected health information occurs without any fault on their part.

The AMA continues to closely monitor the situation and gather information on the impact of this breach and others affecting health systems and other health care stakeholders.

Augmented Intelligence

Augmented Intelligence (AI) technology holds the promise to radically transform health care for both physicians and patients. For AI to meet its potential to improve care delivery and health, the AMA has called for a whole government regulatory approach that engages the physician community to ensure necessary safeguards and protections are in place. The AMA released Principles for Augmented Intelligence Development, Deployment and Use in the fall of 2023 that will guide the organization's engagement with the administration, Congress, and industry stakeholders in discussions on the future of governance policies to regulate the development, deployment and use of health care AI. For example, transparency around health care AI design, development, and deployment processes should be mandated by law and physicians should be provided sufficient detail and information to make their own informed decisions about using AI. These principles build on existing AMA policies on AI that go back to 2018, which encourage a comprehensive government approach to AI governance policies to mitigate risks. The principles lay out an appropriate strategy for AI in health care, including:

- Above all else, health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, and transparent;
- Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient; and
- Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the potential overall or disparate harm and consequences the AI system might introduce.

More information on AMA AI efforts is included in Board Report 01-A-24.

Physician-Owned Hospitals

The AMA continues to be a strong proponent of lifting the existing ban on physician-owned hospitals. Representatives Michael Burgess, MD (R-TX), Tony Cardenas (D-CA), Morgan Griffith (R-VA), and Vicente Gonzalez (D-TX) introduced, H.R. 9001, "the Physician Led and Rural Access to Quality Care Act." This bipartisan legislation would permit the establishment of select physician-owned hospitals that meet certain criteria. More specifically, the legislation defines a "covered rural hospital" as a physician-owned hospital that is located in a rural area and more than a 35-mile drive (or a 15-mile drive in mountainous terrain or areas with only secondary roads) from another hospital or critical access hospital. The legislation also only permits these hospitals that meet this narrow definition to expand existing physician-owned hospitals. If enacted, H.R. 9001 will help foster greater competition and provide better health care access, especially in rural areas.

Physician Workforce

To address the current and growing physician workforce crisis, the AMA is emphasizing a multi-pronged solution. This includes seeking additional Graduate Medical Education (GME) slots and funding so more physicians can be trained. Legislation on this recommendation, H.R. 2389, the "Resident Physician Shortage Reduction Act," currently has more than 170 bipartisan House cosponsors. The AMA is calling for additional funding in support of programs created through the "Dr. Lorna Breen Health Care Provider Protection Act" and more loan repayment and scholarship programs for physicians, such as through the National Health Service Corps. The AMA is also urging greater access for international medical graduates through expansion of the Conrad 30 program (H.R. 4922/S. 665) and reclaiming unused employment-based visas from the past 30 years (H.R. 6205/S. S. 3211).

Non-Compete Agreements

In April, the Federal Trade Commission (FTC) approved a final rule banning all non-competes except for current non-competes involving senior executives. The rule does permit other types of clauses such as typical confidentiality agreements, non-disclosure agreements, and training repayment agreements. It is likely that the final rule will not apply to some, and perhaps many, 501(c)(3) hospitals, health systems, and other 501(c)(3) health care organizations. This means that under the final rule, many non-profit hospitals may be able to continue using non-competes while for-profit physician practices could not. In June, a federal district court judge temporarily enjoined the enforcement of the FTC noncompete rule. The injunction only applies to the plaintiffs that filed the lawsuit, which includes the U.S. Chamber of Commerce, an accounting firm, and a couple Texas business groups. The AMA continues to watch this case closely and, regardless of the court's decision, expects the ruling to be appealed to higher courts. The AMA has developed and released to the Federation a comprehensive legislative template that provides an in-depth analysis of all state non-compete laws applicable to physicians as well as key non-compete cases involving physicians.

Aligned with new HOD-adopted policy, the AMA opposes all restrictive covenants between employers and physician employees and will regularly update its state restrictive covenant legislative template. The AMA will also continue assisting the Federation in developing strategies for physician employee retention. The AMA has helped several state medical associations enact laws limiting non-competes, including Pennsylvania.

Medicaid/Children's Health Insurance Program (CHIP)

On April 22, CMS finalized two major rules to strengthen access to high-quality medical care for Medicaid and Children's Health Insurance Program (CHIP) beneficiaries and advance transparency related to quality, access, and payment rates.

The "Managed Care Rule" establishes federal maximum appointment wait-time and other standards for the first time and requires public reporting of quality and payment data for key services. The "Access Rule" requires states to publish Medicaid fee-for-service payment rates and compare them to Medicare rates for key services and prove that any plans to restructure plans or reduce rates will not result in sufficiently diminished or insufficient access.

The AMA strongly supported many of the provisions when both rules were proposed and welcomed the historic changes in a statement, noting that the AMA has long sought changes to Medicaid payment and coverage policies to overcome longstanding barriers to care for low-income patients and advance health equity. In a statement, then-AMA President Jesse M. Ehrenfeld, MD, MPH, underscored that the AMA looks forward to working with CMS to implement these reforms to advance patient access and quality of care while emphasizing the need for common-sense protections to ensure managed care plans do not unfairly pass the burden of compliance onto safety net practices.

The AMA also continues to work with state medical associations, federal agencies, and other stakeholders to protect Medicaid beneficiaries during the Medicaid "unwinding." At the national level, the AMA has been participating in the Connecting to Coverage Coalition (CCC), which holds weekly calls. In April, the CCC issued a press release commending administration renewal actions, which included a quote from then-President Jesse M. Ehrenfeld, MD, MPH. In addition, the AMA has continued to engage with administration officials about unwinding and provided feedback on state experiences with unwinding and best practices. At the state level, the AMA has been working with state medical associations to raise awareness of coverage disruptions and distribute resources aimed at both physicians and patients to mitigate coverage losses. Speakers at the 2023 AMA State Advocacy Roundtable and 2024 State Advocacy Summit also highlighted redetermination challenges and strategized on ways physician practices and medical associations could provide direct assistance to patients and advocate for supportive policy changes with state Medicaid agencies and state legislators.

The AMA continues to work with state medical associations to increase Medicaid reimbursement rates in order to ensure patients with low-income can access the care they need. The AMA also continues to support state medical associations as they push for Medicaid expansion, in states that have not yet opted to expand eligibility under the Affordable Care Act (ACA).

Protecting Against Government Intrusion into Clinical Care

The AMA strongly opposes government interference in the practice of medicine and strongly opposes laws that prohibit physicians from providing evidence-based medical care that is in the best interest of their patients.

Abortion
The AMA supports patients' access to the full spectrum of reproductive health care options, including abortion and contraception, as a right. Physicians have an ethical obligation to help patients choose the optimal course of treatment, through shared decision-making that is fully informed by medical science and shaped by patient autonomy. Anything less puts patients at risk and undermines both the practice of medicine and our nation's health.

The AMA spoke out forcefully against court actions that undermined the U.S. Food and Drug Administration (FDA) decision-making and threaten to impact the availability of mifepristone and potentially other drugs. The AMA has also filed briefs to inform U.S. Supreme Court deliberations. The court heard oral arguments in the mifepristone case on March 26 and issued a decision in June. The decision preserved access to medication abortion but did not resolve the issue on the merits.
The AMA supported the Administration's privacy guidance that makes it clear that physicians are not required to disclose private medical information to third parties and provides patients with tips on the use of personal cell phones and tablets.

Further, the AMA is working closely with state medical associations to make sense of confusing legal obligations in restrictive states, identifying strategies to mitigate harm, and advocating against new restrictive laws. In states where abortion remains legal, the AMA is working with state medical associations to enact additional legal and professional protections for physicians in those states. In 2024, two additional states, Maine and Rhode Island, enacted shield law protections, bringing the total number of states to 19, including the District of Columbia. The AMA supported both laws.

Finally, the AMA has convened a "Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," at the direction of the House of Delegates, to identify and create practice and advocacy resources and guide organized medicine's response to bans on abortion and gender-affirming care. Five AMA Councils, 11 national medical specialty associations, and seven state medical associations are represented on the Task Force. The Task Force will continue to meet over the next two years. More information on the Task Force's work can be found in Board Report 21-A-24.

In-Vitro Fertilization (IVF)
The AMA is deeply concerned about state activity to limit access to the full range of reproductive health services, including the Alabama Supreme Court decision earlier this year that included cryopreserved embryos created through in-vitro fertilization (IVF) in the legal definition of "children." The decision was unprecedented and the first time a court recognized embryos stored outside the human body as people. In response, the AMA HOD in June adopted policy to oppose legislation or ballot measures that could criminalize IVF. The AMA offered support to the Medical Association of the State of Alabama which played a key role in developing a legislative fix to allow IVF to continue in the state. The AMA is poised to assist other states when this issue arises.

Gender-Affirming Care
The AMA has advocated against state restrictions on evidence-based gender-affirming care in several states including Missouri, Montana, New Hampshire, and South Dakota and will continue to work closely with state medical associations across the country to oppose bans on evidence-based care. The AMA has also supported shield laws in several states, including Maine and Rhode Island in 2024, that provide legal and professional protections to physicians and other health care providers of gender-affirming care. The AMA has filed and joined briefs in multiple federal court cases supporting evidence-based gender-affirming care. The AMA is deeply concerned about increasingly hostile rhetoric and threats of violence directed at physicians who provide evidence-based gender-affirming care.

Firearm Violence

One of the AMA's top public health priorities is responding to public health crises impacting physicians, patients, and the public. Included within this bucket is preventing firearm injuries and deaths. At the 2016 Annual Meeting,

following the Pulse nightclub shooting, policy was adopted declaring that "gun violence represents a public health crisis which requires a comprehensive public health response and solution." The AMA adopted policy in 2022 to establish a task force focused on firearm violence prevention, including firearm-involved suicide. The AMA has convened this task force with physician leaders and high-level staff from several national medical associations to increase collaboration on topics related to firearm safety. The AMA continues to push lawmakers to adopt common-sense policies, broadly supported by the American public, to prevent avoidable deaths and injuries caused by firearm violence including banning assault weapons; high-capacity magazines; and other weapons of war. Our nation must also address the root causes that have fueled these mass murders and casualties. The AMA is working at the state level to encourage and assist states in implementing some of the new federal law's provisions, especially regarding passage of extreme risk protection order (ERPO) legislation. During the 2024 state legislative sessions, the AMA worked closely with state medical associations to craft ERPO legislation and to support community violence prevention strategies, as well as strengthening waiting period and background check requirements. With AMA support, two such bills—LD 2224 and LD 2238—were enacted in Maine.

The AMA has advocated for Congress to appropriate increased funding for research to prevent firearm violence. The AMA is working with national medical specialties societies, including the American Academy of Pediatrics (AAP), to support funding for the U.S. Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and the National Institute of Justice (NIJ) to conduct public health research on firearm morbidity and mortality prevention. The goal is to ensure at least level funding for next year; in the current environment, it is unlikely that funding will be increased but the coalition is advocating against any cuts. The AMA is also participating in the Health Professional Education and Advocacy/Policy committees of the Healthcare Coalition for Firearm Injury Prevention, (HCFIP) which is being led by American College of Physicians, with AAP, American College of Emergency Physicians, American College of Surgeons, and the Council of Medical Specialty Societies participating. HCFIP is focusing on safe storage and preventing suicide.

Maternal Health

To bolster federal and state efforts and provide recommendations to improve maternal health outcomes, the AMA has worked collaboratively over the last year with a variety of members of the Federation, including national medical societies, state medical associations, and physicians from rural areas. The AMA released a new set of concrete steps that the administration and Congress can take to improve maternal health outcomes in the U.S. The AMA also published a comprehensive document that provides extensive recommendations to policymakers and advocates. The AMA advocated for improvements to a new maternal health alternative payment model and urged CMS to consult with the AMA, the American College of Obstetricians and Gynecologists, and other interested parties prior to moving forward with an obstetrical services condition of participation. Additionally, the AMA submitted a Statement for the Record to the U.S. Senate Committee on Health, Education, Labor, and Pensions as part of the hearing entitled, "What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?"

Overdose Epidemic

Our nation's drug-overdose epidemic continues to kill more than 100,000 Americans each year, which is why the AMA continues to call on policymakers and other stakeholders—including health insurers, pharmacy benefit management companies, and national pharmacy chains—to remove barriers to evidence-based care for opioid use disorder and for pain and increase access to harm reduction initiatives, including decriminalizing fentanyl test strips, sterile needle and syringe exchange services, and piloting overdose prevention sites as well. The AMA's 2023 Overdose Epidemic Report, released in November, shows a nearly 50 percent decrease in opioid prescribing nationwide since 2012. At the same time, the country is facing a worsening drug-related overdose epidemic, fueled by a dramatic increase in use of illicit fentanyl and fentanyl analogs, as well as methamphetamine and cocaine. State prescription drug monitoring programs were used more than 1.3 billion times in 2022.

AMA advocacy helped lead to FDA approving the first-ever over-the-counter naloxone product in 2023. The AMA has supported multiple bills at the state level to remove barriers to opioid therapy for patients with pain, including a new Minnesota law; bills to ensure that opioid litigation settlement funds from major distributors would go to public health and treatment; and language from AMA model legislation has been included in at least 10 new laws since 2022 that remove fentanyl test strips from state drug paraphernalia laws. The Federation of State Medical Boards (FSMB) recently adopted revisions to its recommendations relating to opioids and pain care at its April 2024 Annual

Meeting. The AMA was part of the FSMB Workgroup on Opioid and Addiction Treatment that helped update the proposed "Strategies for Prescribing Opioids for the Management of Pain" over a two-year period.

Climate Change

At the 2022 Annual Meeting of the House of Delegates, policy was adopted declaring "climate change a public health crisis that threatens the health and well-being of all individuals." Concern has grown in recent decades about the connection of human activities to rapid climate change, such as the burning of fossil fuels and deforestation, and the impacts on health. Climate change is adversely affecting people's physical and mental health; however, climate-related risks are not distributed equally. The AMA recognizes that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change. The AMA has called for limiting global warming to no more than 1.5 degrees Celsius, as well as reducing U.S. greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050. The AMA is developing a formal strategy to address climate change and health, with an anticipated release at the AMA I-24 meeting.

The AMA participates in the American Lung Association's (ALA) Healthy Air Partners campaign, which is a coalition of 40 national public health, medical, nursing, and health care organizations engaged in healthy air advocacy efforts. The Coalition is united in calling for strong federal laws and policies to slash air pollution and address climate change, recognizing climate change can affect air quality, and certain air pollutants can affect climate change. In 2024, the AMA joined the Coalition on a letter to the Environmental Protection Agency (EPA) on their draft Revised Technical Guidance for Assessing Environmental Justice in Regulatory Analysis, which included the addition of climate change as a factor of vulnerability when conducting environmental justice analysis. The AMA also joined the Coalition on a letter to the EPA on Waste Emissions Charges for Petroleum and Natural Gas and on a letter on CMS' Decarbonization and Resilience Initiative. The AMA sent a letter providing comments to the EPA on National Primary Drinking Water Regulations for Lead and Copper: Improvements. In addition, the AMA continues to engage in the Medical Society Consortium on Climate and Health (MSCCH or Consortium), which brings together associations representing over a million clinical practitioners. The AMA sits on the executive committee of this group. The AMA was a sponsor of the MSCCH Annual Meeting held in February 2024 in Washington, DC. The AMA joined with MSCCH in sending a letter to Congress on the farm bill. The AMA is working with the Consortium and the ALA Coalition to draft comments on proposed regulations on heat standards issued by the Occupational Safety and Health Administration.

Nutrition

The AMA is committed to preventing and reducing the burden of chronic diseases and recognizes the critical link between diet and chronic disease in America. Moreover, we recognize that access to nutritious food is not equal, and that this inequity increases incidents of chronic diseases, such as diabetes and cardiovascular disease in historically marginalized communities. The AMA submitted a comprehensive statement to the U.S. Senate Committee on Health, Education, Labor and Pensions, Subcommittee on Primary Health & Retirement Security, on the hearing entitled, Feeding a Healthier America: Current Efforts and Potential Opportunities for Food is Medicine. The AMA also joined a sign-on letter to Congress, with over 75 societies and organizations, including the MSCCH, in support of farm policy that prioritizes both affordable and nutritious food and clean air and water.

AMA ADVOCACY ONGOING UPDATES AND MEETINGS

The AMA offers several ways to stay up to date on our advocacy efforts, and we urge the HOD to avail themselves of all of them to stay informed and advance our grassroots efforts:

- Sign up for AMA Advocacy Update a biweekly newsletter that provides updates on AMA legislative, regulatory, and private sector efforts. We try to make sure all HOD members are on the email list, but if you are not receiving AMA Advocacy Update, please subscribe and encourage your colleagues to do so as well. Subscribers can read stories from previous editions here.
- Join the Physicians Grassroots Network for updates on AMA calls to action on federal legislative issues. And if you have connections with members of Congress, or are interested in developing one, the Very Influential Physician (VIP) program can help grow these relationships.
- Connect with the Physicians Grassroots Network on Facebook, Twitter, and Instagram.

The AMA also encourages HOD members to attend the State Advocacy Summit and National Advocacy Conference. The 2025 State Advocacy Summit will take place on Jan. 9-11 at the Omni La Costa Resort & Spa in Carlsbad, California. The 2025 National Advocacy Conference will occur on Feb. 10-12 at the Grand Hyatt in Washington, D.C.

CONCLUSION

The AMA and the Federation of Medicine have faced numerous legislative and regulatory challenges in 2024. There has been progress on some issues, but others remain problematic. The keys for success on these issues moving forward will be maintaining a unified message and increasing engagement. Please continue to read Advocacy Update for the latest news, look for grassroots communications as they are released to our networks, and stay engaged with other AMA news sources. The AMA needs your help as the current 118th Congress is set to wrap up in the coming months, and organized medicine begins to plan for 2025 after the dust from the upcoming elections settles.

21. TASK FORCE TO PRESERVE THE PATIENT-PHYSICIAN RELATIONSHIP WHEN EVIDENCE-BASED, APPROPRIATE CARE IS BANNED OR RESTRICTED

Informational report; no reference committee hearing

HOD ACTION: FILED

This report provides an update on the activities of the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted (Task Force) and a legislative update in accordance with Policies G-605.009, D-5.998, and D-425.989. (Note: Because of approval deadlines, this report was prepared in July and may not include more recent developments.)

BACKGROUND

American Medical Association (AMA) Policy G-605.009 entitled, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," was adopted at the 2022 Annual Meeting of the AMA House of Delegates (HOD). Policy G-605.009 instructs that:

1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
    a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;
    b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
    c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;
    d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;
    e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;

f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and
g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.

Adopted during the AMA 2022 Interim Meeting, Policy D-5.998 entitled, "Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era," added a requirement for an annual report of the Task Force. Policy D-5.998(1) instructs that:

1. Our AMA Task Force developed under HOD Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," will publish a report with annual updates with recommendations including policies, strategies, and resources for physicians who are required by medical judgment and ethical standards of care to act against state and federal laws.

At the AMA 2023 Interim Meeting, the HOD amended Policy G-605.009 entitled, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," adding the creation of an ad hoc committee on payment and reimbursement issues in gender affirming care to the Task Force's directives. Specifically, the amendment instructs that:

3. Our American Medical Association will appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend d solutions to address these barriers to care.

Lastly, the HOD adopted Policy D-425.989 entitled, "Protecting Access to IVF Treatment," during the AMA 2024 Annual Meeting, directing the Task Force to report on legislation involving restrictions to assisted reproductive technology. Policy D-425.989 instructs that:

> Our AMA, through the AMA Task Force to Preserve the Patient-Physician Relationship, report back at I-24 on the status of, and AMA's activities surrounding, proposed ballot measures or legislation and pending court rulings, that (a) would equate gametes or embryos with children and/or (b) would otherwise restrict or interfere with evidence-based care for Assisted Reproductive Technology (ART).

DISCUSSION OF TASK FORCE ACTIVITIES

As directed by the HOD and in response to the U.S. Supreme Court's landmark 2022 decision in *Dobbs v. Jackson Women's Health Organization*, which held that the U.S. Constitution does not confer a constitutional right to abortion and returned the authority to regulate abortion to the states and the subsequent enactment of abortion bans in half the states, the AMA Board of Trustees' (Board) formed the Task Force in June of 2023. With the formation of the Task Force and consistent with AMA Policies G-605.009 and D-5.998, as noted above, the Board envisioned that the Task Force would advise the Board of new and emerging threats to the provision of evidenced-based medical care and appropriate and innovative responses to protect access to care and to preserve the role of the patient-physician relationship as a central element in medical decision-making.

In accordance with the specific language of AMA Policies G-605.009 and D-5.998, in September 2023, the Chairs of the Councils on Legislation, Medical Service, Medical Education, Science and Public Health, and Ethics and Judicial Affairs each appointed two Council members to serve on the Task Force. As a result, 10 Council representatives serve on the Task Force. The then-Chair of the Board, Willie Underwood III, MD, MSc, MPH, appointed Madelyn E. Butler, MD, AMA Trustee, and Maryanne C. Bombaugh, MD, MBA, MSc, member of the Executive Committee for the AMA Council on Legislation, to serve as Co-Chairs of the Task Force.

In addition, and in accordance with underlying policy, in the spring of 2024, AMA invited 10 state medical associations and 13 national medical specialty societies to appoint a physician representative to serve on the Task

Force. The organizations were selected based on their expertise, experience, and response to an AMA survey fielded in November 2022 (which was described in detail in the 2023 report on the Task Force) that asked about priorities and capacity to engage on the issues identified in AMA Policy G-605.009.

Seven state medical associations and 11 national medical specialty societies nominated a physician representative to serve on the Task Force. The participating national medical specialty societies include:

- American Academy of Child and Adolescent Psychiatry,
- American Academy of Dermatology,
- American Academy of Family Physicians,
- American Academy of Pediatrics,
- American College of Emergency Physicians,
- American College of Obstetricians & Gynecologists,
- American College of Physicians,
- American Psychiatric Association,
- American Society for Reproductive Medicine,
- American Society of Clinical Oncology, and
- The Endocrine Society.

The participating state medical associations include:

- California Medical Association,
- Idaho Medical Association,
- The Maryland State Medical Society (MedChi),
- Massachusetts Medical Society,
- Pennsylvania Medical Society,
- Texas Medical Association, and
- Medical Society of Virginia.

In total, there are 29 physician members of the Task Force.

Concurrently, staff across the AMA conducted environmental scans and gaps analyses of the issues identified in Policy G-605.009. These landscape analyses identify implementation-focused practice and advocacy resources on issues including health equity, practice management, medical education, privacy, and legal issues and identify potential resource gaps. The landscape analyses were presented to Council representatives, monthly, beginning in January of 2024 and concluding in May of 2024. The landscape analyses were used (and will continue to be used) to identify key topics of discussion for meetings of the Task Force and were distributed to all Task Force members prior to the first in-person meeting of the Task Force.

The Task Force held a virtual kick-off meeting on May 15, 2024, in which the Task Force Co-Chairs laid out the Task Force's scope, deliverables, and calendar for upcoming meetings.

The Task Force held its first in-person meeting on July 10, 2024, in Chicago. The in-person meeting focused on legal issues in abortion care and featured a range of speakers and presenters on topics all relating to legal issues in abortion care including, abortion-related litigation activity across the country, legal resources for physicians, the Emergency Medical Treatment and Active Labor Act (EMTALA), and shield law protections for abortion care providers.

Speakers included: Kyle Palazzolo, JD, Assistant General Counsel, AMA Office of General Counsel, who provided an update and analysis on recent important court decisions, including litigation impacting access to medication abortion, emergency care, state bans, and other issues; Rachel Rebouché, JD, LLM, Kean Family Dean and Peter J. Liacouras Professor of Law, Temple University Beasley School of Law, who discussed the landscape of state shield laws and protections afforded to abortion care providers under shield laws, as well as the potential impact of the Comstock Act on abortion access; Hannah Katch, Senior Advisor, Office of the Administrator, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, who presented the Administration's position and strategy regarding pregnant patients' rights during a medical emergency under EMTALA and the interaction of

EMTALA with state abortion laws; and Brynn Weinstein, JD, Legal Defense Specialist, Resources for Abortion Delivery, who highlighted legal resources and services available to physicians providing abortion care through the Abortion Defense Network (ADN).

Following each presentation, Task Force members asked questions and discussed issues and concerns. During a working lunch, Task Force members were asked to strategize and identify resource gaps and potential deliverables for the Task Force regarding advocacy, health equity, medical education and workforce, legal issues, practice issues, and public health. The exercise generated numerous ideas for action. At the conclusions of the day, as directed by the Board and in accordance with Policies G-605.009 and D-5.998, which instruct the Task Force to identify and create implementation-focused practice and advocacy resources, the Task Force discussed existing resources and limitations of those resources, and identified gaps where resources need to be developed. Accordingly, AMA staff are in the process of developing a new website to serve as a resource hub for physicians and others navigating abortion restrictions. The website will exist separately from the AMA's website and will be available to the public. It will house resources created by the Task Force, as well as resources created and provided by Federation partners and other external organizations. Task Force members have been asked to share resources to be made available on the website.

In addition, the Task Force will host an informational session at the AMA 2024 Interim Meeting to engage AMA Delegates, Alternate Delegates, and representatives from AMA Sections, including but not limited to the Resident and Fellows Section, Medical Student Section, Women Physicians Section, Minority Affairs Section, and others. This session is an opportunity to elevate important voices that are not members of the Task Force. Attendees of the informational session will hear about the activities of the Task Force and be asked to share their perspective on the issues being considered by the Task Force. As of the time of drafting this report, Task Force staff are working with AMA Section staff to ensure optimal engagement and the sharing of concerns and perspectives. The Board encourages all interested members to participate in this informational session in November.

In addition, and in accordance with the amendment to Policy G-605.009 adopted at the AMA 2023 Interim Meeting, the Task Force has formed a subcommittee to focus on payment and reimbursement issues in gender-affirming care. AMA staff has conducted a landscape analysis on payment and reimbursement issues that hinder access to gender-affirming care, which, like the landscape analyses on abortion, identified existing resources and gaps in those resources and will help inform discussion during in-person meetings. The Task Force anticipates holding an in-person meeting in February 2025 dedicated to these issues and as of the writing of this report in July 2024, was in the process of working with the subcommittee on an agenda.

Lastly, in addition to the Task Force meeting planned in February 2025 on gender-affirming care payment and reimbursement issues, the Task Force is planning to host an in-person meeting in July 2025 to discuss abortion-related issues in education, training, and workforce; an informational session at the 2025 Interim Meeting of the HOD; and a final, in-person meeting in February 2026 to discuss the intersection of abortion care and health equity.

LEGISLATIVE AND ADVOCACY UPDATE

Opposing third-party intrusion into the practice of medicine – including government interference with abortion, assisted reproductive technology (ART) and gender-affirming care – has long been a core priority for the AMA. The AMA continues to execute a multifaceted strategy, including engagement with policymakers at the state and federal levels, judicial advocacy, and more, to counter the deleterious impact of legislative efforts to criminalize the practice of medicine. The AMA continues to work extensively with state medical associations and national medical specialty societies, both publicly and behind-the-scenes, to oppose laws targeting reproductive health care services and evidence-based gender-affirming care.

Abortion

The AMA supports patients' access to the full spectrum of reproductive health care options, including abortion, as a right. Physicians have an ethical obligation to help patients choose the optimal course of treatment, through shared decision-making that is fully informed by medical science and shaped by patient autonomy. Anything less puts patients at risk and undermines both the practice of medicine and our nation's health.

As of the drafting of this report in July 2024, 14 states (Alabama, Arkansas, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, and West Virginia) prohibit the provision of nearly all abortions; four states (Florida, Georgia, Iowa, and South Carolina) prohibit abortion after fetal cardiac activity is detected around six weeks of pregnancy; two states (Nebraska and North Carolina) prohibit abortion after 12weeks of pregnancy; and five states (Arizona, Kansas, Ohio, Utah, and Wisconsin) between 15 and 22 weeks of pregnancy. Importantly, the status of state abortion laws is fluid. Legal challenges are ongoing and the legality of abortion in those states is subject to change.

In 2024, though dozens of new abortion restrictions were introduced in legislatures across the country, no new categorical bans on abortion were enacted. However, other troubling legislation was successful. Louisiana enacted Senate Bill (SB) 276 which reclassified mifepristone and misoprostol as Schedule IV controlled substances under the state's Uniform Controlled Dangerous Substances Law, making possession of the medication without a valid prescription a felony and increasing requirements on physicians and pharmacies that prescribe and dispense, respectively, the medications and chilling access to care. The law will take effect on October 1, 2024. Tennessee enacted SB 1971 which created the criminal offense of abortion trafficking, mirroring a law passed in Idaho in 2023 which has since been enjoined. The law prohibits an adult from recruiting, harboring, or transporting a minor for the purpose of obtaining an abortion in violation of the state's abortion ban or, if procured in another state, which would constitute a criminal abortion under the laws of Tennessee. The law took effect on July 1, 2024, and is being challenged in court. Kansas enacted House Bill (HB) 2749 which requires abortion providers and facilities to, among other things, ask patients to identify the reasons why they decided to seek an abortion and to report that information to the state. The Kansas law has been enjoined as of the writing of this report in July 2024. Given the sensitive political dynamics in these states, AMA staff provided background support to state medical associations as needed. The AMA continues to work closely with state medical associations in these and other states to make sense of confusing legal obligations, identify strategies to mitigate harm, and advocate against new restrictive laws.

In a victory for physicians and patients and thanks to the tremendous work of the Arizona Medical Association, state medical specialty associations, and other advocates in Arizona, the Arizona legislature repealed a near-total abortion ban following a decision by the Arizona Supreme Court that found the 1865 law enforceable. The state's 15-week ban, however, remains in effect.

Additionally, in 2024, two states, Maine and Rhode Island, enacted shield laws to protect abortion care providers (and providers of gender-affirming care) from extraterritorial enforcement of abortion bans in restrictive states, bringing the total number of states with shield laws to 19, including the District of Columbia. These laws protect health care professionals who provide abortion care (and gender-affirming care) from out-of-state civil, criminal, professional and other forms of liability. AMA has assisted state medical associations in supporting shield laws in many states, including providing technical assistance on both the Maine and Rhode Island bills. The AMA also sent a letter of support to Rhode Island legislators.

In November, voters in at least six states (Colorado, Florida, Maryland, Nevada, New York, and South Dakota) will decide whether to adopt state constitutional amendments to protect abortion rights in their states. As of the writing of this report, four additional ballot measures (in Arizona, Missouri, Montana, and Nebraska) to protect abortion rights are currently pending. One ballot initiative in Arkansas has been disqualified, though proponents are challenging the decision. Ballot measures to restrict abortion rights are pending in two states (Nebraska and Pennsylvania.) The AMA is closely monitoring this activity.

In addition to state advocacy, the AMA continues to fight for access to reproductive care at the federal level and in the courts. The AMA supported the Administration's privacy guidance that makes it clear that physicians are not required to disclose private medical information to third parties and provides patients with tips on the use of personal cell phones and tablets and continues to advocate to the Administration to preserve patient access to abortion care. Often through the AMA's Litigation Center, the AMA has joined dozens of court filings in state and federal courts around the country, including the United States Supreme Court, to articulate and support relevant AMA policies. The AMA spoke out forcefully against court actions that undermined the U.S. Food and Drug Administration decision-making and threaten to impact the availability of mifepristone and potentially other drugs. The court heard oral arguments in the mifepristone case on March 26 and issued a decision in June that preserved access to medication abortion but did not resolve the issue on the merits. The AMA also urged the Supreme Court to confirm that patients in every state are entitled to prompt, complete, and unbiased emergency health care that is

medically and scientifically sound and provided in compliance with EMTALA. In an opinion issued in June, the Court reinstated a pause on parts of Idaho's abortion ban, but again did not resolve the issue on the merits.

Currently, AMA litigation-related resources and activities are devoted to challenging the laws, regulations, and other barriers that interfere with the patient-physician relationship and a physician's medical judgment and ethical standards, rather than supporting the violation of those laws. In accordance with Policy D-5.998, which calls on the Task Force to identify "policies, strategies, and resources for physicians who are required by medical judgment and ethical standards of care to act against state and federal laws," the Task Force wishes to draw attention to the resources available through ADN and Resources for Abortion Delivery (RAD) which were presented to the Task Force during its meeting on July 10. ADN is a network of law firms, legal organizations, and attorneys that offer legal advice, representation, and funding to reproductive health care clinics, providers, and staff. After submitting a form on www.abortiondefensenetwork.org, physicians will be connected with an organization or law firm that can assist with legal issues on a pro bono basis. ADN also creates and shares resources for abortion providers, supporters, and seekers. State-specific guides to help medical professionals navigate their state's laws are available at www.abortiondefensenetwork.org/resources/providers. Additionally, the RAD Abortion Provider Legal Defense Fund covers legal defense costs for independent abortion providers subject to legal action for providing regulated abortion services to someone from or in a restricted state.

Assisted Reproductive Technology

The AMA supports patients' access to the full spectrum of reproductive health care options, including fertility services, as a right. The AMA was deeply concerned when, in February 2024, the Alabama Supreme Court found cryopreserved embryos created through in vitro fertilization (IVF) to be "extrauterine children" and therefore included in the definition of "minor child" under the Alabama Wrongful Death of a Minor Act. The ruling was unprecedented and the first time a court recognized embryos stored outside of the human body as people. The decision greatly increased the liability risks for clinics and physicians who provide in vitro fertilization (IVF) services in Alabama, and, in response to the court's decision, fertility clinics around the state paused services.

Following the decision, the AMA was in close communication with the Medical Association of the State of Alabama (the Medical Association) to offer assistance and coordinate the AMA's advocacy activities. As a result of the tremendous advocacy efforts of the Medical Association and others, legislation (SB 159) to protect IVF was enacted less than three weeks after the Supreme Court's decision. The legislation grants "civil and criminal immunity for death or damage to an embryo to any individual or entity when providing or receiving services related to in vitro fertilization" and provides "criminal immunity and damage calculations for death or damage to an embryo against manufacturers of goods used to facilitate the in vitro fertilization process." Following enactment of SB 159, fertility clinics in the state resumed services, though clinics still feel the impact of the Alabama Supreme Court decision.

As of the writing of this report in July 2024, no other state expressly recognizes personhood rights of cryopreserved embryos or criminalizes IVF. Following the controversy in Alabama, legislation in other states that may have threatened access to IVF was defeated, including, notably, in Iowa (HF 2575) and Florida (HB 651). However, bills to protect IVF, including in Missouri, Kentucky, and Kansas also failed.

Many states recognize the rights of fetuses, often through laws authorizing criminal charges for fetal homicide, protecting children from abuse, neglect, or endangerment, or prohibiting abortion, for example. Some of these do not create liability for providing ART services. Laws in Alaska, Georgia, and Wyoming, for example, recognize the rights of a fetus "who is carried in the womb" and Arizona's law—which was enjoined in 2022—bars civil action against a person who performs IVF. It is unclear, however, whether courts can or will interpret other laws to restrict or prohibit IVF, though the developments in Alabama demonstrate that fetal personhood laws can have far-reaching consequences. Further, lawmakers continue to pursue fetal personhood laws and, in 2024, introduced legislation in 13 states, though none were enacted.

Despite the existence of fetal personhood laws in many states, IVF services continue, and the question remains whether the laws granting fetuses personhood rights could threaten the status of IVF. The AMA continues to closely monitor developments in this space and stands ready to work with state medical associations in legislatures and courts to protect physicians and preserve access to ART.

Gender-Affirming Care

As of the drafting of this report in July 2024, four states (New Hampshire, Ohio, South Carolina, and Wyoming) enacted bans on gender affirming care in 2024. These actions bring the total count of states to 26 (Alabama, Arizona, Arkansas, Florida, Georgia, Iowa, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Montana, Missouri, North Carolina, North Dakota, Nebraska, New Hampshire, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, and Wyoming) that have enacted laws that prohibit the provision of gender-affirming care to minor patients, including medications to delay puberty, hormonal therapy, and surgeries. Three of those states (Arizona, Nebraska, and New Hampshire) prohibit surgical interventions on patients younger than 18 years of age but do not ban non-surgical interventions. Due to legal challenges, laws in Arkansas, Florida, Montana, and Ohio are enjoined, in whole or part.

Some, but not all, states impose criminal penalties for violations. In other states, violations are subject to professional discipline, including, in some places, mandatory revocation of the health care professional's license. Several state laws also authorize patients and their families to bring civil suits against health care professionals for decades after the care was provided.

The AMA has advocated against state restrictions on evidence-based gender-affirming care in several states including Missouri, Montana, New Hampshire, and South Dakota and will continue to work closely with state medical associations across the country to oppose bans on evidence-based care. Due to political dynamics in many states, much of the AMA's advocacy is conducted through state medical associations behind-the-scenes. The AMA has also assisted state medical associations in supporting shield laws in many states that are supportive of access to gender-affirming care, including in Maine and Rhode Island, both of which enacted shield laws in 2024. Additionally, the AMA has filed and joined briefs in multiple federal court cases supporting evidence-based gender-affirming care. The AMA and other Federation members have also been the subject of subpoenas on issues related to the patient-physician relationship, notably with respect to policies and resources around gender-affirming care. The AMA is also deeply concerned about increasingly hostile rhetoric and threats of violence directed at physicians who provide evidence-based gender-affirming care.

CONCLUSION

The Board, through the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted, will continue to implement Policies G-605.009, D-5.998, and D-425.989, monitor and prepare for new and emerging threats to the provision of evidenced-based medical care, and work to protect access to care and preserve the role of the patient-physician relationship as a central element in medical decision-making.

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

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

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy D-600.984

The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) required to submit information and materials for the 2024 American Medical Association (AMA) Interim Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020, "Summary of Guidelines for Admission to the House of Delegates for Specialty Societies," and AMA Bylaw 8.5, "Periodic Review Process."

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

The following organizations were reviewed for the 2024 Interim Meeting:

American College of Cardiology
American College of Chest Physicians
American College of Emergency Physicians
American College of Gastroenterology
American College of Nuclear Medicine
American Medical Group Association
International Society for the Advancement of Spine Surgery
National Association of Medical Examiners

The American Academy of Allergy, Asthma & Immunology was also reviewed at this time because it failed to meet the requirements in November 2023 and was granted a one-year grace period.

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

The materials submitted indicate that: American College of Cardiology, American College of Chest Physicians, American College of Emergency Physicians, American College of Gastroenterology, American College of Nuclear Medicine, American Medical Group Association, International Society for the Advancement of Spine Surgery, and National Association of Medical Examiners meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicate that the American Academy of Allergy, Asthma & Immunology met all guidelines and is in compliance with the five-year review requirements of specialty organizations represented in the HOD.

RECOMMENDATIONS

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

1. The American Academy of Allergy, Asthma & Immunology, American College of Cardiology, American College of Chest Physicians, American College of Emergency Physicians, American College of Gastroenterology, American College of Nuclear Medicine, American Medical Group Association, International Society for the Advancement of Spine Surgery, and National Association of Medical Examiners retain representation in the American Medical Association House of Delegates.

APPENDIX

Exhibit A - Summary Membership Information

Organization	**AMA Membership of Organization's Total Eligible Membership**
American Academy of Allergy, Asthma & Immunology*	306 of 1,550 (20%)
American College of Cardiology*	7,932 of 36,839 (22%)
American College of Chest Physicians*	1,660 of 10,233 (16%)
American College of Emergency Physicians*	8,252 of 32,468 (25%)
American College of Gastroenterology*	2,660 of 12,664 (21%)
American College of Nuclear Medicine*	46 of 173 (27%)
American Medical Group Association*	3,692 of 24,734 (15%)

International Society for the Advancement of Spine Surgery	105 of 268 (39%)
National Association of Medical Examiners*	193 of 968 (20%)

* *Represented in the House of Delegates at the 1990 Annual Meeting*

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

Policy G-600.020

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

Exhibit C

8.2 **Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations.** Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:

8.2.1 To cooperate with the AMA in increasing its AMA membership.

8.2.2 To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.

8.2.3 To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.

8.2.4 To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.

8.2.5 To provide information and data to the AMA when requested.

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

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

8.5 **Periodic Review Process.** Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society, or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.

8.5.1 If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting or may take such other action as it deems appropriate.

8.5.2 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

8.5.3 Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.

8.5.3.1 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.

8.5.3.2 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:

8.5.3.2.1 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.

8.5.3.2.2 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

23. ADVOCATING FOR THE INFORMED CONSENT FOR ACCESS TO TRANSGENDER HEALTH

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

HOD ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 011-I-22
REMAINDER OF REPORT FILED
See Policies H-140.824, H-185.905, H-185.927, H-185.950, and H-295.847

At the 2022 Interim Meeting, the House of Delegates (HOD) referred Resolution 011-I-22, "Advocating for the Informed Consent for Access to Transgender Health Care," introduced by the Washington Delegation, which asked:

> That our American Medical Association advocate and encourage the adoption of an informed consent model when determining coverage for transgender health care service.

This report, therefore, provides background, discussion, and recommendations.

BACKGROUND

Gender-affirming care (GAC) refers to interventions that minimize the incongruence between a transgender person's gender identity and their sex assigned at birth. GAC can encompass a wide range of social, psychological, behavioral, and medical interventions designed to support and affirm an individual's gender goals and gender identity.[1] Supportive, non-medical interventions may include choosing a name, pronouns, and appearance that align with gender identity. Medical interventions generally include feminizing or masculinizing hormone therapy or surgeries that enable the patient to better align with their gender identity. GAC may be provided during or before adolescence; however, recognizing that providing GAC for children is fundamentally different than for adults due to differences in biology, psychology, and autonomy, the scope of this report is limited to gender-affirming medical interventions provided to adults.

GAC is associated with improved quality of life and mental health among transgender and gender diverse individuals, and while not all trans people seek GAC the majority do.[2] GAC is a deliberate, multi-stage process in which the patient and a multidisciplinary care team work together in order to give the patient time to live with each stage and determine whether or how they want to proceed with the next stage as they seek to affirm their gender identity.

Many, but not all, transgender people experience gender dysphoria, a medical condition defined by the American Psychiatric Association in the DSM-5 as a "marked incongruence between one's experienced/expressed gender and natal gender of at least 6 months in duration […] associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning."[3] Transgender patients may also be diagnosed with gender incongruence. "Gender incongruence of adolescence or adulthood" is characterized by ICD-11 as "a marked and persistent incongruence between an individual´s experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual´s body align, as much as desired and to the extent possible, with the experienced gender."[4] Importantly for this discussion, ICD-11 categorizes gender incongruence as a condition related to sexual health, whereas gender dysphoria is a mental disorder in the DSM-5.

Models of care

Currently in the United States, many health insurers limit coverage of GAC to patients who have been diagnosed with gender dysphoria, a practice that effectively conditions receipt of GAC on prior mental health evaluation and posits GAC as a mental health treatment. This practice is often referred to as the "Standards of Care Model." The Standards of Care Model is derived from clinical guidelines and recommendations from professional organizations such as the World Professional Association for Transgender Health's (WPATH) Standards of Care for the Health of Transgender and Gender Diverse People and The Endocrine Society's Clinical Practice Guidelines on Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons, both of which emphasize the importance of mental health care before, during, and sometimes after GAC.[5]

The Endocrine Society guidelines rely on a diagnosis of gender dysphoria or gender incongruence and state that, "adults seeking gender-affirming hormone treatment and surgery should satisfy certain criteria before proceeding" including a diagnosis of gender dysphoria or gender incongruence.[6] The guidelines emphasize mental health care and state that only trained mental health professionals who, among other criteria, "are able to do a psychosocial assessment of the patient's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy" should make such diagnoses.[7]

An earlier version of WPATH's standards recommended mental health screening and/or assessment as a prerequisite to referral to hormonal and surgical treatments for gender dysphoria.[8] However, in 2022, WPATH published an updated Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, which eliminated the recommendation for psychological evaluation prior to the initiation of medical treatment. Current WPATH standards acknowledge that, "no single assessment process will fit every person or every situation" and that their guidance is intended to be flexible to best meet the needs of local settings around the world.[9] In recommendation 5.1.b, of the WPATH standards, WPATH writes that health professionals should use the latest edition of the World Health Organization's (WHO) International Classification of Disease (ICD) for diagnosis in countries that require a diagnosis for care but does not state that diagnosis should be a prerequisite to treatment.[10] WPATH's updated position recognizes that the importance of patient autonomy must be balanced with the reality that in some cases there may exist a need for psychological evaluations prior to treatment.

Requiring a mental health evaluation prior to the provision of GAC has been criticized by some who argue that the requirement of a gender dysphoria diagnosis conflates a social identity with a mental disorder and can be stigmatizing, inappropriately pathologizes diverse gender identities, and can be used by insurers as a barrier to coverage for treatment. Those opposed to the Standards of Care Model have proposed an alternative model to direct the provision of GAC: the Informed Consent Model. The Informed Consent Model for gender-affirming care situates treatment decisions between patient and physician and does not require a psychological evaluation or diagnosis as a prerequisite to treatment. It is important to note, however, that both models of care support informed consent by patients and collaborative care with their physician and members of their care team.

AMA policy

HOD policy H-185.927, "Clarification of Medical Necessity for Treatment of Gender Dysphoria," states that our AMA "recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice" and that our AMA also "oppose[s] laws and policies that criminalize, prohibit or otherwise impede the provision of evidence-based, gender-affirming care." HOD Policy H-185.927 further advocates "for equitable, evidence-based coverage of gender-affirming care by health insurance providers, including public and private insurers."

This is consistent with HOD policy H-140.824, "Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population," which states that our AMA supports "treatment models for gender diverse people that promotes informed consent, personal autonomy, increased access for gender affirming treatments and eliminates unnecessary third party involvement outside of the physician-patient relationship in the decision making process."

Furthermore, HOD policy H-185.950, "Removing Financial Barriers to Care for Transgender Patients," states, "Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician." These policies build on HOD policy H-180.980, "Sexual Orientation and/or Gender Identity as Health Insurance Criteria," which states, "The AMA opposes the denial of health insurance on the basis of sexual orientation or gender identity."

Lastly, policy adopted at the 2023 AMA Interim Meeting directed the AMA to "identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care." In accordance with this policy, the AMA Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted (established by HOD policy G-605.009) has undertaken a study of payment issues impeding the provision of gender-affirming care with the objective of recommending further actions to address barriers to care. The Task Force is comprised of representatives from the AMA Councils on Legislation,

Medical Service, Medical Education, Science and Public Health, and Ethics and Judicial Affairs, and representatives from Federation organizations, as directed in G-605.009.

DISCUSSION

Our AMA unambiguously supports access to and insurance coverage of medically necessary GAC but does not identify a preferred model of care for determining medical necessity. The Board of Trustees does not wish to depart from this approach and endorse one particular model of care over another. Rather, the AMA vigorously advocates for equitable payment policies while relying on the evidence-based professional guidelines and recommendations set by professional medical associations, as well as individual physician clinical judgment, on questions of appropriate clinical criteria.

The Board of Trustees has found that current AMA policies are comprehensive and address the concerns raised by Resolution 011-I-22. However, in recognition that not all transgender individuals experience gender dysphoria, the Board of Trustees recommends that policy H-185.950, "Removing Financial Barriers to Care for Transgender Patients," be amended to be more inclusive and acknowledge that not all transgender individuals experience gender dysphoria. Finally, the Board of Trustees acknowledges that the insurance coverage concerns raised by Resolution 011-I-22 are being further addressed by the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted.

RECOMMENDATIONS

In light of these considerations, the Board of Trustees recommends that the following be adopted in lieu of Resolution 011-I-22, "Advocating for the Informed Consent for Access to Transgender Health Care," and the remainder of this report be filed:

1. That our AMA unambiguously supports access to and insurance coverage of medically necessary gender-affirming care but does not identify a preferred model of care for determining medical necessity. The AMA vigorously advocates for equitable payment policies, relying on the evidence-based professional guidelines and recommendations set by professional medical associations, as well as individual physician clinical judgment, on questions of appropriate clinical criteria.

2. That Policy H-185.927, "Clarification of Medical Necessity for Treatment of Gender Dysphoria," be reaffirmed.

3. That Policy H-140.824, "Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population," be reaffirmed.

4. That Policy H-295.847, "Increasing Access to Gender-Affirming Care Through Expanded Training and Equitable Coverage," be reaffirmed.

5. That Policy H-185.950, "Removing Financial Barriers to Care for Transgender Patients," be amended by addition and deletion to read as follows:
   Our AMA supports public and private health insurance coverage for evidence-based ~~treatment of~~ gender-affirming care ~~gender dysphoria~~ as recommended by the patient's physician.

REFERENCES

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2 Arjee J. Restar, *Gender-Affirming Care is Preventative Care*, 24 LANCET REG HEALTH AM 100544 (Aug. 2023).
3 AMERICAN PSYCHIATRIC ASSOCIATION, "gender dysphoria", DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, (5th ed., text revision 2022).

4 WORLD HEALTH ORGANIZATION, *Gender incongruence of adolescence or adulthood*, INTERNATIONAL CLASSIFICATION OF DISEASES (11th ed. 2021).
5 Wylie C. Hembree, Peggy T. Cohen-Kettenis, Louis Gooren, et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J CLINICAL ENDOCRINOLOGY & METABOLISM 11, 3869-3903 (Nov. 2017).
6 *Id*.
7 *Id*.
8 Eli Coleman, Walter Bockting, Marsha Botzer, et al., *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7*, 13 INT'L J TRANSGENDERISM 4, 165-232 (Aug. 2012).
9 WPATH, *supra* note 1.
10 *Id*.

24. PHYSICIANS ARRESTED FOR NON-VIOLENT CRIMES WHILE ENGAGING IN PUBLIC PROTESTS

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

HOD ACTION: RECOMMENDATION ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy D-65.973

INTRODUCTION

At the 2023 Interim meeting the House of Delegates (HOD) referred 009-I-23 (Res 009) from the Academic Physicians Section which asked: "our AMA advocate to appropriate credentialing organizations and payers – including the Federation of State Medical Boards, state and territorial licensing boards, hospital and hospital system accrediting boards, and organizations that compensate physicians for provision of healthcare goods and services – that *misdemeanor or felony arrests* of physicians as a result of exercising their First Amendment rights of protest and through nonviolent civil disobedience should not be deemed germane to the ability to safely and effectively practice medicine. (Directive to Take Action)" (Emphasis added).

BACKGROUND

Recent years have seen a rise in political civil disobedience in American society, often in the context of protests promoting civil rights, e.g. the Black Lives Matter movement, the AIDS movement, and the protests condemning the Supreme Court's repeal of abortion rights after their overturning of *Roe v. Wade* [1,2]. The subject matter of these protests often have an impact on public health and thus are connected to a physician's duty to advocate for social changes promoting the betterment of public health. The right to assemble and engage in peaceful protest is protected by the First Amendment of the United States Constitution. Despite constitutional protection, some physicians involved in non-violent protests have been arrested for civil disobedience. Arrests that do not result in charges and subsequent conviction occur largely in the context of political protests due to the use of controversial techniques, such as "kettling", where police use mass arrests without the broader goal to prosecute as a form of crowd control [3]. Arrests without conviction for engaging in civil disobedience during non-violent protests have the potential to negatively affect physician's careers and medical licenses when reported to state medical boards, which make determinations for fitness to practice medicine. Indeed, the professional and psychological toll on sanctioned physicians is enormous and includes reputational harm, discrimination, stigma, and the burden to defend oneself before a state medical board. Additionally, arrests for non-violent public protests are different from other types of criminal arrests, as arrests for non-violent protests are not equivalent to arrests for other types of crimes (e.g., violent crimes) that do have relevant impact on a physician's ability to practice. Hence, it is important to distinguish between arrests stemming from non-violent protests (which are low-risk in nature, not associated with fitness to practice, and are associated with exercising constitutional rights) from other crimes, especially when medical boards may not make such a distinction and conflate all arrests as deserving of equal scrutiny. Resolution 009-I-23 seeks protection for physicians who are arrested, but not subsequently charged or convicted for engaging in an act of civil disobedience during a non-violent protest.

AMA POLICY

Our AMA has several policies relevant to the issues and concerns described in Resolution 009-I-23.

House Policy

- D-295.949 - Criminal Background Checks for Medical Students states that the "AMA opposes the imposition of criminal and civil penalties or other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage or clinical privileges against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services." (Emphasis added)
- H-355.979 – National Practitioner Data Bank states that the "AMA supports requiring felony convictions of physicians to be reported to state licensing boards."
- H-373.995 – Government Interference in Patient Counseling states that the AMA "opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and

patients" and that the AMA supports blocking state or federal legislation that "violate[s] the First Amendment rights of physicians in their practice of the art and science of medicine."

Ethics Policy

- Opinion 1.2.10, "Political Action by Physicians" recognizes the rights of physicians to participate in the political process. The opinion states that "physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical *responsibility to seek change* when they believe the requirements of law or policy are contrary to the best interests of patients." (Emphasis added)
- Opinion 1.1.7, "Physician Exercise of Conscience" recognizes that "physicians are moral agents in their own right" and are "informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs". This dictate to conscience allows "physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician"
- Opinion 2.3.4, "Political Communications" explains that "[p]hysicians enjoy the rights and privileges of free speech shared by all Americans" and that physicians should "work towards and advocate for the reform and proper administration of laws related to health care.
- Opinion 9.4.3, "Discipline & Medicine" provides guidance about reporting physician misconduct. The opinion says that "medical societies have a civic and professional obligation to [r]eport to the appropriate governmental body or state board of medical examiners credible evidence that may come to their attention involving the alleged *criminal conduct* of any physician relating to the practice of medicine." (Emphasis added)
- Preamble of the Code of Medical Ethics explains that "[t]he relationship between ethics and law is complex. Ethical values and legal principles are usually closely related, but *ethical responsibilities usually exceed legal duties*" (Emphasis added) Then, the preamble notes that "[i]n some cases, the law mandates conduct that is ethically unacceptable. When physicians believe a law violates ethical values or is unjust they should work to change the law. In exceptional circumstances of unjust laws, *ethical responsibilities should supersede legal duties*." (Emphasis added).

DISCUSSION

Civil Disobedience

Civil disobedience is principally defined by John Rawls as "public, non-violent and conscientious breach of law undertaken with the aim of bringing about a change in laws or government policies [4]." While the civil and/or criminal law will be broken during civil disobedience, key is that actions undertaken are non-violent and are meant to call about public attention on an issue to produce political change. Non-violent acts of civil disobedience may often be in the form of protests like those made famous in the civil rights movement in the 1960's and the more recent racial justice protests and include activities such as illegally blocking traffic, boycotts, and sit-ins. Hence, the intent behind such non-violent protests is noble and in pursuit of changing unjust laws or social policy and are thus fundamentally different from arrests associated with other types of criminal behavior that may be relevant to medical practice, e.g. violent crimes or criminal negligence.

Also, while arrests from non-violent civil disobedience are not germane to the fitness to practice medicine, such arrests are additionally problematic in that they result in inequities. Certain groups of people, including physicians of color and women, face a higher likelihood of arrest for low-level offenses [5] and protests [6] leading to more severe charges during protests, resulting in unjust disparities.

Arrests vs. Criminal Charges and Conviction

Reference Committee testimony for Res 009 notes that the resolution limits its scope to "arrests" and does not include charges or convictions. Some testimony reflected the concern that making a distinction between arrest and conviction is sometimes arbitrary, in that it is not inherent that conduct resulting in a conviction is necessarily "worse" or more "unethical" than conduct that results in no criminal conviction. This is not a cogent point because the presumption of innocence until proven guilty is recognized as a due process right under the Fifth Amendment - meaning that one is considered innocent even after arrest up until they are convicted. Furthermore, the evidentiary standard of proof required for an arrest is lower than the threshold required for a conviction. Therefore, expanding

the scope of recommended policy beyond "arrests" is problematic as the distinction between arrests and convictions has practical significance in that an arrest is not necessarily indicative of guilt whereas a conviction is indicative of guilt in the eyes of the law.

Additionally, most states' law define "unprofessional conduct" to include "conviction of a felony" which is then reportable to state medical boards, which can then make a decision about a physician's licensure and fitness to practice [7]. While there is some debate about whether or not a criminal conviction unrelated to a physician's medical practice should be considered in determining fitness to practice, the linkage exists in our public policy [8]. State medical boards find a "connection between 'moral turpitude' outside the practice of medicine and the ability to practice medicine safety has been accepted as social policy".[8] Hence, a criminal conviction (whether connected to the practice of medicine or not) is relevant and will be used by licensing board to assess fitness.

Misdemeanor vs. Felony

In American criminal law, there are broadly three categories of crimes: infractions, misdemeanors and felonies. Infractions are the least serious crimes, misdemeanors are slightly more serious, while felonies are the most serious category of crimes [9]. When describing arrests, Res 009 uses the language "misdemeanor or felony arrests" without providing a definition or reason for highlighting a distinction between the legal classifications. Additionally, Res 009 makes no reference to arrests for infractions. In the context of Res 009 and the arrests for non-violent protests and civil disobedience the resolution envisions, many such arrests would likely be for infractions and misdemeanors. Depending on the facts and jurisdictions, some arrests may be felony arrests. Keeping the focus of our AMA policy only on *arrests* will cover all scenarios and legal variances across jurisdictions.

CONCLUSION

Res 009-I-23 raises an important issue that physicians should not be unduly punished for engaging in civil disobedience during non-violent protests which result in an arrest without a charge or conviction. However, this resolution should be modified to remove "misdemeanor and felony" as this distinction is not relevant in the context of an arrest only and may lead to confusion about arrests that lead to formal charges or a conviction of a misdemeanor or felony.

RECOMMENDATION

The Board of Trustees recommends that Res 009 be adopted as amended and the remainder of the report be filed:

> That our AMA advocate to appropriate credentialing organizations and payers – including the Federation of State Medical Boards, state and territorial licensing boards, hospital and hospital system accrediting boards, and organizations that compensate physicians for provision of healthcare goods and services – that ~~misdemeanor or felony~~ arrests of physicians for nonviolent civil disobedience occurring while ~~as a result of~~ exercising their First Amendment rights of protest ~~through nonviolent civil disobedience~~ should not be deemed germane to the ability to safely and effectively practice medicine.

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25. WORLD MEDICAL ASSOCIATION OBSERVER STATUS IN THE HOUSE OF DELEGATES

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: RECOMMENDATION ADOPTED
REMAINDER OF REPORT FILED
See Policy G-600.025

The Board of Trustees has received a request from the World Medical Association (WMA) to be considered for Official Observer status in the House of Delegates (HOD) of the American Medical Association (AMA). The WMA's request has been thoroughly considered using the criteria below (Policy G-600.025, "Official Observers in Our AMA House"):

1. The organization and the AMA should already have established an informal relationship and have worked together for the mutual benefit of both;
2. The organization should be national in scope and have similar goals and concerns about health care issues;
3. The organization is expected to add a unique perspective or bring expertise to the deliberations of the HOD; and
4. The organization does not represent narrow religious, social, cultural, economic, or regional interests so that formal ties with the AMA would be welcomed universally by AMA members.

The Board has discussed the WMA's request and presents the following report.

DISCUSSION

As part of its request, WMA submitted information on how it has met the criteria for Official Observer status, which is summarized below.

Criterion 1. The organization and the AMA should already have established an informal relationship and have worked together for the mutual benefit of both.

As specified in the guidelines, the AMA and WMA have a longstanding relationship. The WMA was established in 1947. The AMA is a founding member. The WMA Secretary General has attended the Annual HOD meeting for over 15 years. At each meeting he briefs the Board of Trustees. Many international guests, most of whom are WMA members, also attend the Annual meeting each year. They are recognized during the open session of the HOD.

Criterion 2. The organization should be national in scope and have similar goals and concerns about health care issues.

Although the WMA is international in scope it has a broad mission and interests that align with the AMA. The organization was created to ensure the independence of physicians and to work for the highest possible standards of ethical behavior and care by physicians. The purpose of the WMA is to serve humanity by endeavoring to achieve the highest international standards in medical education, medical science, medical art and ethics, and health care for all people in the world. Besides ethics and science, core activities focus on physician advocacy, representation, and service and outreach.

The WMA is the internationally recognized voice of physicians. It is the only international organization for national medical associations (NMA) and individual physician members. There are now 114 NMA members of the WMA from all regions of the globe.

Criterion 3. The organization is expected to add a unique perspective or bring expertise to the deliberations of the HOD.

AMA policy recognizes the AMA's commitment to the WMA which is reflected by AMA's involvement in the WMA including participation of AMA presidents as members of the delegation that represents the AMA at WMA meetings. AMA officers have frequently held leadership positions in the organization and play critical roles in leading policy development through working groups and by introducing new policy.

Criterion 4. The organization does not represent narrow religious, social, cultural, economic, or regional interests so that formal ties with the AMA would be welcomed universally by AMA members.

The WMA does not represent narrow religious, social, cultural, economic, or regional interests and has already been welcomed to participate in previous AMA activities.

The Board of Trustees appreciates the long-standing relationship with the WMA. Allowing the WMA to be an Official Observer in the HOD will acknowledge this longstanding and important relationship and further assist in promoting the highest physician ethical standards and policies, both in the US and globally.

RECOMMENDATION

The Board of Trustees recommends that the World Medical Association be admitted as an Official Observer in the House of Delegates, and that the remainder of this report be filed.

Appendix - Official Observers to the House of Delegates

Organization	Year Admitted
Accreditation Association for Ambulatory Health Care	1993
Alliance for Continuing Medical Education	1999
Alliance for Regenerative Medicine	2014
Ambulatory Surgery Center Association	2005
American Academy of Physician Assistants	1994
American Association of Medical Assistants	1994
American Board of Medical Specialties	2014
American Dental Association	1982
American Health Quality Association	1987
American Hospital Association	1992
American Nurses Association	1998
American Public Health Association	1990
American Podiatric Medical Association	2019
Association of periOperative Registered Nurses	2000
Association of State and Territorial Health Officials	1990
Commission on Graduates of Foreign Nursing Schools	1999
Council of Medical Specialty Societies	2008
Educational Commission for Foreign Medical Graduates	2011
Federation of State Medical Boards	2000
Federation of State Physician Health Programs	2006
Medical Group Management Association	1988
National Association of County and City Health Officials	1990
National Commission on Correctional Health Care	2000
National Council of State Boards of Nursing	2000
National Indian Health Board	2013
PIAA	2013

Society for Academic Continuing Medical Education	2003
United States Professional Association for Transgender Health	2024
US Pharmacopeia	1998

REPORT OF THE SPEAKERS

The following reports were presented by Lisa Bohman Egbert, MD, Speaker; and John H. Armstrong, MD, Vice Speaker:

1. REPORT OF THE ELECTION TASK FORCE 2

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: RECOMMENDATION ADOPTED AS FOLLOWS
REMAINDER OF THE REPORT FILED
See Policy G-610.090

BACKGROUND

At the 2023 Interim Meeting, Speakers' Report 3-I-23 "Report of the Election Task Force 2" was presented with 29 recommendations. Fourteen of these recommendations were adopted, 14 were referred, and one was not adopted.

Speakers' Report 2-A-24, "Report of the Election Task Force 2," was submitted as an informational report which included suggested additions and deletions to AMA policy as well as a glossary to provide clear definitions related to AMA elections. An open forum seeking input on these items was held on Sunday, June 9, 2024, during the 2024 AMA Annual Meeting. The open forum was well attended, and additional feedback was provided. Subsequently, the Election Task Force 2 (ETF2) met and developed the following report and recommendations.

DISCUSSION

The goal of both Election Task Forces was to ensure that qualified candidates are selected in free and fair elections by reducing obstacles or perceived obstacles that dissuade members from seeking elective office and by enabling and facilitating an informed electorate. On reviewing current policy and the testimony provided, the ETF2 has identified several areas to clarify the rules in order to achieve this goal.

Following adoption of recommendation 29 of the 2023 Interim Meeting, Speakers' Report 3-I-23 "Report of the Election Task Force 2," the election rules previously found in multiple policies were consolidated into AMA Policy G-610.090 AMA Election Rules and Guiding Principles (Appendix A). For ease of further discussion and consideration, each recommendation in this report addresses a single subsection of our consolidated election rules. The first recommendation offers the addition of a glossary which defines terms used within the election policy.

Section II. Guidelines for Nominations for AMA Offices

Amendments to Section II of AMA Policy G-610.090 are recommended to further clarify the policy by using the correct terminology regarding sponsoring versus nominating candidates.

Section III. Candidate Announcement, Nominations and Open Positions

The first suggested amendment to Section III clarifies sponsoring versus endorsing candidates as previously defined by the Election Committee. Per action by the HOD at A-24, the HOD Office was tasked with developing and administering a process by which all candidates are able to determine from which groups they are eligible to ask for endorsement and monitoring the eligibility for endorsement by listed groups. The HOD Office is only able to verify the group an individual represents in the HOD; thus, that group may sponsor a candidate without the need for HOD Office reporting. Individual membership in all other groups represented in the House cannot be confirmed by the HOD Office. Therefore, groups wishing to publicly support a candidate, other than those candidates that the group is eligible to sponsor, would have to offer an endorsement via the new endorsement process.

Another recommended change in Section III is to remove email addresses from the candidate announcement card to limit any potential unintended interaction with candidates, prior to the active campaigning window, which could be perceived as violating election rules.

Section IV. Communications, Campaign Memorabilia and Literature

Section IV of our Election rules had several areas that needed clarification. The first recommended modification in item 1 succinctly defines the announcement of and timeline for the active campaign window. Previously, the Board of Trustees announced the active campaign window after its Spring meeting. However, in recent practice, the Speaker has made the announcement after the Spring Board of Trustees meeting in conjunction with the distribution of the Official Candidate Notification. The language was changed to reflect this practice. Additionally, the ETF2 heard proposals to move up the window. Testimony was mixed about opening the active campaign window earlier, with no clear consensus heard. Therefore, the task force is not recommending a change to the current timeline.

A new second item in this section provides very clear guidance pertaining to communications about campaigns prior to active campaigning. The task force is aware of the concerns that a rule prohibiting candidates from communicating about their campaigns prior to active campaigning could be interpreted as limiting their ability to form a campaign team or discuss campaign strategy with their team. This clarifies that both are expected and permitted and does not limit the formation of campaign teams nor the discussion of strategy prior to the announcement of the active campaign window.

The ETF2 also seeks to clarify the policy in item 6 as it pertains to communication by candidates to other delegates. Language has been added to specifically prohibit mass outreach by candidates. However, personal communication from candidates is allowed while simultaneously encouraging the reduction in overall volume of communication. Language was added to allow freedom of communication within campaign teams.

To ensure equitable ability for all candidates to share their message with HOD members, the ETF2 believes the route of access should be limited to the official AMA channels: the Election Manual, AMA Candidates' Page and the HOD Office candidate email (which includes campaign materials submitted by candidates). The ETF2 is recommending that candidates may not distribute additional printed or digital campaign materials other than by these AMA channels. The task force further recommends that candidates should neither produce nor link to external websites that contain campaign-related content.

Section VI. Interview Rules

The Election Task Force heard concerns about definitions of timelines, candidacy, and potential election violations that would be incurred by delegations meeting with their own members who happened to be candidates. The proposed language in this section seeks to clarify that there is no restriction on a group's ability to hold meetings at which all of their members, including announced candidates, may participate.

Recommended amendments in this section better define the interview rules for candidates who announce after the active campaign window opens. Additional proffered language provides clarity that candidates who make presentations to groups in their current formal capacity are not in violation of the interview rules.

CONCLUSION

The work of the Election Task Force 1 and Election Task Force 2 over the last several years have made substantial improvements in AMA policy to address fairness and transparency of AMA Elections. The ETF2 has taken into consideration concerns expressed at I-23 and during the A-24 open forum and makes the following recommendations.

RECOMMENDATIONS

Recommendations adopted from this report will be in effect at the close of Interim 2024. For clarification purposes only, additions within existing policy language are shown in red.

1. That the following "Glossary of Election Terms" be added to our AMA Election Policy:

Glossary

Active campaign window – period of time after the Speaker's notice of the opening of active campaigning until the Election Session during the House of Delegates meeting at which elections are being held.

Active campaigning – Outreach by candidates or their surrogate(s), including but not limited to, members of their campaign team, to members of the House of Delegates with the goal of being elected by the AMA House of Delegates.

Announced candidate – person who has indicated their intention to run for elected position; announcement can be made only by sending an electronic announcement card to the Speakers via the HOD office by email to hod@ama-assn.org.

Campaign manager(s) – person(s) identified by the candidate to the HOD Office as the person(s) responsible for running the campaign.

Campaign team – campaign manager(s) and/or staff identified by the candidate to the HOD Office.

Campaign-related – any content that includes reference to an announced candidate in the context of their candidacy for an elected position within the AMA.

Digital – relating to, using, or storing data or information in the form of digital signals; involving or relating to the use of computer technology; this includes, but is not limited to, social media and communication platforms.

Elected position(s) – Council or Officer position within the AMA elected by the House of Delegates of the AMA.

Endorsing group - Any group that wishes to endorse candidates other than the candidates they are eligible to sponsor. See definition of "Sponsoring Group."

Endorse - any public acknowledgement by a candidate or members of a group of the group's support of a candidate. Internal discussions of support in a closed session of the group are not considered public for the purpose of this definition.

Featured – identification of a candidate at an event by the host or organizer of the event, including but not limited to, written or verbal announcement of the candidate or their candidacy.

Sponsoring group

- Sponsoring group is an endorsing group that may offer endorsements to the delegate(s) and/or alternate delegate(s) representing that sponsoring group without the need to provide their endorsement process to the HOD Office.
- The association, society, AMA section, or other entity for which a prospective candidate serves as an AMA HOD delegate or alternate delegate as certified with the HOD office.
- The Section delegate and alternate delegate are the only individuals who may be sponsored by their respective AMA Section.
- Current trustees or Council members seeking re-election or election to president-elect may be sponsored by the delegation for which they served as an AMA HOD delegate or alternate delegate immediately prior to their election.
- Individuals may self sponsor (self nomination).

2. Policy G-610.090 Section II be amended by addition and deletion to read as follows:

II. Guidelines for Candidacy ~~for Nominations~~ for AMA Offices

1. Every effort should be made to have two or more candidates ~~nominate two or more eligible members~~ for each ~~Council~~ vacancy.
2. The Federation (in ~~nominating or~~ sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) should consider the need to enhance and promote diversity.

3. Policy G-610.090 Section III items 1 and 6 be amended by addition and deletion to read as follows:

III. Candidate Announcement, Nominations and Open Positions

1. Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, ~~email address,~~ the office sought, the sponsoring group, if any, and a list of endorsing groups, if any~~societies~~. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed to members of the House by any method.
6. Our AMA believes that:

a. specialty society candidates for our AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides.

b. elected specialty society members should be identified in that capacity while serving their term of office.

c. nothing in the above recommendations should preclude ~~formal~~ ~~co-~~endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose.

4. Policy G-610.090 Section IV items 1, 6, and 7 be amended by addition and deletion to read as follows:

IV. Communications, Campaign Memorabilia and Literature

1. Active campaigning for ~~our AMA elective office~~ an elected AMA position may not begin until the active campaign window opens as announced by the Speaker following the Spring Board of Trustees meeting immediately preceding the meeting at which the election is scheduled to take place. ~~Board of Trustees, after its April meeting, announces the candidates for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates.~~
6. Active campaigning via mass outreach to delegates by candidates or on behalf of a candidate by any method is prohibited. A reduction in the volume of telephone calls and personal electronic communication from candidates and on behalf of candidates is encouraged. No part of this rule shall be interpreted to limit developing or communicating within a campaign team. ~~The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of~~ Eelectronic messages ~~to contact electors should be minimized, and if used~~ must include a simple mechanism to allow recipients to opt out of receiving future messages.
7. Printed and digital ~~C~~campaign materials may not be distributed to members of the House other than by the HOD office candidate email and on the AMA Candidates' Page. ~~by postal mail or its equivalent. The AMA Office of House of Delegates Affairs will not longer furnish a file containing the names and mailing addresses of members of the AMA HOD. Printed campaign materials may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials.~~

5. Policy G-610.090 Section IV be amended by the addition of a new second and final item with appropriate renumbering to read as follows:

2. An announced candidate may discuss their candidacy on an individual basis in private conversations after the announcement of candidacy until the active campaigning period begins. Prior to the active

campaigning period, no other individual may discuss the candidacy except in private conversations with the announced candidate on an individual basis. This rule does not prohibit any candidate from discussions for the purpose of forming a campaign team or from a campaign team discussing a candidate or campaign strategy. This rule also does not prohibit persons not associated with a campaign from discussing candidates in private conversations.

9. Candidates and campaigns may not produce a personal campaign-related website or other digital campaign-related content. Candidates may not direct to personal or professional websites as a method of campaigning other than to the AMA Candidates' Page.

6. Policy G-610.090 Section VI item 4 be amended by addition and deletion to read as follows:

VI. Interview Rules

Candidates and interviewers must comply with the following rules:

4. Groups conducting interviews with announced candidates for a given office must offer an interview to all ~~individuals that have officially announced their candidacy~~ announced candidates at the time the group's interview schedule is finalized.
    a. A sponsoring group may meet with an announced candidate who is a member of their group during the active campaign window without meeting with ~~interviewing~~ other candidates for the same office.
    b. Interviewing groups may, but are not required to, interview ~~late announcing candidates~~persons who become announced candidates during the active campaign window. Should an interview be offered to such a ~~late~~ candidate, all other announced candidates for the same office (even those previously interviewed) must be afforded the same opportunity and medium.
    c. 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~~campaign-related presentation to an assembly by an announced candidate, with or without being followed by a discussion, question and answer session, or a vote of the assembly regarding the candidate, is an interview and subject to the rules on in-person interviews. No portion of this rule shall be interpreted to mean that a candidate acting in their current formal capacity would be unable to present or discuss matters pertaining to that formal capacity with any group.

7. Virtual interviews are subject to the following constraints:
    a. Interviews may be conducted only during a ~~4-7 day~~9-14 day window (preferably across two separate weekends) as designated by the Speaker beginning at least two weeks but not more than ~~4~~six (6) weeks prior to the scheduled Opening Session of the House of Delegates meeting at which elections will take place.
    b. Interviews 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.
    c. Caucuses and delegations scheduling interviews for candidates within the parameters above must offer alternatives to those candidates who have conflicts with the scheduled time.

Appendix A

AMA Election Rules and Guiding Principles G-610.090

The Speaker and Vice Speaker of the House of Delegates are responsible for overall administration of our AMA elections, although balloting is conducted under the supervision of the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker will advise candidates on allowable activities and when appropriate will ensure that clarification of these rules is provided to all known candidates. The Speaker, in consultation with the Vice Speaker and the Election Committee, is responsible for declaring a violation of the rules.

I. Guiding Principles

The following principles provide guidance on how House elections should be conducted and how the selection of AMA leaders should occur:

1. Our American Medical Association delegates should:
   a. avail themselves of all available background information about candidates for elected positions in our AMA.
   b. determine which candidates are best qualified to help the AMA achieve its mission.
   c. make independent decisions when voting for candidates.
2. Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable. This principle applies between as well as within caucuses and delegations.
3. Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.
4. Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for our AMA leadership positions.
5. Incumbency should not assure the re-election of an individual to an AMA leadership position.
6. Service in any AMA leadership position should not assure ascendancy to another leadership position.
7. Delegations and caucuses when evaluating candidates may provide information to their members encouraging open discussion regarding the candidates.
8. Delegations and caucuses should be a source of encouragement and assistance to qualified candidates. Nomination and endorsement should be based upon selecting the most qualified individuals to lead our AMA regardless of the number of positions up for election in a given race. Delegations and caucuses are reminded that all potential candidates may choose to run for office, with or without their endorsement and support.
9. Every state and specialty society delegation is encouraged to participate in a caucus, for the purposes of candidate review activities.

II. Guidelines for Nominations for AMA Offices

1. Every effort should be made to nominate two or more eligible members for each Council vacancy.
2. The Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) should consider the need to enhance and promote diversity.

III. Candidate Announcement, Nominations and Open Positions

1. Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, email address, the office sought and a list of endorsing societies. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed to members of the House by any method.
2. Announcement cards of all known candidates will be projected on the last day of the Annual and Interim Meetings of our House of Delegates and posted on the AMA website. Following each meeting, an "Official Candidate Notification" will be sent electronically to the House. It will include a list of all announced candidates and all potential newly opened positions which may open as a result of the election of any announced candidate. Additional notices will also be sent out with regular Speaker communications to the HOD and with the Speaker's notice of the opening of active campaigning which generally follows the April Board meeting.
3. Candidates may notify the HOD Office of their intention to run for potential newly opened positions, as well as any scheduled open positions on the elected councils or the Board of Trustees, at any time by submitting an announcement card to the House Office. They will then be included in all subsequent projections of announcements before the House, "Official Candidate Notifications," and in any campaign activity that had not yet been finalized. All previously announced candidates will continue to be included on each Official Candidate Notification. Any candidate may independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than on Official Candidate Notifications.
4. The Federation and members of the House of Delegates will be notified of unscheduled potential newly opened positions that may become available as a result of the election of announced candidates. Candidates will be allowed to announce their intention to run for these positions.

5. If a potential newly opened position on the Board or a specified council does not open but there are other open positions for the same council or the Board, an election will proceed for the existing open seats. Candidates will be offered the opportunity to withdraw their nomination prior to the vote. If there are no scheduled open seats on the Board or specified council for which a potential newly opened position is announced and if the potential newly opened position does not open (ie., the individual with the unexpired term is not elected to the office they sought), no election for the position will be held. In the event that a prior election results in a newly opened position without a nominated candidate or more positions are open than nominated candidates, the unfilled positions would remain unfilled until the next annual meeting.
6. Our AMA believes that:
   a. specialty society candidates for our AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides.
   b. elected specialty society members should be identified in that capacity while serving their term of office.
   c. nothing in the above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose.
7. Our AMA requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election. Conflict of interest forms must be submitted after an individual has announced their candidacy and before the active campaign window begins or, if not previously announced, within 24 hours of the conclusion of the HOD Opening Session. The HOD Office will post such information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.
8. Candidates will be provided with a copy of the current election rules and will be required to attest to abiding by them. Candidates are responsible for any and all actions or inaction undertaken on their behalf that is campaign related.

IV. Communications, Campaign Memorabilia and Literature

1. Active campaigning for our AMA elective office may not begin until the Board of Trustees, after its April meeting, announces the candidates for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates.
2. An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual will provide a link to the AMA Candidates' Page, but links to personal, professional or campaign related websites will not be allowed. The Election Manual provides an equal opportunity for each candidate to present the material they consider important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates.
3. Our AMA Office of House of Delegates Affairs will provide an opportunity for all announced candidates to submit material to the HOD office which will then be sent electronically by the HOD Office in a single communication to all delegates and alternates. Parameters regarding content and deadlines for submission will be established by the Speaker and communicated to all announced candidates.
4. An AMA Candidates' Page will be created on our AMA website or other appropriate website to allow each candidate the opportunity to post campaign materials. Parameters for the site will be established by the Speaker and communicated to candidates.
5. Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. Campaign memorabilia and giveaways that include a candidate's name or likeness may not be distributed at any time.
6. A reduction in the volume of telephone calls and electronic communication from candidates and on behalf of candidates is encouraged. The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of electronic messages to contact electors should be minimized, and if used must include a simple mechanism to allow recipients to opt out of receiving future messages.
7. Campaign materials may not be distributed by postal mail or its equivalent. The AMA Office of House of Delegates Affairs will no longer furnish a file containing the names and mailing addresses of members of

the AMA-HOD. Printed campaign materials may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials.

8. Displays of campaign posters, signs, and literature in public areas of the venue at which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at a single campaign reception at which the candidate is featured. No campaign literature shall be distributed in the House of Delegates and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates.
9. Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies, state and regional delegations and health related causes that do not include any candidate identifier. These pins should be small, not worn on the badge and distributed only to members of the designated group. General distribution of any pin, button or sticker is disallowed.

V. Group Dinners and Meetings

1. Candidates for our AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society.
2. At any AMA meeting convened prior to the time period for active campaigning, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited. It is permissible for candidates seeking election to engage in individual outreach meant to familiarize others with a candidate's opinions and positions on issues.
3. Group dinners, if attended by an announced candidate in a currently contested election, must be "Dutch treat" - each participant pays their own share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. Gatherings of 4 or fewer delegates or alternates are exempt from this rule.

VI. Interview Rules

Candidates and interviewers must comply with the following rules:

1. Groups wishing to conduct interviews must designate their interviewing coordinator and provide the individual's contact information to the Office of House of Delegates Affairs. The Speaker's Office will collect contact information for groups wishing to conduct interviews as well as for candidates and their campaign teams and will provide the information to both groups. Groups must indicate whether they wish to interview in-person or virtually and for which contest by the deadlines designated by the speaker.
2. Any formal questioning of an announced candidate, excluding a written questionnaire, is an interview and subject to the rules for interviews.
3. Interviews may be arranged between the parties once active campaigning is allowed.
4. 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.
    a. A group may meet with a candidate who is a member of their group without interviewing other candidates for the same office.
    b. 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.
    c. 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.
5. Groups may elect to conduct interviews virtually or in-person.
6. In-person interviews may be conducted between Friday and Monday of the meeting at which elections will take place.
7. Virtual interviews are subject to the following constraints:
    a. Interviews may be conducted only during a 4–7-day window designated by the Speaker beginning at least two weeks but not more than 4 weeks prior to the scheduled Opening Session of the House of Delegates meeting at which elections will take place.
    b. Interviews conducted on weeknights must be scheduled between 5 pm and 10 pm or on weekends between 8am and 10 pm based on the candidate's local time, unless another mutually acceptable time outside these hours is arranged.
    c. caucuses and delegations scheduling interviews for candidates within the parameters above must offer alternatives to those candidates who have conflicts with the scheduled time.

8. Recording of interviews is allowed only with the knowledge and consent of the candidate.
9. Interviews are recommended to be recorded with consent of all participating individuals and disseminated to the interviewing group members when all are not able to be present for the interview.
10. Recordings of interviews may be shared only among members of the group conducting the interview.
11. A candidate is free to decline any interview request.
12. In consultation with the Election Committee, the Speaker, or where the Speaker is in a contested election, the Vice Speaker, may issue special rules for interviews to address unexpected situations.
13. The Speakers are encouraged to continue recorded virtual interviews of announced candidates in contested races, to be posted on the AMA website.

VII. Campaign Receptions

1. Our AMA will sponsor the AMA Candidate Reception which will be open to all candidates and all meeting attendees. Any candidate may elect to be "featured" at the AMA Candidate Reception. There will not be a receiving line at the AMA Candidate Reception. The rules regarding cash bars only at campaign receptions and limiting each candidate to be featured at a single reception will apply to the AMA Candidate Reception.
2. A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, or (b) appearing by name or in a picture on a poster or notice in or outside of the party venue. At these events, alcohol may be served only on a cash or no-host bar basis.

VIII. Election Process

1. At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place their name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker.
2. Nominating speeches for unopposed candidates for office, except for President-elect, will not be heard.
3. AMA elections will be held on Tuesday at each Annual Meeting.
4. Voting for all elected positions including runoffs will be conducted electronically during an Election Session to be arranged by the Speaker.
5. All delegates eligible to vote must be seated within the House at the time appointed to cast their electronic votes.
6. The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House.
7. The Speaker is encouraged to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced, including collecting written personal points from candidates to be shared electronically with the House after the meeting or imposing time limits on such comments.

IX. Election Committee

1. In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 9 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime maximum tenure of 8 terms) to report to the Speaker. These individuals would agree not to be directly involved in a campaign during their tenure and would be appointed from various regions, specialties, sections, and interest groups. The primary role of the committee would be to work with the Speakers to adjudicate any election complaint. Additional roles to be determined by the Speaker and could include monitoring election reforms, considering future campaign modifications and responding to requests from the Speaker for input on election issues that arise. The Speaker and Vice Speaker shall be full members of the Election Committee.

X. Campaign Complaint Reporting, Validation and Resolution Process

1. Campaign violation complaints should be directed to the Speaker, the Vice Speaker, or the AMA General Counsel and should include the following details:
    a. The name of the person(s) thought to have violated the rules
    b. The date of the alleged violation and the location if relevant
    c. The specific violation being alleged (i.e., the way the rules were violated)
    d. The materials, if any, that violate the rules; original materials are preferred over copies. Where necessary, arrangements for collection of these materials will be made.

2. Campaign violation complaints will be investigated by the Election Committee or a subcommittee thereof with the option of including the Office of General Counsel or the Director of the House of Delegates.
    a. The Committee will collectively determine whether a campaign violation has occurred. As part of the investigation process the Election Committee or its subcommittee shall inform the candidate of the complaint filed and give the candidate the opportunity to respond to the allegation.
    b. If the complaint implicates a delegation or caucus, the Election Committee or its subcommittee shall inform the chair of the implicated delegation or caucus of the complaint filed and give the implicated delegation or caucus chair(s) the opportunity to answer to the allegation as a part of the investigative process.
    c. For validated complaints, the Committee will determine appropriate penalties, which may include an announcement of the violation by the Speaker to the House.
    d. Committee members with a conflict of interest may participate in discussions but must recuse themselves from decisions regarding the merits of the complaint or penalties.
    e. Deliberations of the Election Committee shall be confidential.
    f. The Speaker shall include a summary of the Election Committee's activities in "Official Candidate Notifications" sent to the House, following each meeting at which an election was held. Details may be provided at the discretion of the Election Committee and must be provided when the penalty includes an announcement about the violator to the House.
3. A record of all complaints and the results of the validation and the resolution processes, including penalties, shall be maintained by our AMA Office of General Counsel and kept confidential.
4. The Election Committee will review the Campaign Complaint Reporting, Validation and Resolution Process as implemented and make further recommendations to the House as necessary.

XI. Endorsements

1. Our American Medical Association requires all groups that endorse candidates turn in information about their endorsement process, the deadline, and a staff contact for applications in a timely and streamlined manner.
2. Our AMA will then post this information on the election website in a timely manner, with the information being easily digestible and accessible.
3. Our AMA will not allow any group that fails to provide this information in a timely manner to offer an endorsement during that election cycle.
4. Our AMA will create a specific period (similar to virtual elections) during which endorsements may be sought.

2. RECONCILIATION REPORT

Informational report; no reference committee hearing

HOD ACTION: FILED

Policy G-600.111, "Consolidation and Reconciliation of AMA Policy," calls on your Speakers to "present one or more reconciliation reports for action by the House of Delegates relating to newly passed policies from recent meetings that caused one or more existing policies to be redundant and/or obsolete." Should other policies be identified that require updates, please email suggestions to your Speakers at hod@ama-assn.org. These will be addressed in future reconciliation reports.

Where changes to policy language will be made, additions are shown with underscore and deletions are shown with strikethrough in red font. Given the length of many of the policies, only the affected portions are reproduced.

RECOMMENDED RECONCILIATIONS

Policies to be modified

1. Through their work with the Election Task Force 2 and the Resolution Modernization Task Force, your Speakers identified policies that required corrections which would not change the intent of the policy but would update the language. The first removes a reference to a specific nationality, and the second refers to a tool that is no longer in use in our House policy making process.

- G-610.090, "AMA Election Rules and Guiding Principles," Section V, Item 3:
  Each participant in ~~G~~group dinners, if attended by an announced candidate in a currently contested election, must ~~be "Dutch treat" - each participant~~ pay~~s~~ their own share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. Gatherings of 4 or fewer delegates or alternates are exempt from this rule.

- G-600.055, "Options for Informational Reports Submitted to the House of Delegates,"
  Item 1:
  Informational reports will be included in the AMA House of Delegates Online ~~Member Forums~~Reference Committees.

2. AMA policy H-65.942 states, "our American Medical Association will recognize the importance of using gender-neutral language such as gender neutral pronouns, terms, imagery, and symbols in respecting the spectrum of gender identity." The policy further states that policy will be amended prospectively by way of the reaffirmation and sunset processes. In addition, policy D-65.977 directs your Speakers to "review and update the language used in AMA policy and other resources and communications to ensure that the language used to describe families and persons in need of obstetric and gynecologic care is inclusive of all genders and family structures."

   In response to the House's request, your Speakers completed a policy search for the following terms: obstetric, pregnant, pregnancy, mother, father, he, she, him, her, his, man, men, woman, and women and have recommended appropriate alternate language for these terms. Ongoing review of gendered language should continue prospectively as policy states.

   - Appendix A includes relevant portions of policies that contain gendered language and the recommended gender neutral alternative language.

   - Appendix B contains other policies with gendered language that is relevant to the intent of the policy and would substantively change the policy if replaced with gender neutral language. Therefore, your Speakers are recommending the following policies be retained as written.

Recommended policy changes do not reset the sunset clock and will be implemented when this report is filed.

Appendix A - Recommendations for gender neutral language

Policy Number	Title	Policy Language
D-65.984	Humanitarian and Medical Aid Support to Ukraine	2. Our AMA will advocate for an early implementation of mental health measures, including suicide prevention efforts, and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian refugees with special attention to vulnerable populations including but not limited to young children, ~~**mothers**~~**their parents**, pregnant ~~**women**~~**people**, and the elderly.
D-95.956	Cannabis Product Safety	Our American Medical Association will draft state model legislation to help states implement the provisions of AMA policies H-95.924, Cannabis Legalization for Adult Use and H-95.936, Cannabis Warnings for Pregnant and Breastfeeding ~~**Women**~~**People** that currently do not have such model language, including regulation of retail sales, marketing and promotion (especially those aimed at children), misleading health claims, and product labeling regarding dangers of use during pregnancy and breastfeeding.

D-290.982	State Children's Health Insurance Program Reauthorization (SCHIP)	2. Our AMA will lobby Congress to: c. Allow states to explicitly use SCHIP funding to cover eligible pregnant ~~women~~people. d. Allow states the flexibility to cover all eligible children residing in the United States and pregnant ~~women~~people through the SCHIP program without a mandatory waiting period.
D-310.950	Protecting Trainees' Breastfeeding Rights	Our AMA will: (2) work with appropriate bodies, such as the LCME, ACGME, and Association of American Medical Colleges (AAMC), to include language related to the learning and work environments for breastfeeding ~~mothers~~people in regular program reviews.
D-315.971	Physician Access to Their Medical and Billing Records	(2) that, where physician possession of all ~~his or her~~ billing records is not already required by state law, the employment or other contractual arrangement between a physician and entity submitting claims on behalf of the physician should specify that the physician is entitled to copies of ~~his or her~~ billing records subsequent to the termination of employment or contractual arrangement, when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician; (3) for legislation or regulation to eliminate contractual language that bars or limits the treating physician's access to ~~his or her~~ billing records and associated medical records, such as treating these records as trade secrets or proprietary.
D-383.989	Physician Freedom to Collectively Negotiate with Managed Care Plans and Health Insuring Organizations	Our AMA will: (4) speak forcefully to its membership that no member should feel compelled to sign any contractual agreement that harms ~~his/her~~ their ability to provide compassionate and quality care to ~~his/her~~ their patients; and
D-420.990	Pain Management Following Caesarean Birth	(3) supports counseling of ~~women~~patients who are prescribed opioid analgesics following caesarean birth about the risk of central nervous system depression in the ~~woman~~patient and the breastfed infant.
D-420.991	Improving Treatment and Diagnosis of ~~Maternal~~Peripartum Depression Through Screening and State-Based Care Coordination	Our AMA: (1) will work with stakeholders to encourage the implementation of a routine protocol for depression screening in pregnant and postpartum ~~women~~people presenting alone or with their child during prenatal, postnatal, pediatric, or emergency room visits; (2) encourages the development of training materials related to ~~maternal~~peripartum depression to advise providers on appropriate treatment and referral pathways; and (3) encourages the development of state-based care coordination programs (e.g., staffing a psychiatrist and care coordinator) to assure appropriate referral, treatment and access to follow-up ~~maternal~~peripartum-mental health care.
D-420.992	Research into Preterm Birth and Related Cardiovascular and Cerebrovascular Risks in ~~Women~~Pregnant People	Our AMA will advocate for more research on ways to identify risk factors linking preterm birth to cardiovascular or cerebrovascular disease in pregnant ~~women~~people.

D-440.930	Enhanced Zika Virus Public Health Action	3. Our AMA will consider collaboration with other educational and promotional entities (e.g., the AMA Alliance) to promote family-directed and community-directed strategies that minimize the transmission of Zika virus to potentially pregnant ~~women~~people.
G-600.031	Roles and Responsibilities of AMA Delegates and Alternate Delegates	(2) The roles and responsibilities of delegates and alternate delegates are as follows: (a) regularly communicate AMA policy, information, activities, and programs to constituents so ~~he/she~~they will be recognized as the representative of the AMA;
G-600.060	Introducing Business to the AMA House	5. The submission of resolutions calling for similar action to what is already existing AMA policy is discouraged. Organizations represented in the House of Delegates are responsible to search for alternative ways to obtain AMA action on established AMA policy, especially by communicating with the Executive Vice President. The EVP will submit a report to the House detailing the items of business received from organizations represented in the House which ~~he or she~~they considers significant or when requested to do so by the organization, and the actions taken in response to such contacts.
G-630.010	Executive Vice President	The office of the Executive Vice President shall be filled, if possible, by a Doctor of Medicine or Osteopathy who is an active member of our AMA at the time of ~~his~~their appointment and who possesses the necessary managerial qualifications.
H-5.989	Freedom of Communication Between Physicians and Patients	1. to strongly condemn any interference by the government or other third parties that causes a physician to compromise ~~his or her~~their medical judgment as to what information or treatment is in the best interest of the patient.
H-20.905	HIV/AIDS Research	(1) Information on the HIV Epidemic Our AMA: b) Requests the Secretary of the Department of Health and Human Services to make available information on HIV expenditures, services, programs, projects, and research of agencies under ~~his/her~~their jurisdiction and, to the extent possible, of all other federal agencies for purposes of study, analysis, and comment. The compilation should be sufficiently detailed that the nature of the expenditures can be readily determined;
H-20.906	Health and Disability Coverage for Health Care Workers at Risk for HIV and Other Serious Infectious Diseases	2. Disability Coverage a. each health care worker should consider the risks of exposure to infectious agents posed by ~~his/her~~their type of practice and the likely consequences of infection in terms of changes needed in that practice mode and select disability insurance coverage accordingly. The policy selected should contain a reasonable definition of "sickness" or "disability," an own-occupation clause, and guaranteed renewability, future insurability, and partial disability provisions; c. since there are a variety of disability insurance coverages available and a diversity of practice modes, each health care professional should individually assess ~~his/her~~their risk of infection and that of ~~his/her~~their employees and select disability coverage accordingly.
H-20.907	Financing Care for HIV/AIDS Patients	4. Our AMA supports government funding of all medical services that are deemed appropriate by both the patient and physician for pregnant seropositive ~~women~~people lacking other sources of funding.
H-20.910	HIV-Infected Children	2. Our AMA encourages the physician responsible for care of an HIV-infected child in a day-care, preschool, or school setting to receive information from the school on other infectious diseases in the environment and temporarily remove the HIV-infected child from a setting that might pose a threat to ~~his/her~~their health.

H-20.915	HIV/AIDS Reporting, Confidentiality, and Notification	(3) Contact Tracing and Partner Notification Our AMA: d) Promulgates the standard that a physician attempt to persuade an HIV-infected patient to cease all activities that endanger unsuspecting others and to inform those whom ~~he/she~~they might have infected. If such persuasion fails, the physician should pursue notification through means other than by reliance on the patient, such as by the Public Health Department or by the physician directly.
H-20.917	Neonatal Screening for HIV Infection	2. Our AMA favors giving consideration to rapid HIV testing of newborns, with ~~maternal~~ consent of the gestational parent, when the individual's HIV status has not been determined during pregnancy or labor.
H-20.918	Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV Transmission	In view of the significance of the finding that treatment of HIV-infected pregnant ~~women~~people with appropriate antiretroviral therapy can reduce the risk of transmission of HIV to their infants, our AMA recommends the following statements: (1) Given the prevalence and distribution of HIV infection among ~~women~~individuals in the United States, the potential for effective early treatment of HIV infection ~~in both women and their infants~~, and the significant reduction in perinatal HIV transmission with treatment of pregnant ~~women~~people with appropriate antiretroviral therapy, routine education about HIV infection and testing should be part of a comprehensive health care program for all ~~women~~individuals. The ideal would be for all ~~women~~people to know their HIV status before considering pregnancy. (2) Universal HIV testing of all pregnant ~~women~~people, with patient notification of the right of refusal, should be a routine component of perinatal care. Basic counseling on HIV prevention and treatment should also be provided to the patient, consistent with the principles of informed consent. (3) The final decision about accepting HIV testing is the responsibility of the ~~woman~~patient. The decision to consent to or refuse an HIV test should be voluntary. When the choice is to reject testing, the patient's refusal should be recorded. Test results should be confidential within the limits of existing law and the need to provide appropriate medical care for ~~the woman~~patients and ~~her~~their infant. (4) To assure that the intended results are being achieved, the proportion of pregnant ~~women~~people who have accepted or rejected HIV testing and follow-up care should be monitored and reviewed periodically at the appropriate practice, program or institutional level. Programs in which the proportion of ~~women~~patients accepting HIV testing is low should evaluate their methods to determine how they can achieve greater success. (5) ~~Women~~Pregnant people who are not seen by a health care professional for prenatal care until late in pregnancy or after the onset of labor should be offered HIV testing at the earliest practical time, but not later than during the immediate postpartum period. (6) When HIV infection is documented in a pregnant ~~woman~~person, proper post-test counseling should be provided. The patient should be given an appropriate medical evaluation of the stage of infection and full information about the recommended management plan for ~~her~~their own health. Information should be provided about the potential for reducing the risk of perinatal transmission of HIV infection to ~~her~~the infant through the use of antiretroviral therapy, and about the potential but unknown long-term risks to ~~herself~~the patient and ~~her~~the infant from the treatment course. The final decision to accept or reject antiretroviral treatment recommended for ~~herself~~the patient and ~~her~~their infant is the right and responsibility of the ~~woman~~patient. When the ~~woman's~~ serostatus is either unknown or known to be positive, appropriate counseling should also be given regarding the risks associated with breastfeeding for both her own disease progression and disease transmission to the infant.

		(7) Appropriate medical treatment for HIV-infected pregnant ~~women~~people should be determined on an individual basis using the latest published Centers for Disease Control and Prevention recommendations. The most appropriate care should be available regardless of the stage of HIV infection or the time during gestation at which the ~~woman~~patient presents for prenatal or intrapartum care. (8) To facilitate optimal medical care for ~~women~~pregnant people and the~~ir~~ infants, HIV test results (both positive and negative) and associated management information should be available to the physicians taking care of both ~~mother and infant~~individuals. Ideally, this information will be included in the confidential medical records. Physicians providing care for a ~~woman~~pregnant person or ~~her~~their infant should obtain the appropriate consent and should notify the other involved physicians of the HIV status of and management information about the ~~mother~~pregnant person and their infant, consistent with applicable state law. (9) Continued research into new interventions is essential to further reduce the perinatal transmission of HIV, particularly the use of rapid HIV testing for ~~women~~patients presenting in labor and ~~for women~~those presenting in the prenatal setting who may not return for test results. The long-term effects of antiretroviral therapy during pregnancy and the intrapartum period for both ~~women~~pregnant patients and their infants also must be evaluated. For both infected and uninfected infants exposed to perinatal antiretroviral treatment, long-term follow-up studies are needed to assess potential complications such as organ system toxicity, neurodevelopmental problems, pubertal development problems, reproductive capacity, and development of neoplasms. (10) Health care professionals should be educated about the benefits of universal HIV testing, with patient notification of the right of refusal, as a routine component of prenatal care, and barriers that may prevent implementation of universal HIV testing as a routine component of prenatal care should be addressed and removed. Federal funding for efforts to prevent perinatal HIV transmission, including both prenatal testing and appropriate care of HIV-infected ~~women~~pregnant people, should be maintained.
H-20.920	HIV Testing	(2) Informed Consent Before HIV Testing b) Informed consent should include the following information: (i) patient option to receive more information and/or counseling before deciding whether or not to be tested and (ii) the patient should not be denied treatment if ~~he or she~~they refuse~~s~~ HIV testing, unless knowledge of HIV status is vital to provide appropriate treatment; in this instance, the physician may refer the patient to another physician for care; (10) Counseling and Testing of Pregnant ~~Women~~People for HIV Our AMA supports the position that there should be universal HIV testing of all pregnant ~~women~~people, with patient notification of the right of refusal, as a routine component of perinatal care, and that such testing should be accompanied by basic counseling and awareness of appropriate treatment, if necessary. Patient notification should be consistent with the principles of informed consent.
H-30.940	AMA Policy Consolidation: Labeling Advertising, and Promotion of Alcoholic Beverages	3. Our AMA a. recommends that health education labels be used on all alcoholic beverage containers and in all alcoholic beverage advertising (with the messages focusing on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant ~~women~~people, as well as the dangers of irresponsible use to all sectors of the populace).

H-35.989	Physician Assistants	2. A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of ~~his or her~~their practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which: 4. While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly responsible as the attending physician for the patient care services delegated to ~~his~~their physician assistant.
H-50.996	Blood for Medical Use	(1) Blood transfusions and the use of other bodily tissues or substances or biological substances in rendering medical care to patients are often essential to save the life of a patient or to protect ~~his~~their health. Protecting the welfare of patients requires that blood for transfusions and bodily tissues or substances and biological substances be available and that use when needed be encouraged and not burdened with unreasonable restrictions and increased costs.
H-60.918	Lead Contamination in Municipal Water Systems as Exemplified by Flint, Michigan	3. Our AMA will advocate for appropriate nutritional support for all people exposed to lead contaminated water with resulting elevated blood lead levels, but especially exposed pregnant ~~women~~people, lactating ~~mothers~~people and exposed children. Support should include Vitamin C, green leafy vegetables and other calcium resources so that their bodies will not be forced to substitute lead for missing calcium as the children grow.
H-60.924	Reducing Lead Poisoning	2. Our AMA will call on the United States government to establish national goals to: (b) eliminate lead exposures to pregnant ~~women~~people and children, so that by 2030, no child would have a blood lead level >1 µg/dL (10 ppb). 3. Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals: a. adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant ~~women~~people and children from lead toxicity and neurodevelopmental impairment; f. establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and

		implementation, to achieve the national goal of eliminating lead toxicity in pregnant ~~women~~people and children, defined as blood lead levels above 1 µg/dL (10 ppb).
H-65.965	Support of Human Rights and Freedom	1. Our American Medical Association continues to support the dignity of the individual, human rights and the sanctity of human life, 2. Our AMA reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with ~~his or her~~ individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age.
H-85.955	Hospice Care	4. Our AMA believes that each patient admitted to a hospice program should have ~~his or her~~their designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program.
H-85.961	Accuracy, Importance, and Application of Data from the US Vital Statistics System	Our American Medical Association encourages physicians to provide complete and accurate information on prenatal care and hospital patient records of the ~~mother~~birthing patient and their infant, as this information is the basis for the health and medical information on birth certificates.
H-85.968	Patient Self Determination Act	(1) lend its administrative, legislative, and public relations support to assuring that the specific wishes of the individual patient as specified in ~~his or her~~their advance directive be strictly honored in or out of the hospital setting; (3) promote efforts to develop a national system to assist emergency medical personnel to rapidly ascertain a person's wishes with regard to resuscitation, regardless of ~~his or her~~their state of location.
H-95.912	Involuntary Civic Commitment for Substance Use Disorder	Our American Medical Association opposes civil commitment proceedings for patients with a substance use disorder unless: b. Judicial oversight is present to ensure that the patient can exercise ~~his or her~~their right to oppose the civil commitment. c. The patient will be treated in a medical or other health care facility that is staffed with medical professionals with training in mental illness and addiction, including medications to help with withdrawal and other symptoms as prescribed by ~~his or her~~their physician.
H-95.924	Cannabis Legalization for Adult Use (commonly referred to as recreational use)	3. Our AMA discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant ~~women~~people, and ~~women~~people who are breastfeeding. 10. Our AMA will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among ~~women~~people who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving.
H-95.952	Cannabis and Cannabinoid Research	4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant ~~women~~people, and ~~women~~people who are breastfeeding.
H-95.967	Harmful Substance Use	Our AMA encourages every physician to make a commitment to join ~~his/her~~their community in attempting to reduce harmful substance use and that said commitment encourage involvement in at least one of the following roles:

H-95.976	Addiction and Unhealthy Substance Use	(2) encourages the development of addiction treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant ~~women~~people and ~~women~~parents with infant children through a comprehensive array of essential services; (3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant ~~women~~people, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals; (7) affirms the concept that addiction is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the ~~mother~~pregnant person, the fetus and resultant offspring; and (8) calls for better coordination of research, prevention, and intervention services for ~~women~~pregnant people and infants at risk for both HIV infection and perinatal addiction.
H-100.951	Medication Brown Bagging	2. Our AMA affirms that "brown bagged" pharmaceuticals be accepted for in-office or hospital administration only after the physician responsible for administering these medications determines that the individual patient, or ~~his or her~~their agent, is fully capable of safely handling and transporting the medication.
H-115.974	Prescription Labeling	(1) That when a physician desires to prescribe a brand name drug product, ~~he or she~~they do so by designating the brand name drug product and the phrase "Do Not Substitute" (or comparable phrase or designation, as required by state law or regulation) on the prescription; and when a physician desires to prescribe a generic drug product, ~~he or she~~they do so by designating the USAN-assigned generic name of the drug on the prescription.
H-130.937	Delivery of Health Care by Good Samaritans	3. Where there is no conflict with state or local jurisdiction protocol, policy, or regulation on this topic, our AMA supports the following basic guidelines to apply in those instances where a bystander physician happens upon the scene of an emergency and desires to assist and render medical assistance. For the purpose of this policy, "bystander physicians" shall refer to those physicians rendering assistance voluntarily, in the absence of pre-existing patient-physician relationships, to those in need of medical assistance, in a service area in which the physician would not ordinarily respond to requests for emergency assistance. e. Where voice communication is not available, the bystander physician may sign appropriate documentation indicating that ~~he/she~~they will take responsibility for the patient(s), including provision of care during transportation to a medical facility. Medical oversight systems lacking voice communications capability should consider the addition of such communication linkages to further strengthen their potential in this area. f. The bystander physician should avoid involvement in resuscitative measures that exceed ~~his or her~~their level of training or experience.
H-130.978	Billing Procedures for Emergency Care	(2) In the interest of high quality care, patients who seek medical attention on an emergency basis should have the benefit of an immediate evaluation of any indicated diagnostic studies. The physician who provides such evaluation is entitled to adequate compensation for ~~his or her~~their services. When such evaluations are provided as an integral part of and in conjunction with other routine services rendered by the emergency physician, ideally an inclusive charge, commensurate with the services provided, should be made. Where the carrier collapses or eliminates CPT-4 coding for payment purposes, the physician may be left with no realistic alternative other than to itemize. Such an itemized bill should not be higher than the amount which would be paid if the appropriate inclusive charge were recognized. The interpretation of diagnostic procedures by a consulting specialist, as a separate and independent service provided the emergency patient, is equally important to

		good patient care. Physicians who provide such interpretations are also entitled to adequate compensation for their services
H-140.951	Professionalism in Medicine	Our AMA believes that the primary mission of the physician is to use ~~his~~ best efforts and skill in the care of ~~his~~ patients and to be mindful of those forces in society that would erode fundamental ethical medical practice. The AMA affirms that the medical profession is solely responsible for establishing and maintaining standards of professional medical ethics and that the state neither legislate ethical standards nor excuse physicians from their ethical obligations. The AMA House of Delegates, Board of Trustees, staff, and membership rededicate themselves to professionalism such that it permeates all activities and is the defining characteristic of the AMA's identity.
H-140.970	Decisions to Forgo Life-Sustaining Treatment for Incompetent Patients	(1) Advance directives (living wills and durable powers of attorney for health care) are the best insurance for individuals that their interests will be promoted in the event that they become incompetent. Generally, it is most effective if the individual designates a proxy decisionmaker and discusses with the proxy ~~his or her~~their values regarding decisions about life support.
H-140.984	Physicians' Involvement in Commercial Ventures	Our AMA opposes an across-the-board ban on self-referrals because of benefits to patients including increased access and competition, but proposes a list of standards to ensure ethical and acceptable financial arrangements: (3) Patient Referral Requirement - No investor in the medical facility can be required or coerced in any manner to refer patients to the facility. No investor can be required to divest ~~his or her~~ investment for failure to refer patients. No investor can be required to divest because ~~he or she~~they move~~s~~ from the area or ceases practicing medicine. (5) Disclosure of Ownership Interest - A physician or other health care professional or provider with an ownership interest in a medical or other health care facility or service to which the physician refers patients must disclose to the patients this ownership interest. A general disclosure can be made in a manner which is appropriate to ~~his or her~~their practice situation. (6) Request for Care - Each patient of a physician with an ownership interest (or whose immediate family member has an interest) must be provided with a physician's request for ancillary care to enable the patient to select a facility for such care. However, in accordance with the physician's ethical responsibility to provide the best care for the patient, the physician must be free to recommend what in the physician's judgment is the most appropriate facility, including ~~his or her~~their own facility. (7) Notification of Ownership Interest to Payer - If the physician (or immediate family member) has an ownership interest in a medical or health care facility or service to which ~~he or she~~they refer~~s~~ patients who are Medicare beneficiaries, this physician should identify the ownership interest on the Medicare claim form. If the Medicare carrier detects a pattern suggesting inappropriate utilization, the matter could be referred to the PRO for follow-up pursuant to the existing PRO review process. Such PRO review would have to be conducted in a uniformly fair, open-minded manner.
H-140.989	Informed Consent and Decision-Making in Health Care	(6) A patient should have access to the information in ~~his or her~~their health record, except for that information which, in the opinion of the health care professional, would cause harm to the patient or to other people.
H-150.989	Weight Loss Programs	1. Our AMA encourages any person considering participation in a weight loss program to first consult ~~his or her~~their regular attending physician, or any other independent physician, for a physical examination and an objective professional evaluation of the proposed weight loss program as it relates to the individual's physical condition.

H-160.888	Urgent Care Centers	1. Our American Medical Association supports that any individual, company, or other entity that establishes and/or operates urgent care centers (UCCs) adhere to the following principles: b. UCCs must transfer a patient's medical records to ~~his or her~~their primary care physician and to other health care providers, with the patient's consent, including offering transfer in an electronic format if the receiving physician is capable of receiving it.
H-160.912	The Structure and Function of Interprofessional Health Care Teams	2. Our AMA will advocate that the physician leader of a physician-led interprofessional health care team be empowered to perform the full range of medical interventions that ~~she or he is~~they are trained to perform.
H-160.921	Retail Clinics	4. Our AMA supports that any individual, company, or other entity that establishes and/or operates retail health clinics adhere to the following principles: b. Retail health clinics must use electronic health records to transfer a patient's medical records to ~~his or her~~their primary care physician and to other health care providers, with the patient's consent;
H-160.942	Evidence-Based Principles of Discharge and Discharge Criteria	(7) The AMA endorses the following principles in the development of evidence-based discharge criteria and an organized discharge process: (c) The discharge process includes, but is not limited to: (iv) Responsibility/Accountability: Responsibility/accountability for an appropriate transition from one setting to another rests with the attending physician. If that physician will not be following the patient in the new setting, ~~he or she is~~they are responsible for contacting the physician who will be accepting the care of the patient before transfer and ensuring that the new physician is fully informed about the patient's illness, course, prognosis, and needs for continuing care. If there is no physician able and willing to care for the patient in the new setting, the patient should not be discharged. Notwithstanding the attending physician's responsibility for continuity of patient care, the health care setting in which the patient is receiving care is also responsible for evaluating the patient's needs and assuring that those needs can be met in the setting to which the patient is to be transferred.
H-160.947	Physician Assistants and Nurse Practitioners	10. The physician is responsible for clarifying and familiarizing the physician assistant with ~~his/her~~their supervising methods and style of delegating patient care.
H-165.856	Health Insurance Market Regulation	4. Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine ~~his or her~~their premium.
H-165.877	Increasing Coverage for Children	Our AMA: (1) supports appropriate legislation that will provide health coverage for the greatest number of children, adolescents, and pregnant ~~women~~people;
H-165.920	Individual Health Insurance	(3) actively supports the principle of the individual's right to select ~~his/her~~a health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. (6) supports the individual's right to select ~~his/her~~a health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;

H-180.960	Insurance Company Medical Test Disclosures	AMA policy is that insurance companies must inform insurance applicants of any abnormal results that are found during an insurance health evaluation; that insurance companies should inform an applicant that if ~~he or she~~they receive~~s~~ information concerning an evaluation that has an abnormal result, ~~he or she~~they should send the results to ~~his or her~~their physician for further consultation; and that all insurance applicants should be made aware that all health information obtained from insurance evaluations is available upon an applicant's request.
H-210.996	Providing Cost Estimate with Home Health Care Order Authorization	The AMA urges physicians to request home health care providers to provide a cost estimate with the physician authorization form, when the form is sent to the physician for ~~his/her~~ signature.
H-210.998	Home Health Service Abuse	(3) urges physicians not to authorize the provision post-acute or long-term care to any patient with whom ~~he or she is~~they are not professionally involved in providing care.
H-220.977	Chief Executive Officer at Medical Staff Executive Committee	The AMA reaffirms its support for amending The Joint Commission Medical Staff Standard MS.02.01.01, Element of Performance 2, to read as follows: "That the Chief Executive Officer of the hospital or ~~his or her~~their designee may be invited to attend meetings of the Executive Committee of the medical staff."
H-225.942	Physician and Medical Staff Member Bill of Rights	IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to ~~his or her~~their patients, the medical staff, and the health care organization:
H-225.946	Preserving Physician/Patient Relationships During Hospitalizations	1. Our AMA advocates that hospital admission processes should include: a determination of whether the patient has an existing relationship with an actively treating primary care or specialty physician; where the patient does not object, prompt notification of such actively treating physician(s) of the patient's hospitalization and the reason for inpatient admission or observation status; to the extent possible, timely communication of the patient's medical history and relevant clinical information by the patient's primary care or specialty physician(s) to the hospital-based physician; notice to the patient that ~~he/she~~they may request admission and treatment by such actively treating physician(s) if the physician has the relevant clinical privileges at the hospital; honoring requests by patients to be treated by their physician(s) of choice; and allowing actively treating physicians to treat to the full extent of their hospital privileges.
H-225.950	AMA Principles for Physician Employment	1. Addressing Conflicts of Interest d. A physician's paramount responsibility is to ~~his or her~~their patients. Additionally, given that an employed physician occupies a position of significant trust, ~~he or she~~they owe~~s~~ a duty of loyalty to ~~his or her~~their employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address. i. No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to ~~his/her~~their religious beliefs or moral convictions. ii. No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because ~~he/she~~they either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates ~~his/her~~their religious beliefs or moral convictions. 3. Contracting c. When a physician's compensation is related to the revenue ~~he or she~~they

		generate~~s~~, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based. d. Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under ~~his/her~~their care. When a physician's employment status is unilaterally terminated by an employer, the physician and ~~his or her~~their employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in ~~his or her~~their new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of ~~his or hertheir~~ patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician. 5. Peer Review and Performance Evaluations f. Upon termination of employment with or without cause, an employed physician generally should not be required to resign ~~his or her~~their hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
H-225.952	The Physician's Right to Exercise Independent Judgement in All Organized Medical Staff Affairs	Our American Medical Association supports the unfettered right of a physician to exercise ~~his/her~~ personal and professional judgment in voting, speaking and advocating on any matter regarding: vi. not to be deemed in breach of ~~his/her~~their employment or independent contractor agreement for asserting the foregoing enumerated rights; and vii. not to be retaliated against by ~~his/her~~their employer in any way, including, but not limited to, termination of ~~his/her~~ employment or independent contractor agreement, commencement of any disciplinary action, or any other adverse action against ~~him/her~~them based on the exercise of the foregoing rights.
H-225.992	Right to Relevant Information	1. The AMA advocates "timely notice" and "opportunity to rebut" any adverse entry in the medical staff member's credential file, believes that any health care organization file on a physician should be opened to ~~him or her~~them for inspection, and supports inclusion of these provisions in hospital medical staff bylaws. 6. The investigating individual or body shall interview the practitioner, unless the practitioner waives ~~his/her~~their right to be heard, to evaluate the potential charges and explore alternative courses of action before proceeding to the formal peer review process.
H-225.997	Physician-Hospital Relationships	9. Both hospitals and hospital-associated medical specialists have an obligation to serve the needs of patients and the medical staff. The primary responsibility for determining the services needed adequately to care for the needs of individual patients should be that of the attending physician subject to review by ~~his~~their-peers.

H-230.954	Privileging Physicians with Low Volume Hospital Activity	3. Hospitals and medical staffs should use data and references, if available, from another hospital at which the applicant physician may be active as an additional method to verify ~~his/her~~their competency within the hospital environment.
H-230.956	Hospital, Ambulatory Surgery Facility, Nursing Home, or Other Health Care Facility Closure: Physician Credentialing Records	1. AMA policy regarding the appropriate disposition of physician credentialing records following the closure of hospitals, ambulatory surgery facilities, nursing homes and other health care facilities, where in accordance with state law and regulations is as follows: C. Documentation of Physician Credentials: The governing body shall make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of ~~his/her~~their credentials, clinical privileges, CME information, and medical staff status.
H-235.961	Employment Status and Eligibility for Election or Appointment to Medical Staff Leadership Positions	1. Our American Medical Association adopted as policy the principle that a medical staff member's personal or financial affiliations or relationships, including employment or contractual relationships with any hospital or health care delivery system, should not affect ~~his or her~~ eligibility for election or appointment to medical staff leadership positions, provided that such interests are disclosed prior to the member's election or appointment and in a manner consistent with the requirements of the medical staff bylaws. 2. Our AMA will draft model medical staff bylaws provisions supporting the principle that a medical staff member's personal or financial affiliations or relationships, including employment or contractual relationships with any hospital or health care delivery system, should not affect ~~his or her~~ eligibility for election or appointment to medical staff leadership positions, provided that such interests are disclosed prior to the member's election or appointment and in a manner consistent with the requirements of the medical staff bylaws.
H-235.967	Medical Staff Legal Counsel and Conflict of Interest	There is an inherent conflict of interest when an attorney represents the hospital and the organized medical staff. Organized medical staffs should require that the following disclosures be made prior to retaining separate legal counsel to avoid any real or perceived conflicts of interest on the counsel's part and to assure ~~his or her~~their loyalty: (1) whether the lawyer or the firm in which ~~he or she is~~they are associated or employed has ever represented the hospital as a client and received payment from the hospital or another party on behalf of the hospital for the legal services provided; (2) whether the hospital has paid legal fees to the lawyer or the law firm with which ~~he or she is~~they are associated or employed for legal opinions or advice on matters pending before the hospital governing board and/or hospital administration; and (3) whether the lawyer or the firm with which ~~he or she is~~they are associated or employed has represented or provided legal opinions and advice to other hospitals in the community or to a local or state hospital association.
H-245.986	Infant Mortality in the United States	It is the policy of the AMA: (1) to continue to address the problems that contribute to infant mortality within its ongoing health of the public activities. In particular, the special needs of adolescents and the problem of teen pregnancy should continue to be addressed by the adolescent health initiative; and (2) to be particularly aware of the special health access needs of pregnant ~~women~~people and infants, especially racial and ethnic minority group populations, in its advocacy on behalf of its patients.
H-265.989	FDA Conflict of Interest	2. It is the position of the AMA that the FDA should undertake an evaluation of pay-later conflicts of interest (e.g., where a FDA advisory committee member develops a financial conflict of interest only after ~~his or her~~their initial appointment on the advisory committee has expired) to assess whether these undermine the independence of advisory committee member recommendations and whether policies should be adopted to address this issue.

H-265.994	Expert Witness Testimony	(3) Existing policy regarding the competency of expert witnesses and their fee arrangements (BOT Rep. SS, A-89) is reaffirmed, as follows: (c) The AMA supports the right to cross examine physician expert witnesses on the following issues: (iv) the frequency with which ~~he or she~~they testified for either plaintiffs or defendants. The AMA supports laws consistent with its model legislation on expert witness testimony.
H-265.997	AMA-ABA Statement on Interprofessional Relations for Physicians and Attorneys	(1) Medical Reports: Physicians, upon proper authorization, should promptly furnish the attorney with a complete medical report, and should realize that delays in providing medical information may prejudice the opportunity of the patient either to settle ~~his~~their claim or suit, delay the trial of a case, or cause additional expense or the loss of important testimony. The attorney should give the physician reasonable notice of the need for a report and clearly specify the medical information which he seeks. (3) Subpoena for Medical Witness: Because of conditions in a particular case or jurisdiction or because of the necessity for protecting ~~himself~~themelves or ~~his~~their client, the attorney is sometimes required to subpoena the physician as a witness. Although the physician should not take offense at being subpoenaed, the attorney should not cause the subpoena to be issued without prior notification to the physician. The duty of the physician is the same as that of any other person to respond to judicial process. (4) Arrangements for Court Appearances: While it is recognized that the conduct of the business of the courts cannot depend upon the convenience of litigants, lawyers or witnesses, arrangements can and should be made for the attendance of the physician as a witness which take into consideration the professional demands upon ~~his~~their time. Such arrangements contemplate reasonable notice to the physician of the intention to call ~~him~~them as a witness and to advise ~~him~~them by telephone after the trial has commenced of the approximate time of ~~his~~their required attendance. The attorney should make every effort to conserve the time of the physician. (5) Physician Called as Witness: The attorney and the physician should treat one another with dignity and respect in the courtroom. The physician should testify solely as to the medical facts in the case and should frankly state ~~his~~their medical opinion. He should never be an advocate and should realize that ~~his~~their testimony is intended to enlighten rather than to impress or prejudice the court or the jury. It is improper for the attorney to abuse a medical witness or to seek to influence ~~his~~their medical opinion. Established rules of evidence afford ample opportunity to test the qualifications, competence, and credibility of a medical witness, and it is always improper and unnecessary for the attorney to embarrass or harass the physician. (7) Payment of Medical Fees: The attorney should do everything possible to assure payment for services rendered by the physician for ~~himself~~themselves or ~~his~~their client. When the physician has not been fully paid, the attorney should request permission of the patient to pay the physician from any recovery which the attorney may receive in behalf of the patient.
H-265.998	Guidelines for Due Process	(1) The physician should be provided with a statement, or a specific listing, of the charges made against ~~him or her~~them. (5) The physician against whom the charges are made should have the opportunity to be present at the hearing and hear all of the evidence against ~~him or her~~them. (6) The physician is entitled to the opportunity to present a defense to the charges against ~~him or her~~them.

H-275.937	Patient/Physician Relationship and Medical Licensing Boards	(1) Without regard to whether an act or failure to act is entirely determined by a physician, or is the result of a contractual or other relationship with a health care entity, the relationship between a physician and a patient must be based on trust and must be considered inviolable. Included among the elements of such a relationship of trust are: (a) Open and honest communication between the physician and the patient, including disclosure of all information necessary for the patient to be an informed participant in ~~his or her~~their care. (5) A (name of state) physician has both medical-legal and ethical obligations to ~~his or her~~their patients. These are well established in both law and professional tradition. Some models of medical practice may result in an inappropriate restriction of the physician's ability to practice quality medicine. This may create negative consequences for the public. It is incumbent that physicians take those actions they consider necessary to assure that medical practice models do not adversely affect the care that they render to their patients.
H-275.953	The Grading Policy for Medical Licensure Examinations	2. Our AMA adopts the following policy on NBME or USMLE examination scoring: b. Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of ~~his or her~~their numerical scores.
H-275.994	Physician Participation in Third Party Payer Programs	The AMA opposes state laws making a physician's licensure contingent upon ~~his~~ providing services to Medicaid beneficiaries or any other specific category of patients should be opposed.
H-275.998	Physician Competence	6. Our AMA urges state medical licensing boards to report all disciplinary actions promptly to the Federation of State Medical Boards and to the AMA Physician Masterfile. (Failure to do so simply allows the incompetent or impaired physician to migrate to another state, even after disciplinary action has been taken against ~~him~~them, and to continue to practice in a different jurisdiction but with the same hazards to the public.)
H-280.968	Do Not Hospitalize Orders	(1) acknowledges that do-not-hospitalize orders in the nursing home situation, when based on the resident's (or ~~his or her~~their family's) informed consent, provide an appropriate means of promoting patient autonomy and carrying out the expressed level of treatment goals and wishes of the resident; and
H-280.999	Physician Involvement in Long-Term Care	1. Our AMA will emphasize in its communications to the medical profession, medical educators, and other professional groups concerned with long-term care the importance of increased physician understanding, supervision of, and involvement in care of the chronically ill and disabled of all ages in all care settings. The AMA believes that physicians have a central role in assuring that all residents of nursing facilities receive thorough assessments and that medical plans of care are instituted or revised to enhance or maintain the resident's physical and psychosocial functioning. The AMA endorses the following "Guidelines for Physicians Attending Patients in Long-Term Care Facilities": D. Each attending physician should designate an alternate physician or should advise ~~his~~their physician exchange of who may be called to see ~~his~~their patients for regular or emergency care when the attending physician is not available. In the event that neither the attending physician nor the designated alternate physician is available to examine and treat a patient requiring immediate attention, the medical director shall have the authority to call another physician for appropriate treatment or treat the patient ~~himself~~themself. E. Prior to or upon admission of a patient, it would be desirable for the attending physician to perform a physical examination of ~~his~~their-patient and provide the facility with an admitting diagnosis, statement of patient's

		functional status, and orders for diet, medication and initial treatment. Other patient information required by the facility may be provided at the time of admission or as soon as practical thereafter and should include a family history, past medical history, report of current medical findings, and a statement of rehabilitation potential and prognosis. The physician should also make arrangements for furnishing the facility with appropriate laboratory, x-ray, and consultation reports. F. Each attending physician is responsible for planning the medical care of ~~his~~their patient. Upon admission of ~~his~~their patient, the physician should make a medical evaluation of ~~his~~their patient's immediate and long-term care needs. This should include information about medications, treatments, rehabilitative services, diets, precautions related to activities undertaken by the patient, and plans for continuing care and, when appropriate, discharge. In developing this plan, it may be necessary for the attending physician to consult with the patient and/or the patient's family. The attending physician should review this plan at least annually and make revisions when appropriate. The plan may be reviewed by the medical director so that he may ensure consistency with the facility's policies. G. The facility should inform each attending physician of the availability of social, psychological and other non-medical aspects of care for ~~his~~their patient so that he may assure ~~himself~~themself that such care is compatible with the medical condition of the patient. H. The attending physician should be aware of the need for the medical director, in fulfilling ~~his~~ required duties, to review the records of patients in the facility and, on occasion, actually contact the patient and/or family. K. The attending physician should visit ~~his~~their patient on a schedule determined by the patient's medical needs, and which is consistent with any state or federal regulations applicable, and this schedule should be documented in the patient's record. The attending physician may review ~~his~~their schedule of visits for each patient in conjunction with an annual reevaluation of the patient's health status. L. During each visit, the attending physician should see ~~his~~their patient, sign all written changes in orders and enter a progress note in the patient's record indicating that the patient has been visited. It should be the duty of the charge nurse to call the attention of the attending physician to orders requiring renewal. Except as specifically indicated below, treatment orders should not be permitted to expire without notification to the attending physician. M. The attending physician should give all orders for treatment in writing. An order may be considered in writing if it is dictated to a licensed nurse, signed and dated by the nurse, and countersigned by the physician at the time of ~~his~~their next visit to the facility or by other acceptable arrangements. Q. The attending physician should be aware that the pharmacist may review the drug regimen of each patient at least monthly and report ~~his~~their comments to the medical director and administrator. In those instances where the medical director and the pharmacist question the appropriateness of the drug regimen, the question should be brought to the attention of the attending physician.

H-285.910	The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community	In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise ~~his/her~~ independent professional judgment and be guided by ~~his/her~~ personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit Physician's right or ability to advocate on behalf of patients' interests or on behalf of good patient care, or to exercise ~~his/her~~**their** own medical judgment. Physician shall not be deemed in breach of this Agreement, nor may Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician's exercise of ~~his/her~~**their** rights under this paragraph.
H-285.952	Amendments to Managed Care Contracts	1. It is policy of our American Medical Association that: e. Our AMA opposes managed care plan mandating that physician to notify all ~~his/her~~**of their** patients. f. Our AMA opposes the preapproval of physician-developed notification letters by managed care plans required if a participating physician who is voluntarily leaving the plan chooses to inform ~~his/her~~**their** patient of the departure.
H-285.962	Anti-Psychiatry Practices of Certain Health Maintenance Organizations and Managed Care Organizations	Our AMA opposes managed care organization (MCO) requirements that a patient determined by ~~his or her~~**their** physician to be in need of specific treatment, including psychiatric treatment, be interviewed by an unqualified employee of the MCO prior to approval of the treatment.
H-285.991	Qualifications and Credentialing of Physicians Involved in Managed Care	1. AMA policy on selective contracting is as follows: (d) Prior to initiation of actions leading to termination or nonrenewal of a physician's participation contract for any reason the physician shall be given notice specifying the grounds for termination or nonrenewal, a defined process for appeal, and an opportunity to initiate and complete remedial activities except in cases where harm to patients is imminent or an action by a state medical board or other government agency effectively limits the physician's ability to practice medicine. Participation in a physician health program in and of itself shall not count as a limit on the ability to practice medicine. Our AMA supports the following appeals process for physicians whose health insurance contract is terminated or not renewed: (v) the physician or ~~his/her~~**their** representative should be able to appear in person at the hearing and present the physician's case;
H-285.998	Managed Care	5. Utilization Review The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payers should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed. Physician of the same specialty must be involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. All health plans conducting utilization management or utilization review should establish an appeals process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and decisions to deny coverage for services, and have the right to review of any coverage denial based on medical necessity by a physician independent of the health plan who is of the same specialty and has appropriate expertise and experience in the field. A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request. Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice

		medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service and should be professionally and individually accountable for ~~his or her~~their decisions. All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the former. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to ~~his or her~~their patients. It is the responsibility of the patient and ~~his or her~~their health benefits plan to inform the treating physician of any coverage restrictions imposed by the plan. All health plans utilizing managed care techniques should be subject to legal action for any harm incurred by the patient resulting from application of such techniques. Such plans should also be subject to legal action for any harm to enrollees resulting from failure to disclose prior to enrollment any coverage provisions; review requirements; financial arrangements; or other restrictions that may limit services, referral, or treatment options, or negatively affect the physician's fiduciary responsibility to ~~his or her~~their patient. When inordinate amounts of time or effort are involved in providing case management services required by a third party payer which entail coordinating access to other health care services needed by the patient, or in complying with utilization review requirements, the physician may charge the payer or the patient for the reasonable cost incurred. "Inordinate" efforts are defined as those "more costly, complex and time-consuming than the completion of standard health insurance claim forms, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage." Any health plan or utilization management firm conducting a prior authorization program should act within two business days on any patient or physician request for prior authorization and respond within one business day to other questions regarding medical necessity of services. Any health plan requiring prior authorization for covered services should provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring prior authorization are recommended by the physicians. In the absence of consistent and scientifically established evidence that preadmission review is cost-saving or beneficial to patients, the AMA strongly opposes the use of this process.
H-290.985	Monitoring Medicaid Managed Care	8. In programs where more than one plan is available, beneficiary freedom to choose ~~his/her~~their plan, enforcement of standards for marketing/enrollment practices, and clear and comparable disclosure of plan benefits and limitations including financial incentives on providers.
H-295.861	Accommodating Lactating ~~Mothers~~Individuals Taking Medical Examinations	*Title change only; no policy change*

H-295.995	Recommendations for Future Directions for Medical Education	(30) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if ~~his or her~~ participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.
H-295.998	Due Process	(2) In addition, to clarify and protect the rights of medical students, the AMA recommends that: (b) These policies and procedures should define the responsible bodies and their function and membership, provide for timely progressive verbal and written notification to the student that ~~his/her~~**their** academic/nonacademic performance is in question, and provide an opportunity for the student to learn why it has been questioned. (c) These policies and procedures should also ensure that when a student has been notified of recommendations by the responsible committee for nonadvancement or dismissal, ~~he/she has~~**they have** adequate notice and the opportunity to appear before the decision-making body to respond to the data submitted and introduce ~~his/her~~**their** own data.
H-315.986	Confidentiality of Patient Records	Our AMA opposes the concept that filing a claim for medical insurance coverage constitutes a blanket waiver of a patient's right to confidentiality of ~~his/her~~**their** medical records for all purposes. The AMA will engage in a major initiative to educate patients about the implications and consequences of blanket medical records releases, and educate patients about the need for possible legislative modifications.
H-315.995	Hospital Face Sheet: Physician Responsibility	The AMA believes that it is the responsibility of the attending physician to specify all diagnoses and procedures in the hospital records, and that no alteration should be made without ~~his or her~~**their** consent.
H-320.954	Post-Partum Hospital Stay and Nurse Home Visits	The AMA: (1) opposes the imposition by third party payers of mandatory constraints on hospital stays for vaginal deliveries and cesarean sections as arbitrary and as detrimental to the health of the ~~mother~~**birthing patient** and of the newborn; and (2) urges that payers provide payment for appropriate follow-up care for the ~~mother~~**birthing patient** and newborn.
H-320.968	Approaches to Increase Payer Accountability	1. Disclosure Requirements. Our American Medical Association supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on: c. Plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to ~~his or her~~**their** patient.
H-320.985	Economic Discharge Order for Utilization Review Committee Denial	(1) reaffirms its policy that economic considerations should not conflict with a physician's primary responsibility to serve the best interests of ~~his or her~~**their** patient and that, if a third party payer or Medicare regulation results in urging of a physician to discharge a patient against the physician's medical judgment, the patient should be so informed and the physician should protest the limitation; and

H-335.996	Spurious Medical Necessity Denials	(2) Until such time as repeal of this provision is achieved, the AMA urges CMS and Medicare Part B carriers to make further changes in the implementation of this authority to correct problems being experienced, including: (f) opposing required wording in the patient waiver form (advance exculpatory notice) that suggests that the physician is about to provide medically unnecessary services to ~~his or her~~their patients.
H-340.907	Notification When Physician Specific Information is Exchanged	Our American Medical Association will petition CMS to require notification of a physician under focused review that ~~his or her~~their name is being exchanged between any carrier and the QIOs and to identify the reason for this exchange of information.
H-340.971	Medicare Program Due Process	The AMA supports legislative and regulatory changes, as necessary, to assure the provision of PRO review with due process protections before any physician is sanctioned under the Medicare Program. Such due process should include at a minimum the following specific protections that would entitle the physician to: (1) a written statement of the charges against ~~him or her~~them; (2) adequate notice of the right to a hearing, ~~his or her~~their rights in the hearing, and a reasonable opportunity to prepare for the hearing; (3) discover the evidence and witnesses against ~~him or her~~them sufficiently in advance of the hearing to enable preparation of the defense; (6) the opportunity to be present at the hearing and hear all of the evidence against ~~him or her~~them;
H-355.975	Opposition to the National Practitioner Data Bank	6. Our AMA opposes any legislative or administrative efforts to expand the Data Bank reporting requirements for physicians, such as the reporting of a physician who is dismissed from a malpractice suit without any payment made on ~~his or her~~their behalf, or to expand the entities permitted to query the Data Bank such as public and private third party payers for purposes of credentialing or reimbursement.
H-365.997	Corporation or Employer-Sponsored Examinations	Our American Medical Association encourages employers who provide or arrange for special or comprehensive medical examinations of employees to be responsible for assuring that these examinations are done by physicians competent to perform the type of examination required. Whenever practical, the employee should be referred to ~~his or her~~their personal physician for such professional services. In the many instances in which an employee does not have a personal physician, efforts should be made to assist ~~him or her~~them in obtaining one, with emphasis on continuity of care. This effort should be aided by the local medical society wherever possible.
H-365.998	Confidentiality of Occupational Medical Records	Our American Medical Association opposes the Department of Labor's rule requiring that, without the informed written consent of the patient-employee, ~~his~~their entire medical record shall be accessible to OSHA.
H-373.995	Government Interference in Patient Counseling	2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use ~~his or her~~their medical judgment as to the information or treatment that is in the best interest of their patients.

H-375.962	Legal Protections for Peer Review	Definitions Proceedings. Proceedings include all of the activities and information and records of a peer review committee. Proceedings are not subject to discovery and no person who was in attendance at a meeting of a peer review organization shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such organization or as to any findings, recommendations, evaluations, opinions, or other actions of such organization or any members thereof. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of a peer review organization, nor should any person who testifies before a peer review organization or who is a member of a peer review organization be prevented from testifying as to matters within ~~his/her~~their knowledge; but such witness cannot be asked about ~~his/her~~their testimony before a peer review organization or about opinions formed by ~~him/her~~them as a result of the peer review organization hearings.
H-375.969	Physician Access to Performance Profile Data	AMA policy is that every physician should be given a copy of ~~his/her~~their practice performance profile information at least annually by each organization retaining such physician information.
H-375.983	Appropriate Peer Review Procedures	(2) Peer review procedures and actions should, at a minimum, meet the Health Care Quality Improvement Act of 1986 standards for federal immunity: (a) In any situation where it appears that a disciplinary proceeding may be instigated against a physician that could result in the substantial loss or termination of the physician's medical staff membership and/or clinical privileges, the advice and guidance of legal counsel should be sought. The accused physician should have legal counsel separate from the health care organization or medical staff. The health care organization and the medical staff should each have separate legal counsel. The attorney of the body bringing the peer review action, be it the health care organization or the medical staff, should undertake the procedures needed to prepare for the hearing including the written notice of charges, the marshaling of evidence and the facts, and the selection of witnesses. This health care organization or medical staff attorney should be instructed that ~~his or her~~their role includes assuring that the proceedings are conducted fairly, bearing in mind the objectives of protecting consumers of health care and the physician involved against false or exaggerated charges. The attorney for the body which is not bringing the peer review action should work to ensure that proper peer review processes as outlined in the medical staff bylaws are followed. The role of the attorney for the accused physician is solely to defend ~~his or her~~their client. (h) Physicians serving on the hearing panel should receive information and training in the elements and essentials of peer review. Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible. Wherever feasible, data collection and analysis, or similar assessment instruments, and multiple reviewers should be used to increase reliability in evaluating whether peer review disciplinary proceedings are warranted. Where feasible, statistical analysis to compare with peers' performance must be used with appropriate case mix adjustments. (i) Physicians who are direct economic competitors of the physician involved may testify as witnesses, whether they are called by the physician or the hearing panel or the health care organization, but a physician should not be deprived of ~~his or her~~their privileges solely on the basis of medical testimony by economic competitors. In any proceedings that result in the termination of privileges, there should be testimony from one or more physicians who are not economic competitors or who do not stand to gain

		economically by an adverse action, but who are knowledgeable in the treatment, patient care management and areas of medical practice or judgment upon which the adverse action is based. (k) When investigation is underway and indicates that a disciplinary proceeding is warranted for the purpose of reducing, restricting, or terminating a physician's hospital privileges, ~~he or she~~they should be notified that resignation will result in a report to the National Practitioner Data Bank.
H-385.923	Definition of "Usual, Customary and Reasonable" (UCR)	1. Our American Medical Association adopts as policy the following definitions: a. "Usual; fee means that fee usually charged, for a given service, by an individual physician to ~~his~~their private patient (i.e., ~~his~~their own usual fee);
H-385.938	Most Favored Nation Clause within Insurance Contracts	Our AMA opposes the inclusion of "Most Favored Nation Clauses" into insurance contracts that require a physician or other health care provider to give a third-party payer ~~his~~their most discounted rate for medical services.
H-385.992	Reimbursement for CT scans and Other Procedures	(1) opposes denial of a physician's right to perform specific services or to be compensated for such services solely on the basis of ~~his~~their specialty designation;
H-390.877	Home Health Care Services	Our AMA urges the federal government to provide an "explanation of medical benefits" statement for post-acute and long-term care (i.e., post-hospital care for sub-acute and chronic illnesses in a variety of health care settings, such as home health agencies and skilled nursing facilities), to the responsible physician, upon ~~his or her~~their request, and to the recipient of such care when covered by Medicare; and urges the federal government to apply a beneficiary co-payment to all home health care services covered by Medicare.
H-390.888	Payment for Concurrent Care	(5) will communicate to CMS the importance of carrier understanding that more than one physician can be involved in a case and that the carrier or insurance company not expect a physician to manage a medical problem outside ~~his/her~~their area of expertise or specialty, and that both the primary care physician or other specialist be reimbursed for this care in accordance with their responsibilities; and
H-390.889	Medicare Reimbursement of Telephone Consultations	5. It is the policy of our AMA to seek enactment of legislation as needed to allow separate Medicare payment for those telephone calls that can be considered discrete and medically necessary services performed for the patient without ~~his/her~~their presence.
H-390.917	Consultation Follow-Up and Concurrent Care of Referral for Principal Care	(1) It is the policy of the AMA that: (a) the completion of a consultation may require multiple encounters after the initial consultative evaluation; and (b) after completion of the consultation, the consultant may be excused from responsibility of the care of the patient or may share with the primary care physician in concurrent care; ~~he/she~~they may also have the patient referred for care and thus become the principal care physician.
H-390.971	Hospitals Limited to Participating Physicians	3. Our AMA urges a return to the original intent of the Medicare Law (Title XVIII) as expressed in Sections 1801 and 1802 enacted in 1965 which read as follows: "Section 1801 [42 U.S.C. 1895] Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person." "Section 1802 [42 U.S.C. 1895a] Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide ~~him~~ such services"

H-410.971	Clinical Algorithm Impact on Patient Care	1) Clinical algorithms are guidelines established to aid a physician in the diagnosis and treatment of patients. As such, they should be used by the physicians as guidelines, but recognizing that each patient is an individual and has unique needs and problems, the physician should use ~~his or her~~their best judgment in the use of the guidelines and should never be forced to specifically follow these guidelines rigidly.
H-420.947	Support for International Aid for Reproductive Health	1. Our American Medical Association opposes restrictions on U.S. funding to non-governmental organizations solely because they provide reproductive health care internationally, including but not limited to contraception and abortion care. 2. Our AMA supports funding for global humanitarian and non-governmental organizations for ~~maternal~~obstrectric care ~~healthcare~~ and comprehensive reproductive health services, including but not limited to contraception and abortion care.
H-420.953	Improving Mental Health Services ~~for~~During Pregnan~~t~~cy and Postpartum ~~Mothers~~	*Title change only; no policy change*
H-420.954	Truth and Transparency in Pregnancy Counseling Centers	4. Our AMA advocates that any entity licensed to provide medical or health services to pregnant ~~women~~people
H-420.957	Shackling of Pregnant ~~Women~~Patients in Labor	1. Our American Medical Association supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering ~~her~~a baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents: • An immediate and serious threat of harm to ~~herself~~themselves, staff or others. • A substantial flight risk and cannot be reasonably contained by other means." If an inmate who is in labor or who is delivering ~~her~~a baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used. 2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant ~~women~~people unless flight or safety concerns exist.
H-420.962	Perinatal Addiction - Issues in Care and Prevention	Our AMA: (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding ~~women~~people wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding ~~women~~people, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children
H-420.964	Fetal Alcohol Syndrome Educational Program	Our American Medical Association supports informing physicians about Fetal Alcohol Syndrome and the referral and treatment of alcohol abuse by pregnant ~~women~~patients or ~~women~~patients at risk of becoming pregnant.

H-420.968	Universal Hepatitis B Virus (HBV) Antigen Screening for Pregnant ~~Women~~People	It is the policy of our American Medical Association to communicate the available guidelines for testing all pregnant ~~women~~people for HBV infection.
H-420.969	Legal Interventions During Pregnancy	Court Ordered Medical Treatments And Legal Penalties For Potentially Harmful Behavior By Pregnant ~~Women~~Persons: (1) Judicial intervention is inappropriate when a ~~woman~~pregnant patient has made an informed refusal of a medical treatment designed to benefit ~~her~~their fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the ~~woman~~pregnant patient, entails a minimal invasion of ~~her~~their bodily integrity, and would clearly prevent substantial and irreversible harm to ~~her~~their fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases which do not present such exceptional circumstances. (2) The physician's duty is to provide appropriate information, such that the pregnant ~~woman~~patient may make an informed and thoughtful decision, not to dictate the ~~woman's~~patient's decision. (3) A physician should not be liable for honoring a pregnant ~~woman's~~patient's informed refusal of medical treatment designed to benefit the fetus. (4) Criminal sanctions or civil liability for harmful behavior by the pregnant ~~woman~~person toward ~~her~~their fetus are inappropriate.
H-420.972	Prenatal Services to Prevent Low Birthweight Infants	Our American Medical Association encourages all state medical associations and specialty societies to become involved in the promotion of public and private programs that provide education, outreach services, and funding directed at prenatal services for pregnant ~~women~~people, particularly ~~women~~those at risk for delivering low birthweight infants.
H-420.973	Adoption	(2) support and encourage the counseling of ~~women~~people with unintended pregnancies as to the option of adoption.
H-420.978	Access to Prenatal Care	1. Our American Medical Association supports development of legislation or other appropriate means to provide for access to prenatal care for all ~~women~~, with alternative methods of funding, including private payment, third party coverage, and/or
H-420.979	AMA Statement on Family, Medical, and Safe Leave	Our American Medical Association supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid: 1. Medical leave for the employee, including pregnancy, abortion, and stillbirth. 2. Maternity leave for the employee ~~mother~~. 3. Leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children. 4. Leave for adoption or for foster care leading to adoption. 5. Safe leave provisions for those experiencing any instances of violence, including but not limited to intimate partner violence, sexual violence or coercion, and stalking.
H-420.998	Obstetrical Delivery in the Home or Outpatient Facility	(3) believes that obstetrical facilities and their staff should recognize the wishes of ~~women~~patients and their families within the bounds of sound obstetrical practice; and

H-435.951	Health Court Principles	AMA PRINCIPLES FOR HEALTH COURTS V. Experts Party Expert Witnesses - Health courts should only allow medical expert witnesses to testify if the expert witness is licensed as a doctor of medicine or osteopathy. - An expert witness should be trained and experienced in the same field as the defendant or has specialty expertise in the disease process or procedure performed in the case. - An expert witness should be certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association, or by a board with equivalent standards. - An expert witness should, within five years of the date of the alleged occurrence or omission giving rise to the claim, be in active medical practice in the same field as the defendant, or have devoted a substantial portion of ~~his~~their-time teaching at an accredited medical school, or in university-based research in relation to the medical care and type of treatment at issue. - A person who testifies as an expert witness in a health court should be deemed to have a temporary license to practice medicine in the state for the purpose of providing such testimony and should be subject to the jurisdiction of the state medical board.
H-435.973	Report of the Special Task Force on Professional Liability and the Advisory Panel on Professional Liability	(2) Implementation of the "Loser Pays" Rule in Medical Liability Litigation: Responsibility for a prevailing party's legal expenses, including attorney fees, should not be shifted to a losing party in medical liability litigation unless (c) the rule is adopted that no losing party will be required to pay expenses including legal fees that exceed ~~his or her~~their own bill for such goods or services; and
H-440.863	Restoring the Independence of the Office of the US Surgeon General	(2) calls for the Office of the United States Surgeon General to be free from the undue influence of politics, and be guided by science and the integrity of ~~his/her~~their role as a physician in fulfilling the highest calling to promote the health and welfare of all people.
H-440.898	Recommendations on Folic Acid Supplementation	2. Our AMA will continue to encourage broad-based public educational programs about the need for ~~women~~people of child-bearing potential to consume adequate folic acid through nutrition, food fortification, and vitamin supplementation to reduce the risk of NTD.
H-440.970	Nonmedical Exemptions from Immunizations	1. Our American Medical Association believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in ~~his or her~~their group and the community at large.
H-470.963	Boxing Safety	(1) Relevant regulatory bodies are encouraged to: (b) develop and enforce standard criteria for referees, ringside officials, and ringside physicians to halt sparring or boxing bouts when a boxer has experienced concussive or subconcussive blows that place ~~him or her~~them at imminent risk of more serious injury.
H-470.978	Blood Doping	The AMA believes that a physician who participates in blood doping is deviating from ~~his~~their professional responsibility and that blood doping must be considered in the category of unnecessary medical services.
H-470.984	Brain Injury in Boxing	(2) Recommend to all boxing jurisdictions that the ring physician should be authorized to stop any bout in progress, at any time, to examine a contestant and, when indicated, to terminate a bout that might, in ~~his~~their opinion, result in serious injury for either contestant.
H-475.997	Same-Day Admission for Elective Surgery	Our American Medical Association accepts the practice of same-day admission for elective surgery, unless this practice is determined to be detrimental to the patient's health by ~~his or her~~their physician. The determination of the advisability of same-day admission and/or outpatient

		surgery should be based on the judgment of the patient's physician and not solely on prescribed lists of procedures.
H-480.943	Integration of Mobile Health Applications and Devices into Practice	6. Our AMA encourages physicians to alert patients to the potential privacy and security risks of any mHealth apps that ~~he or she~~they prescribe~~s~~ or recommend~~s~~, and document the patient's understanding of such risks
H-485.991	Identification of Physicians by the Media	It is the policy of our AMA to communicate to the media that when a physician is interviewed or provides commentary ~~he or she~~they be specifically identified with the appropriate initials "MD" or "DO" after ~~his or her~~their name; and that others be identified with the appropriate degrees after their names.
H-515.965	Family and Intimate Partner Violence	(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before ~~he or she~~they leave~~s~~ the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course;
H-525.980	Expansion of AMA Policy on Female Genital Mutilation	Our AMA: (3) supports legislation to eliminate the performance of female genital mutilation in the United States and to protect young **girls** and **women** at risk of undergoing the procedure; (4) supports that physicians who are requested to perform genital mutilation on a patient provide culturally sensitive counseling to educate the patient and ~~her~~ family members about the negative health consequences of the procedure, and discourage them from having the procedure performed. Where possible, physicians should refer the patient to social support groups that can help them cope with societal mores;

Appendix B - Policies recommending being retained as written

Policy Number	Title	Policy Language
D-245.994	Infant Mortality	2. Our AMA will work with Congress and the Department of Health and Human Services to improve maternal outcomes through: (a) maternal/infant health research at the NIH to reduce the prevelance of premature births and to focus on obesity research, treatment and prevention; (b) maternal/infant health research and surveillance at the CDC to assist states in setting up maternal mortality reviews; modernize state birth and death records systems to the 2003-recommended guidelines; and improve the Safe Motherhood Program; (c) maternal/infant health programs at HRSA to improve the Maternal Child Health Block grant; (d) comparative effectiveness research into the interventions for preterm birth; (e) disparities research into maternal outcomes, preterm birth and pregnancy-related depression; and (f) the development, testing and implementation of quality improvement measures and initiatives.

H-20.903	HIV/AIDS and Substance Use	4. Our AMA urges development of educational, medical, and social support programs for persons who inject drugs and their sexual or needle-sharing partners to reduce risk of HIV infection, as well as risk of other bloodborne and sexually transmissible diseases. Such efforts must target a. pregnant people who inject drugs and those who may become pregnant to address the current and future health care needs of both mothers and newborns and
H-20.922	HIV/AIDS as a Global Public Health Priority	6. Our AMA, in coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods.
H-60.973	Provision of Health Care and Parenting Classes to Adolescent Parents	1. It is the policy of our American Medical Association: a. to encourage state medical and specialty societies to seek to increase the number of adolescent parenting programs within school settings which provide health care for infant and mother, and child development classes in addition to current high school courses; and
H-75.987	Reducing Unintended Pregnancy	Our AMA: (1) urges health care professionals to provide care for women of reproductive age, to assist them in planning for pregnancy and support age-appropriate education in esteem building, decision-making and family life in an effort to introduce the concept of planning for childbearing in the educational process;
H-245.982	AMA Support for Breastfeeding	1. Our AMA: (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places. 2. Our AMA: (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; 3. Our AMA: (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period. 5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines.

H-295.890	Medical Education and Training in Women's Health	1. Our American Medical Association encourages the coordination and synthesis of the knowledge, skills, and attitudinal objectives related to women's health/gender-based biology that have been developed for use in the medical school curriculum. Medical schools should include attention to women's health throughout the basic science and clinical phases of the curriculum. 2. Our AMA does not support the designation of women's health as a distinct new specialty. 3. Our AMA supports that each specialty should define objectives for residency training in women's health, based on the nature of practice and the characteristics of the patient population served. 4. Our AMA supports surveys of undergraduate and graduate medical education, conducted by the AMA and other groups, should periodically collect data on the inclusion of women's health in medical school and residency training. 5. Our AMA encourages the development of a curriculum inventory and database in women's health for use by medical schools and residency programs. 6. Our AMA encourages physicians to include continuing education in women's health/gender-based biology as part of their continuing professional development. 7. Our AMA encourages its representatives to the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education (ACGME), and the various ACGME Review Committees to promote attention to women's health in accreditation standards. 8. Our AMA will work with the ACGME to protect patient access to important reproductive health services by advocating for all family medicine residencies to provide comprehensive women's health, including training in contraceptive counseling, family planning, and counseling for unintended pregnancy. 9. Our AMA encourages the ACGME to ensure clarity when making revisions to the educational requirements and expectations of family medicine residents in comprehensive women's health topics.
H-420.970	Treatment Versus Criminalization - Physician Role in Drug Addiction During Pregnancy	(2) to forewarn the U.S. government and the public at large that there are extremely serious implications of drug addiction during pregnancy and there is a pressing need for adequate maternal drug treatment and family supportive child protective services; (3) to oppose legislation which criminalizes maternal drug addiction or requires physicians to function as agents of law enforcement - gathering evidence for prosecution rather than provider of treatment; and (4) to provide concentrated lobbying efforts to encourage legislature funding for maternal drug addiction treatment rather than prosecution, and to encourage state and specialty medical societies to do the same.
H-420.971	Infant Victims of Substance Abuse	It is the policy of the AMA: (1) to develop educational programs for physicians to enable them to recognize, evaluate and counsel women of childbearing age about the impact of substance use disorders on their children; and (2) to call for more funding for treatment and research of the long-term effects of maternal substance use disorders on children.
H-420.976	Alcohol and Other Substance Abuse During Pregnancy	(3) encourages intensified research into the physical and psychosocial aspects of maternal substance abuse as well as the development of efficacious prevention and treatment modalities.
H-420.995	Medical Care for Indigent and Culturally Displaced Obstetrical Patients and Their Newborns	Our AMA (1) reaffirms its long-standing position regarding the major importance of high-quality obstetrical and newborn care by qualified obstetricians, family physicians, and pediatricians and the need to make such care available to all women and newborns in the United States;

		(3) favors continuing discussion of means for improving maternal and child health services for the medically indigent and the culturally displaced.
H-425.976	Preconception Care	1. Our American Medical Association supports the 10 recommendations developed by the Centers for Disease Control and Prevention for improving preconception health care that state: 1. Individual responsibility across the lifespan--each woman, man, and couple should be encouraged to have a reproductive life plan. 2. Preventive visits--as a part of primary care visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes. 3. Interventions for identified risks--increase the proportion of women who receive interventions as follow-up to preconception risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact). 4. Inter-conception care--use the inter-conception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth). 5. Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and pre-conception and inter-conception care. 6. Public health programs and strategies--integrate components of pre-conception health into existing local public health and related programs, including emphasis on inter-conception interventions for women with previous adverse outcomes. 2. Our AMA supports the education of physicians and the public about the importance of preconception care as a vital component of a woman's reproductive health. 3. Our AMA supports the use of pregnancy intention screening and contraceptive screening in appropriate women and men as part of routine well-care and recommend it be appropriately documented in the medical record.
H-430.986	Health Care While Incarcerated	8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
H-430.990	Bonding Programs for **Women** Prisoners and their Newborn Children	Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, Our American Medical Association supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. However, since there are established benefits of breast milk for infants and breast milk expression for mothers, the AMA advocates for policy and legislation that extends the right to breastfeed directly and/or privately pump and safely store breast milk to include incarcerated mothers. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of incarcerated females who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills and breastfeeding/breast pumping training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children.

H-525.991	Inclusion of Women in Clinical Trials	Our AMA: (1) encourages the inclusion of women, including pregnant women when appropriate, in all research on human subjects, except in those cases for which it would be scientifically irrational, in numbers sufficient to ensure that results of such research will benefit both men and women alike;