

Reference Committee F

Report(s) of the Board of Trustees

- 04 AMA 2025 Dues
- 21 American Medical Association Meeting Venues and Accessibility
- 23 United States Professional Association for Transgender Health Observer Status in the House of Delegates
- 25 Environmental Sustainability of AMA National Meetings. Supporting Carbon Offset Programs for Travel for AMA Conferences
- 26 Equity and Justice Initiatives for International Medical Graduates
- 28 Encouraging Collaboration Between Physicians and Industry in AI Development
- 33 Employed Physicians

Report(s) of the Council on Constitution and Bylaws and the Council on Long Range Planning and Development

- 01 Joint Council Sunset Review of 2014 House Policies

Report(s) of the Council on Long Range Planning and Development

- 01 Establishment of a LGBTQ+ Section

Report of the House of Delegates Committee on the Compensation of the Officers

- 01 Compensation Committee Report

Report(s) of the Speakers

- 01 Report of the Resolution Modernization Task Force Update

Resolutions

- 601 Annual Holocaust Remembrance Event
- 602 Ranked Choice Voting
- 603 End Attacks on Health and Human Rights in Israel and Palestine
- 604 Confronting Ageism in Medicine
- 605 Walking the Walk of Climate Change
- 606 Creation of an AMA Council with a Focus on Digital Health Technologies and AI
- 607 Appealing to our AMA to add clarity to its mission statement to better meet the need of physicians, the practice of medicine and the public health
- 608 The American Medical Association Diversity Mentorship Program

REPORT OF THE BOARD OF TRUSTEES

B of T Report 04-A-24

Subject: AMA 2025 Dues

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee F

1
2 Our American Medical Association (AMA) last raised its dues in 1994. The AMA continues to
3 invest in improving the value of membership. As our AMA’s membership benefits portfolio is
4 modified and enhanced, management will continuously evaluate dues pricing to ensure
5 optimization of the membership value proposition.

6
7 RECOMMENDATION

8
9 2025 Membership Year

10
11 The Board of Trustees recommends no change to the dues levels for 2024, that the following be
12 adopted and that the remainder of this report be filed:

13

14	Regular Members	\$ 420
15	Physicians in Their Fourth Year of Practice	\$ 315
16	Physicians in Their Third year of Practice	\$ 210
17	Physicians in Their Second Year of Practice	\$ 105
18	Physicians in Their First Year of Practice	\$ 60
19	Physicians in Military Service	\$ 280
20	Semi-Retired Physicians	\$ 210
21	Fully Retired Physicians	\$ 84
22	Physicians in Residency/Fellow Training	\$ 45
23	Medical Students	\$ 20

24
25 (Directive to Take Action)

Fiscal Note: No significant fiscal impact.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 21-A-24

Subject: American Medical Association Meeting Venues and Accessibility
(Board of Trustees Report 12-I-23, RES 602-I-22)

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee F

1 At the 2023 Interim Meeting, Board of Trustees Report 12 American Medical Association Meeting
2 Venues and Accessibility responded to Resolution 602-I-22 and proposed amendments to Policy
3 G-630.140 which would have expanded options for meeting venues selection. The Report was
4 referred to the 2024 Annual meeting. Policy G-630.140 (4) states:

5
6 4. It is the policy of our AMA not to hold meetings organized and/or primarily sponsored by
7 our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club,
8 restaurant, or other institution, that has exclusionary policies, including, but not limited to,
9 policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex,
10 sexual orientation, gender, gender identity and gender expression, disability, or age unless
11 intended or existing contracts or special circumstances justify an exception to this policy.
12

13 This report responds to referred Board of Trustees Report 12, specifically addressing concerns
14 about assurances and guarantees for personal safety and medical care in an emergency.
15

16 DISCUSSION

17
18 The Board has heard member concerns and recommends that current policy remain in place and be
19 strictly enforced at all AMA meetings of the AMA. It is at the discretion of the House of Delegates
20 to change current policy.
21

22 CONCLUSION

23
24 This principled approach reflects the AMA's ongoing commitment to advocating for policies that
25 safeguard reproductive rights and combat discrimination. The organization remains steadfast in
26 promoting an inclusive and supportive environment for all members and attendees.
27

28 RECOMMENDATION

29
30 The Board therefore recommends Policy G-630.140 be reaffirmed and is strictly enforced as a
31 resolute stance against all forms of discrimination, and support of evidenced-based medicine,
32 underscoring our commitment to fostering an inclusive and safe environment for all attendees. This
33 strategic recommendation places a primary emphasis on prioritizing attendee safety, reflecting the
34 values and principles upheld by the AMA.

1 **Relevant AMA Policy**

2

3 **Policy G-630.140 Lodging, Meeting Venues, and Social Functions**

4 1. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size,
5 service, location, cost, and similar factors.

6 2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly
7 Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.

8 3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in
9 a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free
10 worksites and public places (including restaurants and bars), unless intended or existing contracts
11 or special circumstances justify an exception to this policy, and our AMA encourages state and
12 local medical societies, national medical specialty societies, and other health organizations to adopt
13 a similar policy.

14 4. It is the policy of our AMA not to hold meetings organized and/or primarily sponsored by our
15 AMA, in cities, counties, or states, or pay member, officer or employee dues in any club,
16 restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies
17 based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual
18 orientation, gender, gender identity and gender expression, disability, or age unless intended or
19 existing contracts or special circumstances justify an exception to this policy.

20 5. Our AMA staff will work with facilities where AMA meetings are held to designate an area for
21 breastfeeding and breast pumping.

22 6. All future AMA meetings will be structured to provide accommodations for members and
23 invited attendees who are able to physically attend, but who need assistance in order to
24 meaningfully participate.

Fiscal Note: Minimal

REPORT OF THE BOARD OF TRUSTEES

B of T Report 23-A-24

Subject: United States Professional Association for Transgender Health Observer Status in the House of Delegates

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee F

1 The Board of Trustees has received a request from the United States Professional Association for
2 Transgender Health (USPATH) to be considered for Official Observer status in the House of
3 Delegates (HOD). The USPATH’s request has been thoroughly considered using the criteria below
4 (Policy G-600.025, “Official Observers in Our AMA House”):
5

- 6 1. The organization and the AMA should already have established an informal relationship
7 and have worked together for the mutual benefit of both;
- 8 2. The organization should be national in scope and have similar goals and concerns about
9 health care issues;
- 10 3. The organization is expected to add a unique perspective or bring expertise to the
11 deliberations of the HOD; and
- 12 4. The organization does not represent narrow religious, social, cultural, economic, or
13 regional interests so that formal ties with the AMA would be welcomed universally by
14 AMA members.
15

16 The Board has discussed the USPATH’s request and presents the following report.

17
18 DISCUSSION

19
20 As part of its request, USPATH submitted information on how it has met the criteria for Official
21 Observer status, which is summarized below.
22

23 *Criterion 1. The organization and the AMA should already have established an informal*
24 *relationship and have worked together for the mutual benefit of both.*
25

26 USPATH has established informal relationships with the AMA through member and board
27 member involvement in the AMA Advisory Committee on LGBTQ Issues as well as the business
28 of the AMA HOD. Given their national scope, USPATH shares similar goals and concerns as the
29 AMA in ensuring appropriate access to and practice of evidence-based medicine and the
30 elimination of barriers to care placed between physicians and their patients.
31

32 *Criterion 2. The organization should be national in scope and have similar goals and concerns*
33 *about health care issues.*
34

35 USPATH is regional affiliate organization of the World Professional Association for Transgender
36 Health (WPATH), which is an interdisciplinary professional and educational organization devoted

1 to transgender health. USPATH professional, supporting, and student members engage in clinical
2 and academic research to develop evidence-based medicine and strive to promote a high quality of
3 care for transgender and gender-nonconforming individuals within the US.

4
5 As a national interdisciplinary, professional organization, USPATH works to further the
6 understanding and treatment of gender dysphoria by professionals in medicine, psychology, law,
7 social work, counseling, psychotherapy, family studies, sociology, anthropology, sexology, speech
8 and voice therapy, and additional related fields. USPATH provides opportunities for professionals
9 from various sub-specialties to communicate with each other in the context of research and
10 treatment of gender dysphoria including sponsoring biennial scientific symposia. USPATH is a
11 regional affiliate of WPATH, which publishes the Standards of Care for the Health of Transgender
12 and Gender Diverse People, Version 8, which articulate a professional consensus about the
13 psychiatric, psychological, medical, and surgical management of gender dysphoria and help
14 professionals understand the parameters within which they may aid those with these conditions.
15 The Standards of Care are frequently cited to support current AMA policy regarding gender-
16 affirming care.

17
18 *Criterion 3. The organization is expected to add a unique perspective or bring expertise to the*
19 *deliberations of the HOD.*

20
21 Given their multi-disciplinary membership and focus on a particular area of health care, USPATH
22 will add a unique perspective and bring expertise to the deliberations of the AMA HOD.

23
24 *Criterion 4. The organization does not represent narrow religious, social, cultural, economic, or*
25 *regional interests so that formal ties with the AMA would be welcomed universally by AMA*
26 *members.*

27
28 The USPATH does not represent narrow religious, social, cultural, economic, or regional interests
29 and has already been welcomed to participate in previous AMA activities.

30
31 The Board of Trustees appreciates the previous involvement of USPATH with the AMA Advisory
32 Committee on LGBTQ Issues and believes that the USPATH should be recognized as an Official
33 Observer and welcomed to the House in that capacity.

34
35 RECOMMENDATION

36
37 The Board of Trustees recommends that the United States Professional Association for
38 Transgender Health be admitted as an Official Observer in the House of Delegates, and that the
39 remainder of this report be filed.

Fiscal Note: Under \$500

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
US Pharmacopeia	1998

REPORT OF THE BOARD OF TRUSTEES

B of T Report 25-A-24

Subject: Environmental Sustainability of AMA National Meetings. Supporting Carbon Offset Programs for Travel for AMA Conferences (RES 603-A-23 and 608-A-23)

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee F

1 At the 2023 Annual Meeting, Resolutions 603- Environmental Sustainability of AMA National
2 Meetings and 608 - Supporting Carbon Offset Programs for travel for AMA Conferences were
3 introduced. Both resolutions received testimony in favor of referral. Testimony also suggested that
4 our American Medical Association (AMA) lead the health care profession by example and that a
5 strategic plan to address environmental sustainability be developed with attention to fiscal impact.
6 This report is in direct response to the two referred resolutions addressing AMA’s commitment to
7 sustainability of AMA National Meetings and exploring supporting carbon offset programs for
8 travel for AMA Conferences
9

10 DISCUSSION

11
12 The AMA recognizes the imperative to lead by example and play a proactive role in promoting
13 environmental stewardship within the health care community. Resolutions 603 and 608 calls for the
14 AMA to commit to reducing carbon emissions and fostering a more sustainable future. Resolution
15 603 calls for the AMA to commit to reaching net-zero emissions for its business operations by
16 2030, and advocates for the reduction of emissions within the broader health care system.
17

18 Resolution 608 focuses on the importance of mitigating carbon emissions related to AMA events
19 and calls for exploring opportunities for attendees to offset their environmental impact. While these
20 resolutions highlight AMA’s dedication to sustainability, it is also crucial to develop a
21 comprehensive plan, considering all related implications and ensuring effective implementation.
22 After initial research and consultation with relevant stakeholders, we are sharing an update on
23 AMA’s progress towards achieving carbon neutrality within our AMA and encouraging similar
24 efforts within the broader health care system. Below is a summary of our findings and the next
25 steps.
26

27 *Net Zero Emissions for Business Operations by 2030*

28
29 AMA is committed to progressing towards reaching net zero emissions for business operations by
30 2030, by continuing to execute against the current initiatives and expanding upon them. Our team
31 has already begun implementing measures to reduce our carbon footprint, including but not limited
32 to:
33

34 Renegotiating the Chicago headquarters’ lease with a LEED-Gold certified building and
35 advocating for sustainable practices with our corporate partner vendors.

1 Making multiple energy efficient upgrades within our facilities:

2
3 New HVAC systems (including Merv-13 filtration) were added on each floor, resulting in a 35
4 percent energy reduction.

5
6 Lighting retrofits, including adding LEDs and a daylight harvesting feature in the lobby to
7 automatically dim the lights according to the amount of sunlight entering the building), produced a
8 savings of two million kilowatt-hours per year, or 70 percent less energy.

9
10 Water conservation programs:

- 11 • A restroom retrofit to incorporate low-flow fixtures (e.g., toilets that use 1.60 gallons
12 of water per minute (gpm), urinals at 1 gpm and faucet aerators at 0.5 gpm).
- 13 • A 20 percent energy savings by re-landscaping with low-water plants like native
14 perennials and sedum.
- 15 • Adding meters on all hoses, and a green-roof water supply to monitor usage and detect
16 leaks.
- 17 • 50 percent of AMA Plaza's roof houses a green vegetable garden, which not only
18 reduces carbon dioxide emissions but also slows the amount of rainfall runoff that goes
19 to Chicago's sewer system. The roof at AMA Plaza is also home to a vegetable garden
20 and bee program, which harvests honey twice a year.

21
22 AMA utilizes a shuttlebus service, bike area, on-site Zipcars and scooter and hybrid vehicle
23 parking: all of which contribute to nine metric tons of carbon emissions reduction (the shuttlebuses
24 alone save an average of 65,000 pounds in carbon dioxide emissions per month).

25
26 AMA's HQ café sources local food and participates in the building's compost program, which
27 collects 70 percent of its waste; AMA staff and visiting members/meeting attendees can charge
28 their electronics using solar-powered benches in AMA plaza.

29
30 AMA reduced its waste generation (paper and otherwise) and implemented enhanced recycling
31 programs.

32
33 Leadership has encouraged telecommuting and virtual meetings to minimize travel emissions.

34 35 *Evaluating Feasibility of Carbon Offsets and Sustainable Meeting Practices*

36
37 Investing in projects to increase AMA's energy efficiency can contribute to reducing AMA's
38 carbon emissions at a relatively low cost. Partnering with vendors that use renewable energy
39 sources can also offer a cost-effective way to offset carbon emissions, and we continue to explore
40 new vendors who generate clean energy, displacing the need for fossil fuel-based electricity and
41 effectively reducing overall carbon emissions.

42
43 Leadership in Energy and Environmental Design (LEED) is the world's most widely used green
44 building rating system, providing a framework for healthy, efficient, cost-effective buildings
45 offering environmental, social, and other benefits. The AMA has tenancy in three locations
46 (Chicago, DC, and Greenville) that have implemented varying sustainability best practices
47 including LEED Green Certification, light sensors, recycling, etc. within their building guidelines.
48 The AMA also instituted a requirement to contract exclusively with LEED-certified conference
49 centers for Annual and Interim meetings in 2030. The Annual and Interim meetings have been
50 contracted through 2029 with Hyatt and Marriott: AMA has committed to Hyatt Regency Chicago,
51 a LEED-certified building, for AMA's Annual meeting through 2029; Hyatt's World of Care

1 program is committed to advancing environmental action. AMA has contracted with Marriott
2 properties through 2029 for Interim meetings; Marriott is integrating sustainability across their
3 properties and is committed to mitigating climate-related risk, reducing environmental impact,
4 building and operating sustainable hotels and sourcing responsibly (Gaylord National Resort and
5 Convention Center in National Harbor, Maryland, recently announced a partnership with Unison
6 Energy to commission a six-megawatt combined heat and power system to reduce its carbon
7 footprint).

8
9 AMA is also pleased to announce that the forthcoming 2027 and 2029 Interim Meetings will be
10 held at the prestigious Gaylord Pacific, currently under construction. Gaylord Pacific is being
11 meticulously designed to adhere to California's stringent energy code Title 24, surpassing even the
12 standards set by LEED certified buildings. The project incorporates all coastal development
13 mandates, positioning it as one of the most sustainable hotel and resort destinations in the United
14 States; this commitment to environmental sustainability aligns seamlessly with the AMA's values
15 and underscores our dedication to hosting events that prioritize sustainability and environmental
16 stewardship.

17 18 CONCLUSION

19
20 In conclusion, the AMA is committed to continuing to execute against our current initiatives, and
21 expanding upon them, to achieve environmental sustainability. These resolutions reflect our
22 proactive stance in reducing carbon emissions and championing sustainability initiatives within our
23 organization and the broader health care sector. Through our efforts, we demonstrate our dedication
24 to mitigating the environmental impact of our business operations. Additionally, our commitment
25 to limiting carbon emissions generated by AMA events and researching opportunities for attendees
26 to offset their environmental impact, highlights our holistic approach to sustainability. Through
27 these initiatives, the AMA reaffirms its commitment to environmental stewardship and welcomes
28 the opportunity to drive meaningful change within the health care ecosystem and beyond.

29
30 RECOMMENDATION: The Board of Trustees recommends that the following be adopted in lieu
31 of Resolutions 603-A-23 and 608-A-23, and the remainder of the report be filed:

- 32
33 1. Our AMA is committed to progression to net zero emissions for its business operations by
34 2030, by continuing and expanding energy efficiency upgrades, waste reduction initiatives, and
35 the transition to renewable energy sources (New HOD Policy).
- 36
37 2. Our AMA will prioritize sustainable organizational practices to reduce emissions over
38 purchasing carbon offsets (New HOD Policy).
- 39
40 3. Our AMA will continue to prioritize collaboration within the health care community by sharing
41 the learnings from our sustainability initiative to inspire our peer organizations to follow suit
42 and adopt similar environmentally conscious practices (Directive-to-Take-Action).

Fiscal Note: \$20,000

REPORT OF THE BOARD OF TRUSTEES

B of T Report 26-A-24

Subject: Equity and Justice Initiatives for International Medical Graduates

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee F

1 BACKGROUND

2

3 At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD),
4 Resolution 605-A-23, “Equity and Justice Initiatives for International Medical Graduatesⁱ,” sponsored by
5 the International Medical Graduates Section, was referred to the Board of Trustees. Resolution 605-A-23
6 requested:

7

8 1. That our American Medical Association, via the Center for Health Equity, create a yearly session
9 (during the Interim or Annual Meeting) as a part of the equity forum that will be dedicated to
10 international medical graduates (Directive to Take Action); and

11

12 2. That our AMA, via the Center of Health Equity, create an amendment to the health equity plan
13 that will address the issues of equity and justice for international medical graduates. (Directive to
14 Take Action)

15

16 DISCUSSION

17

18 This report seeks to provide clarity to two questions: (1) Whether the AMA should, via the Center for
19 Health Equity, create a yearly session (during the Interim or Annual Meeting) as part of the equity forum
20 that will be dedicated to international medical graduates; and (2) Whether the AMA should, via the
21 Center for Health Equity, create an amendment to the health equity plan that will address the issues of
22 equity and justice for international medical graduates.

23

24 *AMA Health Equity Open Forum*

25

26 In 2022, at the Annual Meeting, the HOD adopted new policy titled “Continuing Equity Education G-
27 600.960”, which instructed AMA to establish an Open Forum on Health Equity, to be held at least
28 annually at a House of Delegates Meeting, for members to directly engage in educational discourse and
29 strengthen organizational capacity to advance and operationalize equity.

30

31 Prior to its adoption, Resolution 611-A-22, as it was known at the time, was discussed openly during the
32 Reference Committee F Hearing. The resulting committee report provided:

33

34 Reference Committee heard supportive testimony acknowledging the importance of
35 prioritizing equity through forums, education sessions, and other programming. Testimony
36 supported changing the frequency of educational opportunities to each House of Delegates
37 meeting, noting that it will increase education and awareness of the effects of bias,
38 prejudice, and racism in medicine. During testimony, it was mentioned that a call for

1 education sessions is made prior to each House of Delegates meeting. For the June 2022
2 meeting, the Center for Health Equity opted to host education sessions in lieu of an open
3 forum. Format and timing of educational sessions at the House of Delegates is at the
4 discretion of the Speakers in consultation with subject matter experts. In addition, the
5 proffered language allows for the potential of additional sessions offered online,
6 asynchronous to the House of Delegates meeting, or even at other AMA sponsored
7 meetings.ⁱⁱ
8

9 The report provides many details, but it appears that delegates and attendees did not discuss specific
10 subject matter to be presented at each open forum, subsequently leaving the policy open to interpretation.
11 This is not an uncommon practice, if one were to skim through AMA policy, they would find that many
12 organizational policies have been adopted in the same manner relying on staff experts to take the lead on
13 executing requested actions.
14

15 If we can infer anything from the HOD's decision to adopt the policy on Continuing Equity Education
16 with its current language, it would be that the HOD reserved the task of making equity-based decisions on
17 content development for the open forum for AMA staff. Since the policy was adopted at the 2022 Annual
18 Meeting, the Center for Health Equity has taken the lead on planning and has successfully hosted two
19 forums. During the planning and development stages, staff consistently prioritizes equity by ensuring
20 diverse perspectives are represented; considering the unique needs and experiences of all potential
21 attendees to create inclusive content that resonates with a wide audience; focusing on time-sensitive
22 topics to operationalize equity; and regularly assessing and adjusting their approach to address any
23 disparities and promote fairness in the planning and development process. To permanently designate a
24 particular topic or group over others would be counterproductive to the ideals of fairness and equity and
25 risks the possibility of harm, creating an atmosphere of resentment and discouragement among those who
26 may feel excluded or unfairly treated. Instead, AMA staff has employed an equitable content planning
27 and development process that balances the consideration of competing recommendations. Since policy
28 does require an equity forum at least once a year, each meeting presents an additional opportunity to
29 educate the House on a variety of equity-based topics, which can include, but is not limited to, issues
30 related to IMGs.
31

32 *AMA Strategic Plan to Embed Racial Justice and Advance Health Equity* 33

34 In 2021, the Center for Health Equity published the AMA Strategic Plan to Embed Racial Justice and
35 Advance Health Equity. The 86-page document is a comprehensive initiative aimed at addressing
36 systemic inequities in healthcare. Rooted in the recognition of historical injustices and social drivers of
37 health, the plan outlines strategic actions to promote equity, diversity, and inclusion within the medical
38 community. It emphasizes the need for culturally competent care, increased representation of minoritized
39 and marginalized individuals in healthcare leadership, and the dismantling of barriers that perpetuate
40 racial and ethnic disparities. The Strategic Plan has sought to accomplish many goals, but the document
41 was also scheduled to sunset in 2023. To continue the work that the first Strategic Plan initiated, the
42 AMA has pushed forward with the development of the next iteration of the Plan. Following the goals
43 outlined in the first Strategic Plan, the second plan will go further by highlighting IMGs specifically, their
44 potential for advancing health equity amid significant challenges in training and working within the U.S.
45 It will also include details related to recent policy developments, accomplishments, and a call to action for
46 AMA. Prior to its release, authors of the Plan have worked closely with AMA IMG Section leadership to
47 thoroughly review and ensure that IMG perspectives are prominent in the document. At the 2024 Annual
48 Meeting, the Health Equity Open Forum will be an overview of the 2024-2025 Strategic Plan with
49 designated time to focus on IMG issues and perspectives. Our AMA will continue to support IMGs by
50 advocating for fair and transparent processes in licensing, protection of all rights and privileges, and
51 recognizing the valuable contributions IMGs make to the U.S. health care system.

1 RECOMMENDATION

2

3 The Board of Trustees recommends that Resolution 605-A-23 not be adopted and that the remainder of
4 this report be filed.

Fiscal Note: None.

ⁱ Resolution 605-A-23, "Equity and Justice Initiatives for International Medical Graduates." <https://www.ama-assn.org/system/files/a23-605.pdf>

ⁱⁱ 2022 Annual Meeting Reference Committee F Report. <https://www.ama-assn.org/system/files/a22-reference-committee-reports.pdf>

EXECUTIVE SUMMARY

At the 2023 Annual Meeting of the House of Delegates (HOD), Resolution 609-A-23, “Encouraging Collaboration Between Physicians and Industry in Augmented Intelligence (AI) Development”, was referred. The directives of the referred resolution ask the American Medical Association (AMA) to address physician-centered innovation, specifically in the field of AI and, enhance physician access to the Physician Innovation Network (PIN) community through matchmaking and an advisor network. The following Board of Trustees Report provides detailed information about the AMA’s efforts to ensure the physician voice is front and center in the design, development and use of technology and innovation, including AI, across healthcare, and outlines various ways the AMA is supporting physicians in the implementation and use of these tools. The AMA’s work includes numerous activities in the following areas:

- Engagement between physicians and the AI industry facilitated by the Physician Innovation Network (PIN);
- Advocacy for legislative oversight of health care AI and the development of principles to guide such advocacy;
- Formation of programs and collaborative partnerships with other medical and professional societies, in addition to other stakeholders in the health care AI space;
- Development of educational tools and resources;
- Publication of reports and research; and
- Adoption of multiple related AMA policies

REPORT OF THE BOARD OF TRUSTEES

B of T Report 28-A-24

Subject: Encouraging Collaboration Between Physicians and Industry in AI Development

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee F

1 INTRODUCTION

2
3 At the 2023 Annual Meeting, the House of Delegates (HOD) referred Resolution 609-A-23,
4 “Encouraging Collaboration Between Physicians and Industry in Augmented Intelligence (AI)
5 Development”, for report back at the 2024 Annual Meeting. This resolution was introduced by the
6 Medical Student Section and asked that our American Medical Association (AMA):
7

- 8 1. Augment the existing Physician Innovation Network (PIN) through the creation of advisors
9 to specifically link physician members of AMA and its associated specialty societies with
10 companies or individuals working on AI research and development, focusing on:
11
 - 12 a. Expanding recruitment among AMA physician members,
 - 13 b. Advising AMA physician members who are interested in healthcare innovation/AI
14 without knowledge of proper channels to pursue their ideas,
 - 15 c. Increasing outreach from AMA to industry leaders and companies to both further
16 promote the PIN and to understand the needs of specific companies,
 - 17 d. Facilitating communication between companies and physicians with similar
18 interests,
 - 19 e. Matching physicians to projects early in their design and testing stages,
 - 20 f. Decreasing the time and workload spent by individual physicians on finding
21 projects themselves,
 - 22 g. Above all, boosting physician-centered innovation in the field of AI research and
23 development (Directive to Take Action); and
24
- 25 2. Support selection of PIN advisors through an application process where candidates are
26 screened by PIN leadership for interpersonal skills, problem solving, networking abilities,
27 objective decision making and familiarity with industry (New HOD Policy).
28

29 BACKGROUND

30
31 Artificial intelligence focuses on developing smart machines that can perform tasks that otherwise
32 require human intelligence. Augmented intelligence (AI), a subsection of artificial intelligence,
33 depends on machine learning (ML) techniques to extract large amounts of data to assist humans in
34 solving problems.^{1,2} It has been used within a wide array of fields and is responsible for innovations
35 such as web search, targeted content and product recommendations and autonomous vehicles.¹ In
36 2016, AI projects within medicine attracted more investment than AI projects within any other
37 sector of the global economy.³ AI applications within medicine include diagnostics, drug discovery

1 and development, medical documentation and remote treatment. Several recent strides have been
2 made in this area. For instance, Google developed and trained an AI model to classify images as
3 diabetic retinopathy and macular edema for adult patients with diabetes, producing implications for
4 improved detection, diagnosis and treatment of diabetic retinopathy. Additionally, companies have
5 used ML algorithms to identify drugs that treat neurological diseases.¹

6
7 The purpose of AI application to medicine is to supplement—not supplant—the work of health
8 care practitioners and a misunderstanding of this concept is a major deterrent to the adoption of AI
9 innovations by clinicians and health systems.⁴ It is essential that physicians and members of their
10 care teams are included across all stages of the development of AI innovations in health care so
11 such designs best reflect what they find valuable for treating their patients and reducing
12 administrative and other burdens. The integral role physicians play in the development of health
13 care AI enables the refinement of clinical algorithms, testing of new clinical tools and research
14 designed to improve disease management and outcomes.⁵ However, research shows that current AI
15 applications in health care may not sufficiently reflect that they’ve been designed with health care
16 practitioners at the forefront. Despite physicians’ desire to be consulted on tech decisions, many of
17 them lack any significant influence on these decisions.⁶

18
19 It is especially important that efforts to include physicians in the development of health care AI are
20 diverse and comprise marginalized and minoritized physicians so bias that underlies existing data is
21 not further entrenched into AI solutions and health inequities are not exacerbated. Further,
22 equitable inclusion of physicians in the research and development of AI is imperative to its success,
23 as evidenced by literature on racial concordance in medicine. For example, a 2018 Stanford study
24 illustrated how Black physicians were more likely to engage with Black men—a patient group with
25 a historically lower life expectancy—and even collect consent to provide preventive services like
26 cardiovascular screenings and immunizations.⁷ Additionally, research found that a 10% increase in
27 Black primary care physicians was associated with a 30.61-day increase in life expectancy and a
28 decrease in all-cause mortality by 12.71 deaths per 100,000 among Black individuals.⁸ Despite
29 such statistics, only 5.7% of physicians in 2023 identified as Black.⁹ AI can either improve the
30 system by filling these gaps or inadvertently worsen current health inequities by reproducing and
31 normalizing what exists. While increased application of AI in healthcare is expected to reduce bias
32 and promote health equity by improving evidence-based interventions for marginalized and
33 minoritized communities, the voices of these physicians must be integrated early and more often
34 within the development of these tools to truly improve health outcomes for all patients.¹⁰

35 36 DISCUSSION

37
38 The AMA is committed to ensuring that AI can meet its full potential to advance clinical care and
39 improve clinician well-being. As the number of AI-enabled health care tools continue to grow, it is
40 critical they are designed, developed and deployed in a manner that is ethical, equitable and
41 responsible. The use of AI in health care must be transparent to both physicians and patients, and
42 positioning the physician voice front and center is critical.

43 44 *AMA Physician Innovation Network (PIN)*

45
46 To address concerns around the lack of the physician voice in health care innovation, the AMA
47 launched the [Physician Innovation Network](#) (PIN) in 2016. Since then, the network has grown to
48 over 18,000 users and continues to bring together physicians and health tech companies through its
49 various offerings.

1 The PIN platform is available for all physicians to join and connect with other stakeholders across
2 the innovation ecosystem including responding to opportunities posted by digital health and
3 technology companies seeking feedback from subject matter experts. AMA's [PIN "In Real Life"](#)
4 (IRL) events launched in 2022 with the purpose of bringing the online platform to life, encouraging
5 companies to be transparent about their design challenges and hosting diverse physician voices to
6 create an engaging, live PIN experience. Health tech conferences are not usually the events that
7 most practicing physicians attend to advance their professional development. However, such a
8 structure allows physicians to connect with companies live, share clinical problems and expertise
9 and provide feedback on solutions being developed across the health care industry. The PIN IRL
10 events will evolve this structure in an iterative fashion as we continue to evaluate physicians' needs
11 in the changing technological landscape. Further, PIN Community Office Hours occur bi-weekly
12 and provide an opportunity for subject matter experts across the PIN community to connect with
13 digital health solutions focused on optimizing patient experience and minimizing physician
14 burnout.

15
16 The AMA is engaging PIN Physicians to gather feedback and continue iterating on how to help
17 bring better solutions to market together. All AMA members are invited to join PIN and should be
18 ambassadors to their organizations about the platform's ability to link subject matter experts and
19 solution designers. Companies developing health care solutions enabled by AI and ML are
20 interacting on PIN. However, it is the individual physician member's decision how they would like
21 to interact with each company. Some companies post paid opportunities while others are so early in
22 their development that they only have volunteer opportunities posted. Additionally, the AMA is in
23 conversations with the World Medical Association to expand the PIN to a global audience.
24 Applying for PIN IRL engagements is one of the best ways to be involved. As we examine the
25 successes of PIN and the current clinical technology needs of physicians, the PIN strategy is
26 continuously re-evaluated to ensure the program's impact is maximized.

27 *Advocacy*

28
29
30 AI has been an area of focus for AMA advocacy for several years with the first set of advocacy
31 principles developed in 2018. In addition to interfacing with medical devices, AI is increasingly
32 used in health care administration and to reduce physician burden, and policy and guidance for
33 both device and non-device use of health care AI is necessary. Recognizing this, the AMA
34 developed an updated set of advocacy principles that builds on current AI policy. These [new](#)
35 [principles](#) address the development, deployment and use of health care AI, with particular emphasis
36 on:

- 37
- 38 • Health care AI oversight;
- 39 • When and what to disclose to advance AI transparency;
- 40 • Generative AI policies and governance;
- 41 • Physician liability for use of AI-enabled technologies;
- 42 • AI data privacy and cybersecurity; and
- 43 • Payor use of AI and automated decision-making systems.¹¹
- 44

45 The AMA also continues to keep track of AI-related legislation and policy coming from both the
46 congressional bodies, as well as the federal government.

47
48 Additionally, the AMA plans to research state-based AI policies to better understand local
49 approaches to policy and regulation for the use of AI across health care stakeholders, including
50 health care practices, health systems and payers. *AMA research, programs and other resources*

1
2 The AMA is committed to researching the AI landscape in health care and developing resources to
3 support physicians in getting involved in the design, development and deployment of these tools
4 across the industry. In 2023, the AMA completed a [survey](#) to better understand physician
5 sentiments around AI, including opportunities, current use cases and needs around education and
6 support for the implementation and use of AI. Of the 1,081 physicians surveyed, 41% responded
7 that they were both equally excited and concerned about AI. It was also confirmed that physicians
8 are seeking more information in digestible formats that can help them successfully evaluate and use
9 these tools in their clinical environments.⁶

10
11 In February 2024, the AMA released a foundational AI landscape report as part of its Future of
12 Health work titled, [“The Emerging Landscape of Augmented Intelligence in Health Care”](#). The
13 report aims to create a common lexicon for augmented intelligence in health care, explore the risks,
14 identify current and future use cases and provide guidance for physicians looking to leverage these
15 tools in practice. As part of this research, the AMA completed the previously mentioned survey
16 designed to capture physician sentiments around AI, held a set of one-on-one interviews with key
17 stakeholders from across the industry and hosted a specialty society workshop to align on key
18 priorities across specialties. The report lays the foundation for the development of additional
19 educational content into specific areas of AI to further support the implementation and use of AI in
20 practice including, but not limited to:

- 21
- 22 • Practical case studies of where AI is working in practice today.
 - 23 • Issue briefs aimed at deciphering AI policy. For instance, the AMA released a [guide](#) in
24 2023, providing advice for physicians when considering ChatGPT.
 - 25 • Research on areas where AI is impacting clinician well-being (i.e. documentation burden
26 reduction, etc.).
 - 27 • Step-by-step educational materials on creating governance structures that support the
28 successful selection and deployment of AI solutions.
- 29

30 The AMA ChangeMedEd initiative works with partners across the medical education continuum to
31 help produce a physician workforce that meets the needs of patients today and in the future. As part
32 of these efforts, an [Artificial Intelligence in Health Care](#) learning series was recently published on
33 the AMA EdHub. These modules are geared towards medical students and physician learners, and
34 introduce key concepts related to artificial intelligence and ML in health care. These are developed
35 in collaboration with medical education partners from across the nation.

36
37 Further, the AMA and Accreditation Council for Graduate Medical Education (ACGME) have a
38 shared interest in fostering the use of AI to improve education across a physician’s career. The
39 ACGME is aware of the AMA’s conceptual model of Precision Education and has participated in
40 the AMA Accelerating Change in Medical Education Consortium’s National Advisory Panel
41 around planning the next major initiative. Awardees of AMA grant funding also presented their
42 work on leveraging AI to improve residency selection and education at the 2024 ACGME Annual
43 Education Conference.

44
45 Additionally, the AMA is engaged with the American Board of Medical Specialties, National
46 Board of Medical Examiners, Association of American Medical Colleges, Association for Hospital
47 Medical Education, International Association of Medical Science Educators, as well as several
48 specialty societies, medical schools and academic health systems around advancing AI in medical
49 education. AMA staff will also serve on the planning committee for the Macy Foundation’s next
50 conference which will focus on AI in medical education. These conferences are designed to

1 generate national recommendations which are typically published in the journal, *Academic*
2 *Medicine*.

3
4 The AMA has also crafted a [framework](#) to promote the development and use of responsible,
5 evidence-based, unbiased and equitable health care AI. This ethics-evidence-equity framework
6 envisions the use of AI to advance the quadruple aim (enhancing patient care, improving
7 population health and clinician work-life and reducing costs) and defines the responsibilities of
8 developers, health care organizations (deployers) and physicians to put the framework into action.
9 For instance, the framework outlines the responsibility of all three groups to (1) develop a protocol
10 to identify and correct for potential bias, as well as (2) ensure protocols exist for enforcement and
11 accountability, including a system to ensure equitable implementation. Physicians can use the
12 framework to assess if an AI innovation meets the qualifications for ethics, evidence and equity
13 and can therefore be trusted.¹² This framework has also been leveraged to create a companion
14 resource that considers educational applications of AI and addresses the use of AI to facilitate the
15 process of training health professionals.

16
17 Further, the AMA is in the process of creating a physician development curriculum that will cover
18 topics across physician leadership and the business of medicine. The goal of these materials is to
19 empower and support physicians throughout their professional lives by amplifying AMA-wide
20 resources on the health care landscape, leadership and the business of medicine and develop new
21 resources where gaps exist. These materials will be made available for both individual physicians
22 and member organizations.

23
24 Additionally, the AMA developed the [CPT® Developer Program](#) to assist developers in translating
25 ideas into innovations. The program is dedicated to developers' needs and provides them with
26 access to high-quality AMA CPT content and resources.

27
28 As interest grows in the use of AI solutions and tools that address administrative burden and
29 support physicians in their daily tasks, the AMA is committed to ensuring that the evolution of AI
30 in medicine equitably benefits patients, physicians and other health care stakeholders. The AMA
31 intends to continue developing AI principles for the use of AI in health care, advocate for state and
32 federal policies that ensure appropriate oversight and continued innovation in AI, partner with
33 health and technology leaders to ensure physicians have a leading voice in shaping the ethical use
34 of AI in medicine, promote training in AI across the continuum of medical education and provide
35 high-value insights and actionable resources for physicians.

36 37 *Stakeholder engagement*

38
39 The AMA is a convener around many topics important to physicians including AI. As a follow up
40 to the Specialty Society workshop in 2023, the AMA has created an AI Specialty Collaborative
41 with over 15 specialty associations committed to participating. The goal of the collaborative is to
42 ensure the physician voice is leading in a united way as AI in health care continues to expand.
43 Additionally, this group will collectively identify priorities and collaboratively develop resources
44 to advance AI in health care starting in the second quarter of 2024.

45
46 The AMA also continues to stay abreast of the latest developments in AI across the industry
47 through participation in external industry collaboratives. For example, the AMA is currently a non-
48 profit member organization of [VALID AI](#), an execution accelerator dedicated to bridging the gap in
49 coordinated efforts around generative AI while rapidly advancing validation and governance
50 implementation.

1 Furthermore, as a member of the [Health AI Partnership](#)—a collaboration among 14 health care
2 organizations and ecosystem partners—the AMA is encouraging the collaborative development
3 and dissemination of AI best practices. The AMA will continue to work with this partnership and
4 others to develop resources, including a case-based AI ethics training program that will delve into
5 real-world, contemporary challenges that physicians and health care delivery organizations face
6 when using AI.

7
8 The [In Full Health Learning & Action Community to Advance Equitable Health Innovation](#)
9 initiative seeks to advance equitable opportunities in health innovation investment, solution
10 development and purchasing. The AMA has partnered with founding collaborator organizations to
11 support this community with content, tools, resources and opportunities to connect, engage and
12 learn with and from each other to advance equitable health innovation.

13
14 The AMA also has long standing relationship with the innovation accelerator, MATTER. As part
15 of this sponsorship, AMA employees and physician members have access to the MATTER space
16 and programming. AMA physician members can also reach out to [AMA staff contacts](#) to learn
17 more about getting involved with MATTER and other innovation accelerator programs.

18
19 Further, the AMA participated in a joint clinician panel with the Office of the National Coordinator
20 for Health Information Technology in 2020 titled, [“Artificial Intelligence in Health IT- The Good,
21 The Bad, The Ugly”](#) and continues to engage in additional conferences such as HLTH and ViVE,
22 where AMA representatives engage in a variety of topics around health care technology including
23 AI.

24
25 In addition to the efforts outlined above, the AMA has several internal cross-business unit
26 workgroups in place to ensure alignment across the work in innovation and specifically, AI. There
27 is a Future of Health workgroup meeting that occurs monthly to stay aligned on the latest policy,
28 projects and collaborations in progress around innovation and digital health. Additionally, the
29 Advocacy business unit convenes two monthly meetings specifically focused on aligning AI
30 initiatives across the AMA.

31 32 AMA POLICY

33
34 As a leader in American medicine, the AMA has a unique opportunity to ensure that the evolution
35 of AI in medicine benefits patients, physicians and the health care community. The AMA has
36 several policies in place around ensuring the physician voice is reflected in the design and
37 development of AI innovations in health care.

38
39 The AMA will seek to:

- 40
- 41 1. Leverage its ongoing engagement in digital health and other priority areas for improving
42 patient outcomes and physicians’ professional satisfaction to help set priorities for health
43 care AI.
 - 44 2. Identify opportunities to integrate the perspective of practicing physicians into the
45 development, design, validation, and implementation of health care AI.
 - 46 3. Promote development of thoughtfully designed, high-quality, clinically validated health
47 care AI that:
 - 48 a. is designed and evaluated in keeping with best practices in user-centered design,
49 particularly for physicians and other members of the health care team;
 - 50 b. is transparent;
 - 51 c. conforms to leading standards for reproducibility;

- 1 d. identifies and takes steps to address bias and avoids introducing or exacerbating
- 2 health care disparities including when testing or deploying new AI tools on
- 3 vulnerable populations; and
- 4 e. safeguards patients' and other individuals' privacy interests and preserves the
- 5 security and integrity of personal information.
- 6 4. Encourage education for patients, physicians, medical students, other health care
- 7 professionals, and health administrators to promote greater understanding of the promise
- 8 and limitations of health care AI.
- 9 5. Explore the legal implications of health care AI, such as issues of liability or intellectual
- 10 property, and advocate for appropriate professional and governmental oversight for safe,
- 11 effective, and equitable use of and access to health care AI ([Policy H-480.940](#),
- 12 ["Augmented Intelligence in Health Care"](#)).
- 13

14 The AMA also supports the use and payment of AI systems that advance the quadruple aim. AI
15 systems should enhance the patient experience of care and outcomes, improve population health,
16 reduce overall costs for the health care system while increasing value and support the professional
17 satisfaction of physicians and the health care team. To that end our AMA will advocate that:

- 18
- 19 1. Oversight and regulation of health care AI systems must be based on risk of harm and
- 20 benefit accounting for a host of factors, including but not limited to: intended and
- 21 reasonably expected use(s); evidence of safety, efficacy and equity including addressing
- 22 bias; AI system methods; level of automation; transparency; and conditions of deployment.
- 23 2. Payment and coverage for all health care AI systems must be conditioned on complying
- 24 with all appropriate federal and state laws and regulations, including, but not limited to
- 25 those governing patient safety, efficacy, equity, truthful claims, privacy and security as
- 26 well as state medical practice and licensure laws.
- 27 3. Payment and coverage for health care AI systems intended for clinical care must be
- 28 conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is
- 29 familiar to physicians; and (c) high-quality clinical evidence.
- 30 4. Payment and coverage for health care AI systems must (a) be informed by real world
- 31 workflow and human-centered design principles; (b) enable physicians to prepare for and
- 32 transition to new care delivery models; (c) support effective communication and
- 33 engagement between patients, physicians, and the health care team; (d) seamlessly
- 34 integrate clinical, administrative, and population health management functions into
- 35 workflow; and (e) seek end-user feedback to support iterative product improvement.
- 36 5. Payment and coverage policies must advance affordability and access to AI systems that
- 37 are designed for small physician practices and patients and not limited to large practices
- 38 and institutions. Government-conferred exclusivities and intellectual property laws are
- 39 meant to foster innovation, but constitute interventions into the free market, and therefore,
- 40 should be appropriately balanced with the need for competition, access and affordability.
- 41 6. Physicians should not be penalized if they do not use AI systems while regulatory
- 42 oversight, standards, clinical validation, clinical usefulness and standards of care are in
- 43 flux. Furthermore, our AMA opposes:
- 44 a. Policies by payers, hospitals, health systems or governmental entities that mandate
- 45 use of health care AI systems as a condition of licensure, participation, payment, or
- 46 coverage.
- 47 b. The imposition of costs associated with acquisition, implementation, and
- 48 maintenance of healthcare AI systems on physicians without sufficient payment.
- 49 7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best
- 50 positioned to know the AI system risks and best positioned to avert or mitigate harm do so

- 1 through design, development, validation and implementation. Our AMA will further
2 advocate:
- 3 a. Where a mandated use of AI systems prevents mitigation of risk and harm, the
4 individual or entity issuing the mandate must be assigned all applicable liability.
 - 5 b. Developers of autonomous AI systems with clinical applications (screening,
6 diagnosis, treatment) are in the best position to manage issues of liability arising
7 directly from system failure or misdiagnosis and must accept this liability with
8 measures such as maintaining appropriate medical liability insurance and in their
9 agreements with users.
 - 10 c. Health care AI systems that are subject to non-disclosure agreements concerning
11 flaws, malfunctions, or patient harm (referred to as gag clauses) must not be
12 covered or paid and the party initiating or enforcing the gag clause assumes
13 liability for any harm.
- 14 8. The AMA, national medical specialty societies, and state medical associations—
- 15 a. Identify areas of medical practice where AI systems would advance the quadruple
16 aim;
 - 17 b. Leverage existing expertise to ensure clinical validation and clinical assessment of
18 clinical applications of AI systems by medical experts;
 - 19 c. Outline new professional roles and capacities required to aid and guide health care
20 AI systems; and
 - 21 d. Develop practice guidelines for clinical applications of AI systems.
- 22 9. There should be federal and state interagency collaboration with participation of the
23 physician community and other stakeholders in order to advance the broader infrastructural
24 capabilities and requirements necessary for AI solutions in health care to be sufficiently
25 inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD
26 Policy)
- 27 10. AI is designed to enhance human intelligence and the patient-physician relationship rather
28 than replace it ([Policy H-480.939, “Augmented Intelligence in Health Care”](#)).

29
30 CONCLUSION

31
32 The AMA has various existing initiatives, research, policy, advocacy efforts, educational material
33 and other resources that are aligned with the desire to boost physician-centered innovation in the
34 field of AI research and development. As such, much of the work that Resolution 609-A-23 asks
35 the AMA to conduct is already ongoing.

36
37 The PIN serves as one source of connecting physicians with innovative companies, specifically
38 those working in the AI space. With that said, as noted, the PIN is undergoing a strategic review
39 and updates to maximize its impact to physicians in decreasing the burden of clinical technology.
40 As we continue to evaluate PIN, we will consider the significance of factors such as AI and other
41 evolving technologies to the practice of medicine and incorporate them into our approach to PIN.
42 At this time, the timing and approach are not aligned to create any specific workgroup linked to
43 PIN.

44
45 The costs associated with identifying, establishing and convening a formal advisory board to
46 facilitate relationships between physicians and the AI industry are significant. Additionally, the
47 existing engagement and collaboration the AMA has across initiatives from physicians, specialty
48 and state society and association stakeholders and industry allows AMA to obtain more diverse
49 perspectives and experiences than a formal advisory board. The AMA continues to ensure the
50 AMA is inclusive and equitable in its approach to research, advocacy and education.

1 RECOMMENDATIONS

2

3 The Board of Trustees recommends that Resolution 609-A-23 not be adopted and that this report be
4 filed.

Fiscal Note: Minimal

REFERENCES

1. Basu K, Sinha R, Ong A, Basu T. Artificial Intelligence: How is It Changing Medical Sciences and Its Future? *Indian J Dermatol.* 2020;65(5):365-370.
2. AiThORITY. Difference Between Augmented Intelligence and AI. AiThORITY. Published January 25, 2023. Accessed March 3, 2024. <https://aithority.com/technology/the-difference-between-augmented-intelligence-and-artificial-intelligence/>
3. CBInsights. Healthcare Remains The Hottest AI Category For Deals. CB Insights Research. Published April 12, 2017. Accessed March 3, 2024. <https://www.cbinsights.com/research/artificial-intelligence-healthcare-startups-investors/>
4. Lomis K, Jeffries P, Palatta A, et al. Artificial Intelligence for Health Professions Educators. *NAM Perspect.* Published online September 8, 2021. Accessed March 3, 2024. <https://nam.edu/artificial-intelligence-for-health-professions-educators/>
5. Mandal K. Role of Physician in the era of Artificial Intelligence Revolution. LinkedIn. Published August 11, 2023. Accessed March 4, 2024. <https://www.linkedin.com/pulse/role-physician-era-artificial-intelligence-revolution-kaushik-mandal-/>
6. American Medical Association. AMA Augmented Intelligence Research: Physician Sentiments Around the Use of AI in Health Care- Motivations, Opportunities, Risks, and Use Cases. Presented at: November 2023; American Medical Association. Accessed March 4, 2024. <https://www.ama-assn.org/system/files/physician-ai-sentiment-report.pdf>
7. Alsan M, Garrick O, Graziani GC. Does Diversity Matter for Health?: Experimental Evidence from Oakland. Published online June 2018. Accessed March 4, 2024. https://www.nber.org/system/files/working_papers/w24787/w24787.pdf
8. Snyder JE, Upton RD, Hassett TC, Lee H, Nouri Z, Dill M. Black Representation in the Primary Care Physician Workforce and Its Association With Population Life Expectancy and Mortality Rates in the US. *JAMA Netw Open.* 2023;6(4):e236687. <https://doi.org/10.1001/jamanetworkopen.2023.6687>
9. Howard J. Only 5.7% of US doctors are Black, and Experts Warn the Shortage Harms Public Health. National Medical Association. Published February 21, 2023. Accessed March 4, 2024. <https://www.nmanet.org/news/632592/Only-5.7-of-US-doctors-are-Black-and-experts-warn-the-shortage-harms-public-health.htm>
10. Crigger E, Reinbold K, Hanson C, Kao A, Blake K, Irons M. Trustworthy Augmented Intelligence in Health Care. *J Med Syst.* 2022;46(2):12. <https://doi.org/10.1007/s10916-021-01790-z>
11. American Medical Association. AMA Issues New Principles for AI Development, Deployment & Use. American Medical Association. Published November 28, 2023. Accessed March 4, 2024. <https://www.ama-assn.org/press-center/press-releases/ama-issues-new-principles-ai-development-deployment-use>

12. American Medical Association. Advancing Health Care AI Through Ethics, Evidence and Equity. American Medical Association. Published February 26, 2024. Accessed March 4, 2024. <https://www.ama-assn.org/practice-management/digital/advancing-health-care-ai-through-ethics-evidence-and-equity>

REPORT OF THE BOARD OF TRUSTEES

B of T Report 33-A-24

Subject: Employed Physicians

Presented by: Willie Underwood III, MD, MSc, MPH, Chair

Referred to: Reference Committee F

1 BACKGROUND

2
3 At its November 2021 Special Meeting, the House of Delegates (HOD) referred Resolution 615,
4 which asked AMA to take a variety of actions to ensure that the voice of employed physicians is
5 heard within the organization.

6
7 BOT Report 9-I-22 subsequently argued that creation of an employed physician caucus, already in
8 the works at that time via efforts of the Organized Medical Staff Section (OMSS), would be the
9 most appropriate mechanism for giving voice to employed physicians in the HOD. The report
10 concluded that while it is beyond the scope of the Board to establish caucuses, the Board fully
11 supported the creation of an employed physician caucus in lieu of the asks of original Resolution
12 615.

13
14 As directed by BOT Report 9, this follow-up report provides an update on the caucus and
15 representation of employed physicians within our AMA.

16
17 DISCUSSION

18
19 The inaugural meeting of the OMSS-convened employed physician caucus was held at the 2022
20 Interim Meeting. Since then, the caucus has met in conjunction with each Annual and Interim
21 meeting, and between meetings as the need has arisen. Attendance at these meetings has ranged
22 from 15 to 20 participants per meeting, engaging not only OMSS members but also members from
23 most of the other AMA sections as well as members of the HOD who are not actively involved in
24 any section.

25
26 Facilitated by OMSS leadership, caucus meetings have focused on (1) discussion of resolutions and
27 reports under consideration by the HOD that are especially relevant to employed physicians, and
28 (2) general discussion of issues facing employed physicians and how AMA might address them,
29 whether through the policymaking process or otherwise. Through these actions, the group has
30 directly lent its expertise to the HOD, with one key example being the contributions of the caucus
31 to the development of OMSS-sponsored Resolution 017-A-23, which established AMA's definition
32 of "employed physician." Additionally, the group has served as a resource for AMA staff
33 addressing employment matters – for example, providing input on recent revisions to the *AMA*
34 *Physicians' Guide to Hospital Employment Contracts* and allowing for observation of the caucus
35 by AMA staff to garner ideas for a series of news articles on physician employment.

1 In 2024, the OMSS-convened employed physician caucus will focus on formalizing its structure
2 and processes, developing a charter that outlines caucus membership requirements, how caucus
3 leadership is selected, and the process by which the caucus determines positions it will voice on
4 items of business under consideration in the HOD. The caucus will next meet on Saturday, June 8,
5 from 9:30 to 10:30 a.m. at the Hyatt Regency Chicago (see Speakers' Letter for room location),
6 and all AMA members are invited to attend. The Board of Trustees looks forward to the continued
7 evolution of the caucus and its success in representing the interests of employed physicians within
8 our AMA.

9

10 RECOMMENDATION

11

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

14

- 15 1. That AMA policy D-405.969 be rescinded as having been accomplished by this report
16 (Rescind HOD Policy).

Fiscal Note: No significant fiscal impact.

JOINT REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS AND THE
COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CCB/CLRPD Report 1-A-24

Subject: Joint Council Sunset Review of 2014 House Policies

Presented by: Mark Bair, MD, Chair, Council on Constitution and Bylaws
Gary Thal, MD, Chair, Council on Long Range Planning and Development

Referred to: Reference Committee F

1 Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of
2 American Medical Association (AMA) policies to ensure that our AMA’s policy database is
3 current, coherent, and relevant. Policy G-600.110 reads as follows, laying out the parameters for
4 review and specifying the procedures to follow:
5

6 1. As the House of Delegates (House) adopts policies, a maximum ten-year time horizon shall
7 exist. A policy will typically sunset after ten years unless action is taken by the House to retain
8 it. Any action of our AMA House that reaffirms or amends an existing policy position shall
9 reset the sunset “clock,” making the reaffirmed or amended policy viable for another 10 years.
10

11 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the
12 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of
13 policies that are subject to review under the policy sunset mechanism; (b) Such policies shall
14 be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been
15 asked to review policies shall develop and submit a report to the House identifying policies
16 that are scheduled to sunset; (d) For each policy under review, the reviewing council can
17 recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain
18 part of the policy; or (iv) reconcile the policy with more recent and like policy (per Policy G-
19 600.111(4), The consolidation process permits editorial amendments for the sake of clarity, so
20 long as the proposed changes are transparent to the House and do not change the meaning); (e)
21 For each recommendation that it makes to retain a policy in any fashion, the reviewing council
22 shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way
23 for the House of Delegates to handle the sunset reports.
24

25 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier
26 than its 10-year horizon if it is no longer relevant, has been superseded by a more current
27 policy, or has been accomplished.
28

29 4. The AMA councils and the House of Delegates should conform to the following guidelines for
30 sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has
31 been accomplished; or (c) when the policy or directive is part of an established AMA practice
32 that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA
33 House of Delegates Reference Manual: Procedures, Policies and Practices.
34

35 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

1 6. Sunset policies will be retained in the AMA historical archives.

2

3 RECOMMENDATION

4

5 The Councils on Constitution and Bylaws and Long Range Planning and Development
6 recommend that the House policies that are listed in the appendix to this report be acted upon in
7 the manner indicated and the remainder of this report be filed.

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-478.980	Anonymous Cyberspace Evaluations of Physicians	<p>Our AMA will: (1) work with appropriate entities to encourage the adoption of guidelines and standards consistent with AMA policy governing the public release and accurate use of physician data; (2) continue pursuing initiatives to identify and offer tools to physicians that allow them to manage their online profile and presence; (3) seek legislation that supports the creation of laws to better protect physicians from cyber-libel, cyber-slander, cyber-bullying and the dissemination of Internet misinformation and provides for civil remedies and criminal sanctions for the violation of such laws; and (4) work to secure legislation that would require that the Web sites purporting to offer evaluations of physicians state prominently on their Web sites whether or not they are officially endorsed, approved or sanctioned by any medical regulatory agency or authority or organized medical association including a state medical licensing agency, state Department of Health or Medical Board, and whether or not they are a for-profit independent business and have or have not substantiated the authenticity of individuals completing their surveys.</p>	<p>Consolidate D-445.997 and D-478.980 as editorially amended (by insertion and deletion) and Retain.</p> <p>D-445.997, Online Physician Reputation and Rating: Our AMA will: (1) encourages physicians to take an active role in managing their online reputation in ways that can help them improve practice efficiency and patient care; (2) encourages physician practices and health care organizations to establish policies and procedures to address negative online complaints directly with patients that do not run afoul of federal and state privacy laws; (3) will develop and publish educational material to help guide physicians and their practices in managing their online reputation, including recommendations for responding to negative patient reviews and clarification about how federal privacy laws apply to online reviews; and (4) will work with appropriate stakeholders to (a) consider an outlet for physicians to share their experiences and (b) potentially consider a mechanism for recourse for physicians whose practices have been affected by negative online reviews, consistent with federal and state privacy laws; D-478.980 Our AMA</p>

Policy Number	Title	Text	Recommendation
			<p>will: (1)(5) work with appropriate entities to encourage the adoption of guidelines and standards consistent with AMA policy governing the public release and accurate use of physician data; (2)(6) continue to pursuing initiatives to identify and offer tools to physicians that allow them to manage their online profile and presence; (3)(7) seek legislation that supports the creation of laws to better protect physicians from cyber-libel, cyber-slander, cyber-bullying and the dissemination of Internet misinformation and provides for civil remedies and criminal sanctions for the violation of such laws; and (4)(8) work to secure legislation that would require that the Web sites purporting to offer evaluations of physicians state prominently on their Web sites whether or not they are officially endorsed, approved or sanctioned by any medical regulatory agency or authority or organized medical association including a state medical licensing agency, state Department of Health or Medical Board, and whether or not they are a for-profit independent business and have or have not substantiated the authenticity of individuals completing their surveys.</p>
D-90.999	Interpreters For Physician Visits	Our AMA continues to monitor enforcement of those provisions of the ADA to assure that physician offices are not subjected to undue	Sunset; More recent and comprehensive policies exist.

Policy Number	Title	Text	Recommendation
		<p>burdens in their efforts to assure effective communication with hearing disabled patients.</p>	<p>Policies include: H-385.929, Availability and Payment for Medical Interpreters Services in medical Practices; D-385.957, Certified Translation and Interpreter Services; H-385.928, Patient Interpreters; D-385.946, Physician Reimbursement for Interpreter Services; and D-385.978, Language Interpreters.</p>
<p>D-165.938</p>	<p>Redefining AMA's Position on ACA and Healthcare Reform</p>	<p>1. Our AMA will develop a policy statement clearly stating this organization's policies on the following aspects of the Affordable Care Act (ACA) and healthcare reform: A. Opposition to all P4P or VBP that fail to comply with the AMA's Principles and Guidelines; B. Repeal and appropriate replacement of the SGR; C. Repeal and replace the Independent Payment Advisory Board (IPAB) with a payment mechanism that complies with AMA principles and guidelines; D. Support for Medical Savings Accounts, Flexible Spending Accounts, and the Medicare Patient Empowerment Act ("private contracting"); E. Support steps that will likely produce reduced health care costs, lower health insurance premiums, provide for a sustainable expansion of healthcare coverage, and protect Medicare for future generations; F. Repeal the non-physician provider non-discrimination provisions of the ACA. 2. Our AMA will immediately direct sufficient funds toward a multi-pronged campaign to accomplish these goals. 3. There will be a report back at each meeting of the AMA HOD.</p>	<p>Sunset; No longer necessary.</p> <p><i>Authors' note: While AMA Councils currently collaborate where appropriate on technology-related projects, such AMA initiatives are often enterprise-wide, with the expertise of relevant Councils utilized during project development and implementation. More details about AMA's technology initiatives hcan be found online.</i></p>
<p>G-620.045</p>	<p>Medical Malpractice Discount Rates</p>	<p>Our AMA encourages member organizations of the Federation to offer access to discounted medical liability insurance premiums where legally permissible.</p>	<p>Retain; Still relevant.</p> <p>Nearly every state medical association or society actively endorses a medical liability product with most offering some sort of discount and AMA Insurance's Medical Liability Insurance Plan offers</p>

Policy Number	Title	Text	Recommendation
			<p>competitively priced medical liability insurance coverage (discounted rates for AMA members). However, a recent AMA study, Prevalence of Medical Liability Premium Increases Unseen Since 2000s Continues for Fourth Year in a Row, found that at least in some states medical liability premiums are increasing.</p>
G-635.015	Member Recognition	<p>Our AMA will study ways to provide recognition to member physicians in local communities, to give them and the community a greater personal sense of connection with our AMA.</p>	<p>Sunset; No longer necessary.</p> <p>AMA has a number of recognition and award programs: Women in Medicine Month (September); Senior Physicians Recognition Month (May) and IMG Recognition Week (October); AMA Award for Citizenship and Community Service; AMA Medal of Valor; the President’s Citation for Service to the Public; the Distinguished Service Award; and the AMA Physician's Recognition Award (PRA). The AMA Foundation offers multiple awards (including the AMA Foundation Award for Health Education, Excellence in Medicine Awards, and the Joan F. Giambalvo Fund for the Advancement of Women). Nominees for the AMA and AMA Foundation Awards are solicited from the House</p>

Policy Number	Title	Text	Recommendation
			of Delegates, AMA sections, and the Federation.
G-640.025	Encourage Physicians as Legislative Candidates	Our AMA continues to identify, encourage, and support physicians to run as state and national legislative candidates.	<p>Consolidate with G-640.015 as editorially amended (by insertion and deletion) and Retain.</p> <p>Our AMA <u>will</u> continues to identify, encourage, and support physicians to run as state and national legislative candidates. G-640.015. Our AMA will not use AMA corporate treasury funds to engage in partisan political activity.</p> <p><i>Authors' note: AAMPAC, AMA's bipartisan political action committee, strives to help more physicians get personally involved in politics, and holds workshops each year to educate physicians about the intricacies of politics and political campaigns. AMPAC also publishes political research on public perceptions of physicians as candidates, the latest being a 2022 Research Exploring Voters Perceptions about Physicians as Candidates Running for Elected Office.</i></p>
G-640.045	Helping to Better Inform Legislators on Medical Matters	Our AMA will inform members of Congress and their staff that AMA Morning Rounds is available through our website to the public without charge.	<p>Sunset; No longer necessary.</p> <p>AMA periodically sends faxes to the attention of health staff at Congressional offices encouraging them to subscribe to</p>

Policy Number	Title	Text	Recommendation
			<p>AMA Morning Rounds. Morning Rounds remains available to AMA members, nonmembers and the public.</p>
H-160.905	<p>Non-Physician Practitioners Certifying Medicare Patients' Need for Therapeutic Shoes and Inserts</p>	<p>Our AMA supports authorization of physician assistants, and nurse practitioners who practice in physician-led teams to certify Medicare beneficiaries' need for therapeutic shoes and/or inserts.</p>	<p>Consolidate with H-425.979 (as editorially amended by insertion and deletion) and Retain.</p> <p>H-160.905. (1) Our AMA supports authorization of physician assistants, and nurse practitioners who practice in physician-led teams to certify Medicare beneficiaries' need for therapeutic shoes and/or inserts.</p> <p>H.425.979(2) Our AMA: (4) recommends that public and private health insurance programs provide appropriate therapeutic shoes to patients with peripheral neuropathy who meet the eligibility criteria defined in the Medicare Benefit Policy Manual; and (2) strongly urges public and private health insurance programs to provide appropriate therapeutic shoes to patients with peripheral neuropathy who meeting the following criterion: they are currently being treated under a comprehensive treatment plan and have one of the following: (a) peripheral neuropathy with evidence of callus formation; (b) history of pre-ulcerative calluses; (c) history of previous</p>

Policy Number	Title	Text	Recommendation
			ulceration; (d) foot deformity; (e) previous amputation of the foot or part of the foot; or (f) poor circulation.
H-180.973	The "Hassle Factor"	Our AMA will greatly intensify its efforts (including support of HR 2695) to reduce the burden of government and third-party regulation on medical practice and its intrusion into the physician-patient relationship and doctor-patient time.	Editorially amend (by deletion) and Retain. Our AMA will greatly intensify its efforts (including support of HR 2695) to reduce the burden of government and third-party regulation on medical practice and its intrusion into the physician-patient relationship and doctor-patient time.
H-185.934	Emergency Department Insurance Linking	Our AMA supports the establishment of insurance-linking programs in the emergency department in a manner that does not interfere with providing timely emergency medical services.	Sunset; superseded by more current and comprehensive Policy H-130.970 .
H-225.948	Hospital Policies on Interactions with Industry	1. Our AMA encourages all hospitals to adopt policies governing the interaction of hospital personnel--including both employed physicians and independent members of the medical staff, as well as other hospital staff--with pharmaceutical, medical device, and other industry representatives within the hospital setting. Such policies should: (a) be developed through a collaborative effort of the hospital's organized medical staff, administration, and governing body, and approved by the organized medical staff; and (b) be consistent with applicable AMA policy and ethical opinions on the subject of medicine-industry interaction, including but not limited to: E-1.001 Principles of Medical Ethics E-5.0591 Patient Privacy and Outside Observers to the Clinical Encounter E-8.03 Conflicts of Interest: Guidelines E-8.031 Conflicts of Interest: Biomedical Research E-8.0315 Managing Conflicts of Interest in the Conduct of Clinical Trials E-8.047 Industry Representatives in Clinical Settings E-8.06 Prescribing and Dispensing Drugs and Devices E-8.061 Gifts to Physicians from Industry E-9.0115 Financial Relationships with Industry in Continuing Medical Education	Editorially Amend 1(b) (by deletion) and Retain. *** and 1(b) be consistent with applicable AMA policy and ethical opinions on the subject of medicine-industry interaction; including but not limited to: E-1.001 Principles of Medical Ethics E-5.0591 Patient Privacy and Outside Observers to the Clinical Encounter E-8.03 Conflicts of Interest: Guidelines E-8.031 Conflicts of Interest: Biomedical Research E-8.0315 Managing Conflicts of Interest in the Conduct of Clinical Trials

Policy Number	Title	Text	Recommendation
		<p>H-460.981 University-Industry Cooperative Research Ventures.</p> <p>2. Our AMA will inform the American Hospital Association of the AMA's position on hospital policies governing the interaction of hospital personnel with pharmaceutical, medical device, and other industry representatives within the hospital setting.</p>	<p>E-8.047 Industry Representatives in Clinical Settings E-8.06 Prescribing and Dispensing Drugs and Devices E-8.061 Gifts to Physicians from Industry E-9.0115 Financial Relationships with Industry in Continuing Medical Education H-460.981 University-Industry Cooperative Research Ventures.</p> <p><i>Authors' note: When the AMA Code of Medical Ethics was modernized, many like policies were consolidated—see E-10.6, Industry Representatives in Clinical Settings]</i></p>
H-225.959	Medical Staff Testing	<p>Our AMA: (1) establish policy that, in the absence of statutory and/or regulatory requirements, hospital medical staffs should determine those tests and/or immunization that are required for medical staff members, and delineate under what circumstances such tests or immunizations should be administered; (2) encourages medical staffs to regularly review and update their bylaws and workplace policies to ensure that they reflect current laws, regulations, health care policy, and evidence-based medicine; and (3) encourages appropriate stakeholders to develop, promulgate, and adopt a uniform immunization form for medical students seeking to do rotations at hospitals away from their home institutions.</p>	Retain; Still relevant.
H-235.981	Qualifications, Selection, and Role of Medical Directors, Chief Medical Officers, Vice Presidents for Medical Affairs, and Others Employed by or Under Contract with Hospitals/Health Systems to Provide Medical	<p>1. Our AMA supports the following guidelines regarding the qualifications and selection of individuals employed by or under contract with a hospital/health system to provide medical management services, such as medical directors, chief medical officers, and vice presidents for medical affairs: a. The hospital governing body, management, and medical staff should jointly: (i) determine if there is a need to employ or contract with one or more individuals to provide medical management services; (ii) establish the purpose, duties, and responsibilities of these positions; (iii) establish the qualifications for these positions; and (iv) establish and sustain a mechanism for input</p>	<p>Editorially amend 1.c (by insertion and deletion) and Retain.</p> <p>Physicians providing medical management services at a single hospital should be licensed to practice medicine in the same state as the hospital for which they he or she provide such services. Additionally, he or she</p>

Policy Number	Title	Text	Recommendation
	Management Services	<p>from and participation by elected leaders of the medical staff in the selection, evaluation, and termination of individuals holding these positions.</p> <p>b. An individual employed by or under contract with a hospital or health system to provide medical management services should be a physician (MD/DO). c. A physician providing medical management services at a single hospital should be licensed to practice medicine in the same state as the hospital for which he or she provides such services. Additionally, he or she should be a member in good standing of the organized medical staff of the hospital for which he or she provides medical management services. d. Where feasible, a physician providing medical management services at the system level for a multi-hospital health system should be licensed to practice medicine in each of the states in which the health system has a hospital that will be influenced by the physician's work. At a minimum, the physician should be licensed in at least one state in which the health system has a hospital over which the physician will exert influence, and in as many other states as may be required by state licensing law. e. Where feasible, a physician providing medical management services at the system level for a multi-hospital health system should be a member in good standing of the medical staff of each of the hospitals that will be influenced by the physician's work. At a minimum, the physician should: (i) be a member in good standing of at least one of the medical staffs of the hospitals that will be influenced by the physician's work; and (ii) work in collaboration with elected medical staff leaders throughout the system and with any individuals who provide medical management services at the hospital level.</p> <p>2. Our AMA supports the following guidelines regarding the role of the organized medical staff vis-a-vis individuals employed by or under contract with hospitals/health systems to provide medical management services: a. The purpose, duties, and responsibilities of individuals employed by or under contract with the hospital/health system to provide medical management services should be included in the medical staff bylaws and in the hospital/health system corporate bylaws. b. The organized medical staff should maintain overall responsibility for the quality of care provided to patients by the hospital, including the quality of the professional services provided by individuals with clinical privileges, and should have the responsibility of reporting to the governing body. c. The chief elected officer of the medical staff should represent the medical staff to the administration, governing body, and external</p>	<p><u>they</u> should be a member in good standing of the organized medical staff of the hospital for which he or she <u>they</u> provide medical management services.</p>

Policy Number	Title	Text	Recommendation
		agencies. d. Government regulations that would mandate that any individual not elected or appointed by the medical staff would have authority over the medical staff should be opposed.	
H-315.980	Preservation of Medical Records	It is the policy of the AMA that medical considerations are the primary basis for deciding how long to retain medical records. For example, operative notes, chemotherapy records, and records documenting permanent structural alteration to the patients should always be part of the patient's chart.	Retain; Still relevant. <i>The Authors note that the AMA Code of Medical Ethics 3.3.1 provides extensive guidance related to medical records.</i>
H-35.967	Treatment of Persons with Hearing Disorders	<p>1. Our AMA believes that physicians should remain the primary entry point for care of patients with hearing impairment and continue to supervise and treat hearing, speech, and equilibratory disorders.</p> <p>2. Our AMA expressly opposes statements that the practice of audiology includes the diagnosis and treatment of hearing disorders; affirms that it is in the public interest that a medical assessment of any hearing or balance malfunction be made by a physician knowledgeable in diseases of the ear; reasserts that audiologists are individuals who perform non-medical testing, evaluating, counseling, instruction and rehabilitation of individuals whose communication disorders center in whole or in part in hearing function; and affirms its respect for the contribution which audiologists have made and continue to make to patient welfare and quality health care in their assistance in the treatment of hearing disorders.</p> <p>3. Should there be ambiguities in the statutory language of any state which defines audiology, state, and/or specialty medical societies should take steps to seek a legislative amendment to that statute to secure language that describes appropriately the practice of audiology. Misrepresentation by audiologists of their skills and/or the scope of their practice should be reported to appropriate state authorities.</p>	Retain; Still relevant.
H-365.999	Physician's Role in Returning Patients to Their Jobs	Our AMA encourages physicians everywhere to advise their patients to return to work at the earliest date compatible with health and safety and recognizes that physicians can, through their care, facilitate patients' return to work.	Consolidate with H-365.981 and H-365.976 (as editorially amended by insertion and deletion) and Retain. H-365.981, Workers' Compensation. Our AMA: (1) will promote the development of practice parameters, when appropriate, for use in the treatment of

Policy Number	Title	Text	Recommendation
			<p>injured workers and encourages those experienced in the care of injured workers to participate in such development.</p> <p>(2) will investigate support for appropriate utilization review guidelines for referrals, appropriate procedures and tests, and ancillary services as a method of containing costs and curbing overutilization and fraud in the workers' compensation system. Any such utilization review should be based on open and consistent review criteria that are acceptable to and have been developed in concert with the medical profession. Physicians with background appropriate to the care under review should have the ultimate responsibility for determining quality and necessity of care.</p> <p>(3) encourages the use of the Guides to the Evaluation of Permanent Impairment. The correct use of the Guides can facilitate prompt dispute resolution by providing a single, scientifically developed, uniform, and objective means of evaluating medical impairment.</p> <p>(4) encourages physicians to participate in the development of workplace health and safety programs.</p> <p>Physician input into</p>

Policy Number	Title	Text	Recommendation
			<p>healthy lifestyle programs (the risks associated with alcohol and drug use, nutrition information, the benefits of exercise, for example) could be particularly helpful and appropriate.</p> <p>(5) encourages the use of uniform claim forms (CMS 1500, UB04), electronic billing (with appropriate mechanisms to protect the confidentiality of patient information), and familiar diagnostic coding guidelines (ICD-9-CM, CPT; ICD-10-CM, CPT), when appropriate, to facilitate prompt reporting and payment of workers' compensation claims.</p> <p>(6) will evaluate the concept of Independent Medical Examinations (IME) and make recommendations concerning IME's (i) effectiveness; (ii) process for identifying and credentialing independent medical examiners; and (iii) requirements for continuing medical education for examiners.</p> <p>(7) encourages state medical societies to support strong legislative efforts to prevent fraud in workers' compensation.</p> <p>(8) will continue to monitor and evaluate state and federal health system reform proposals which propose some</p>

Policy Number	Title	Text	Recommendation
			<p>form of 24-hour coverage.</p> <p>(9) will continue to evaluate these and other medical care aspects of workers' compensation and make timely recommendations as appropriate.</p> <p>(10) will continue activities to develop a unified body of policy addressing the medical care issues associated with workers' compensation, disseminate information developed to date to the Federation and provide updates to the Federation as additional relevant information on workers' compensation becomes available.</p> <p><u>(11) H 365.999, Physician's Role in Returning Patients to Their Jobs, Our AMA encourages physicians everywhere to advise their patients to return to work at the earliest date compatible with health and safety and recognizes that physicians can, through their care, facilitate patients' return to work.</u></p> <p><u>(12) H 365.976, Adopting the Use of the Most Recent and Updated Edition of the AMA Guides to the Evaluation of Permanent Impairment: Our AMA supports the adoption of the most current edition of the AMA Guides to the Evaluation of Permanent Impairment by all jurisdictions to</u></p>

Policy Number	Title	Text	Recommendation
			<u>provide fair and consistent impairment evaluations for patients and claimants including injured workers.</u>
H-85.954	Importance of Autopsies	<p>1. Our AMA supports seeking the cooperation of the National Advisory Council on Aging of the National Institutes of Health in recommending to physicians, hospitals, institutes of scientific learning, universities, and most importantly the American people the necessity of autopsy for pathological correlation of the results of the immeasurable scientific advancements which have occurred in recent years. Our AMA believes that the information garnered from such stringent scientific advancements and correlation, as well as coalitions, should be used in the most advantageous fashion; and that the conclusions obtained from such investigations should be widely shared with the medical and research community and should be interpreted by these groups with the utmost scrutiny and objectivity.</p> <p>2. Our AMA: (a) supports the efforts of the Institute of Medicine and other national organizations in formulating national policies to modernize and promote the use of autopsy to meet present and future needs of society; (b) promotes the use of updated autopsy protocols for medical research, particularly in the areas of cancer, cardiovascular, occupational, and infectious diseases; (c) promotes the revision of standards of accreditation for medical undergraduate and graduate education programs to more fully integrate autopsy into the curriculum and require postmortems as part of medical educational programs; (d) encourages the use of a national computerized autopsy data bank to validate technological methods of diagnosis for medical research and to validate death certificates for public health and the benefit of the nation; (e) requests The Joint Commission to consider amending the Accreditation Manual for Hospitals to require that the complete autopsy report be made part of the medical record within 30 days after the postmortem; (f) supports the formalization of methods of reimbursement for autopsy in order to identify postmortem examinations as medical prerogatives and necessary medical procedures; (g) promotes programs of education for physicians to inform them of the value of autopsy for medical legal purposes and claims processing, to learn the likelihood of effects of disease on other family members, to establish the cause of death when death is unexplained or poorly understood, to</p>	Retain; Still relevant.

Policy Number	Title	Text	Recommendation
		<p>establish the protective action of necropsy in litigation, and to inform the bereaved families of the benefits of autopsy; and (h) promotes the incorporation of updated postmortem examinations into risk management and quality assurance programs in hospitals.</p> <p>3. Our AMA reaffirms the fundamental importance of the autopsy in any effective hospital quality assurance program and urges physicians and hospitals to increase the utilization of the autopsy so as to further advance the cause of medical education, research and quality assurance.</p> <p>4. Our AMA representatives to the Liaison Committee on Medical Education ask that autopsy rates and student participation in autopsies continue to be monitored periodically and that the reasons that schools do or do not require attendance be collected. Our AMA will continue to work with other interested groups to increase the rate of autopsy attendance.</p> <p>5. Our AMA requests that the National Committee on Quality Assurance (NCQA) and other accrediting bodies encourage the performance of autopsies to yield benchmark information for all managed care entities seeking accreditation.</p> <p>6. Our AMA calls upon all third-party payers, including CMS, to provide adequate payment directly for autopsies, and encourages adequate reimbursement by all third party payers for autopsies.</p> <p>7. It is the policy of our AMA: (a) that the performance of autopsies constitutes the practice of medicine; and (b) in conjunction with the pathology associations represented in the AMA House, to continue to implement all the recommendations regarding the effects of decreased utilization of autopsy on medical education and research, quality assurance programs, insurance claims processing, and cost containment.</p> <p>8. Our AMA affirms the importance of autopsies and opposes the use of any financial incentives for physicians who acquire autopsy clearance.</p>	

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-A-24

Subject: Establishment of a LGBTQ+ Section

Presented by: Gary Thal, MD, Chair

Referred to: Reference Committee F

1 In May 2023, the American Medical Association (AMA) Council on Long Range Planning and
2 Development (CLRPD) received a Letter of Application from the Advisory Committee (AC) on
3 Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+) Issues requesting a change in status to
4 the LGBTQ+ Section. AMA bylaws on Sections (§7.00) define the mission of AMA sections and
5 identify each section as fixed or delineated. This report presents to the AMA House of Delegates
6 (HOD) CLRPD’s evaluation of the proposal for a LGBTQ+ Section using criteria identified by
7 Policy G-615.001, “[Establishment and Functions of Sections](#)” in consideration of requests for new
8 sections or changing the status of member component groups.
9

10 APPLICATION OF CRITERIA

11
12 Following an initial review and discussion of the AC’s proposal for section status, the CLRPD met
13 with the leadership of the AC to obtain clarification on some of the information presented in the
14 letter of application. This part of the report presents criterion followed by material excerpted from
15 the letter of application and the AC’s response to CLRPD’s request for additional information. The
16 assessment section conveys the Council’s evaluation of the proposal for delineated section status.
17

18 *1. Issue of Concern - Focus will relate to concerns that are distinctive to the subset within the*
19 *broader, general issues that face medicine. A demonstrated need exists to deal with these matters,*
20 *as they are not currently being addressed through an existing AMA group.*
21

22 Currently, the AC serves as the experts on LGBTQ+ issues. Transitioning the group to a section
23 would serve as an entry point to the HOD for most AMA resolutions seeking to advance LGBTQ+
24 physician and medical student needs and the practice of LGBTQ+ medicine. In this sense, the
25 LGBTQ+ Section would provide the opportunity for underrepresented members of the AMA to
26 introduce issues of concern and to participate in the AMA policymaking process.
27

28 The goals and objectives of the LGBTQ+ Section shall include, but not be limited, to:

- 29
- 30 • Provide a dedicated forum for involvement, mentoring, and networking for LGBTQ+
31 physicians and medical students.
- 32 • Increase the membership, participation, and representation of LGBTQ+ physicians and
33 students in the AMA.
- 34 • Advocate for practices at AMA meetings to be inclusive to the needs of LGBTQ+
35 physicians, residents, medical students, and guests in attendance (e.g., gender neutral
36 bathrooms, availability of gender pronouns ribbons for name badges).

- 1 • Enhance AMA policy, advocacy, and education on LGBTQ+ health and professional
2 issues.
- 3 • Advocate for best practices with AMA membership to foster camaraderie and safely
4 identify as LGBTQ+ physicians and trainees.
- 5 • Increase and foster further collaboration with Health Professionals Advancing LGBTQ
6 Equity (GLMA) and additional professional societies, associations, and across AMA
7 business units and sections on mutual interests and goals.
- 8 • Reduce inequities faced by LGBTQ+ students, physicians, and patients and build support
9 systems through representation in membership, LGBTQ+ focused programming, and
10 mentorship opportunities.

11

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

14

15 Members of the LGBTQ+ Section would advocate for physicians and medical students by focusing
16 on strategies, programs, and policies to better serve AMA members, potential members, and
17 patients who identify as LGBTQ+. In 2022, the AC held an impromptu meeting with the Chair of
18 the AMA Board of Trustees (BOT) to discuss the AMA's messaging on Mpox, previously known
19 as Monkeypox or MPV. This meeting was to ensure that no groups affected by this public health
20 crises were further stigmatized, and to address the vaccine shortage so that distribution was
21 performed in an equitable and effective manner to prevent further spread.

22

23 The Committee holds a liaison position that serves on the AMA Foundation (AMAF) Fellowship
24 Commission on LGBTQ+ Health, which determines institutional grants to support the
25 advancement of LGBTQ+ Health and Equity initiatives. Additionally, the AC funds and selects
26 annual awardees for the AMAF LGBTQ+ Award for Excellence. These awards and grants are
27 establishing the pathway for physicians who identify as LGBTQ+ to become involved in the AMA,
28 gain peer recognition, and advance evidence-based practices of health equity standards for
29 LGBTQ+ patients. Given that the AC has been in existence since 2005, and that the strategic plan
30 and work of the Committee has demonstrated its continued need, the section would continue to be
31 essential, with neither change to staffing, nor duplicative efforts arising from the transition.

32

33 In November 2023, the AC sponsored a session with leading experts in the field of LGBTQ+ health
34 policy and legislation who discussed important and timely legislative efforts at the state and federal
35 levels impacting LGBTQ+ health care access and treatment, such as the current landscape of
36 legislation and bills that were passed recently affecting LGBTQ+ health care and access; current
37 court cases that resulted from enacted anti-LGBTQ+ legislation; newer bills, such as Shield laws,
38 that are being passed in an effort to protect access to LGBTQ+ health care services in some states,
39 and the sponsors and organizations backing anti-LGBTQ+ legislation and some of their strategies.

40

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

42

43 Due to its protected class nature and voluntary membership, the LGBTQ+ Section would not enroll
44 members based on sexual orientation, gender identity and expression (SOGIE) data. Instead,
45 members would need to opt in as members of the section. All AMA members may receive the
46 monthly LGBTQ+ newsletter, attend webinars, and AMA Interim and Annual meeting educational
47 programming.

48

49 The current AC leadership consists of a Chair, Vice Chair, GLMA Representative, Medical Student
50 Section (MSS) Representative, Young Physician Section (YPS) Representative, Resident Fellow
Section (RFS) Representative and two Members at-Large. As the LGBTQ+ Section, the governing

1 council (GC) would oversee the elections process for the delegate and alternate delegate positions
2 and allow any member of the section to apply for these positions. Section membership would then
3 vote to elect these positions. Terms of service for GC members will be addressed in the section's
4 internal operating procedure (IOP). The GC, including the delegates, would meet prior to the HOD
5 meetings and at other times throughout the year with elections taking place prior to the Annual
6 Meeting of the HOD. The Chair and Chair-elect positions would be elected positions from
7 members of the GC with the Chair-elect (now Vice Chair under current AC format) ascending to
8 Chair. Voting would be conducted in accordance with the section's IOP and call for a majority
9 consensus.

10
11 *4. Representation Threshold - Members of the formal group would be based on identifiable*
12 *segments of the physician population and AMA membership. A substantial number of members*
13 *would be represented by this formal group. At minimum, this group would be able to represent*
14 *1,000 AMA members. It is important to note this threshold will not be used to determine*
15 *representation, as each new section will be allocated only one delegate and one alternate delegate*
16 *in the AMA HOD.*

17
18 The percentage of U.S. adults who self-identify as gay, lesbian, bisexual, transgender, or something
19 other than heterosexual has increased to a new high of 7.2 percent, which is double the percentage
20 when Gallup first measured it a decade ago. Based on this estimate, there are approximately 23
21 million people who identify as transgender or non-binary, meaning those individuals whose gender
22 identity differs from cultural expectations based on the sex assigned at birth and/or falls outside
23 binary gender categories of “man” or “woman.”^{1 2}

24
25 The Association of American Medical Colleges Graduation Questionnaire notes that over one
26 percent of graduating medical students identify as a different gender than their sex assigned at
27 birth, and nearly 12 percent identify as gay, lesbian, bisexual, or another sexual identity besides
28 heterosexual.³ Of the 250,000 AMA members, nearly seven percent identify as LGBTQ+ based on
29 those who provided SOGIE information. The “prefer not to say” category in SOGIE data, is around
30 two percent, which is consistent with the 2022 Gallup census information. The AC has identified
31 another possible five percent of AMA membership as allies; so, as many as 12,500 active members
32 in the AMA would consider themselves allies to the LGBTQ+ Section.

33
34 With increased visibility as a section and additional opportunities for engagement and
35 collaboration, the section may be able to further reduce stigma within and outside the AMA.
36 Currently, the AC listserv engages a total of 1,703 individuals. Half of those are AMA members
37 (804) and the other half are not (899). As a section, it is anticipated that more LGBTQ+ members
38 will recruit friends and colleagues to be actively engaged members of the section. Groups where
39 the section may find opportunities to recruit new AMA members include GLMA, Medical Student
40 Pride Alliance (MSPA), LGBTQ+ members of specialty societies, and others.

¹ Gallup. US LGBT identification steady at 7.2%. Accessed August 6, 2023. <https://news.gallup.com/poll/470708/lgbt-identification-steady.aspx>.

² UCLA SCHOOL OF LAW WILLIAMS INSTITUTE. HOW MANY ADULTS AND YOUTH IDENTIFY AS TRANSGENDER IN THE UNITED STATES? ACCESSED MAY 19, 2023. <HTTPS://WILLIAMSINSTITUTE.LAW.UCLA.EDU/PUBLICATIONS/TRANS-ADULTS-UNITED-STATES/>.

³ AAMC. 2024 Medical School Graduation Questionnaire. Accessed May 19, 2004. <https://www.aamc.org/data-reports/students-residents/report/graduation-questionnaire-gq>.

1 *5. Stability - The group has a demonstrated history of continuity. This segment can demonstrate*
2 *an ongoing and viable group of physicians, who will be represented by this section. Both the*
3 *segment and the AMA will benefit from an increased voice within the policymaking body.*
4

5 The AC participates in several efforts aimed at growing AMA membership and engagement.
6 While attending outside organizations meetings and events, such as Howard Brown Health LGBTQ
7 Midwest Symposium, MSPA annual meeting, Building the Next Generation of Academic
8 Physicians (BNGAP) LGBT Workforce Conference, and GLMA's annual meeting, AC members
9 provide awareness and greater understanding of the benefits to working with and joining the AMA.
10 The current AC includes physicians from several stakeholder institutions such as Howard Brown
11 Health, MSPA and GLMA. AC members also collaborate and engage with students at the BNGAP
12 meeting and through the MSS representative for outreach to MSPA to engage interested students
13 with the AC and its work. As a section, the group plans on further educational outreach to MSS,
14 RFS and YPS within the AMA and LGBTQ+ groups outside the AMA.
15

16 The AC has convened meetings during Annual and Interim Meetings of the HOD. Attendance at
17 assembly meetings ranges between 80 to 150 members with 20-30 new members attending
18 meetings. The monthly newsletter listserv, which reaches approximately 1,700 individuals, remains
19 vital and connects AC membership between and during meetings. Committee members are very
20 well informed on the socio-economic facets of medicine and the group's leadership has remained
21 stable and consistent, with continuous growth in applicants for open positions. Engagement in the
22 Committee's newsletter continues to be among the highest open and click through rates across the
23 sections. For 2022, the monthly newsletter email was opened by 10,662 individuals with an open
24 percentage rate of 48.92.
25

26 Annually, the AC undergoes a strategic planning process where the top strategic initiatives are
27 identified and supporting tactics and measures are established. AC leadership performs quarterly
28 check-ins to assess how the Committee is progressing on these goals. The AC established its 2022-
29 2023 strategic priorities to:
30

- 31 • Facilitate member involvement, mentoring, leadership development, and networking for
32 LGBTQ+ physicians, medical students, and allies.
- 33 • Improve health equity for LGBTQ+ patients and communities and increase LGBTQ+
34 representation in the physician workforce.
- 35 • Engage internal and external stakeholders in amplifying AMA policy and enhancing
36 education and awareness efforts on LGBTQ+ health and well-being.
37

38 In addition to the strategic objectives, the Committee identified the following items as additional
39 priorities and areas of focus:
40

- 41 1. Promote physician safety from threats and violence, especially when providing medically
42 necessary, evidence-based care.
- 43 2. Mpox eradication including equitable vaccine and treatment distribution.
44

45 The AC has always been focused on establishing goals and priorities that support the mission and
46 continued growth and capacity to reach more LGBTQ+ physicians and medical students, and
47 understands the necessity to remain nimble and open to accommodating issues that inevitably arise
48 and require attention and support from the AC and AMA leadership, such as laws and regulations
49 that seek to deny access to health care, and penalize/criminalize the provision of medically
50 necessary and appropriate care.

1 For the June 2022 meeting, the LGBTQ+ Caucus had 146 registrants, which was nearly seven
2 percent of the total number of registered attendees for section caucus events. Compared to previous
3 caucus events, there has been consistent growth in registered attendees. In 2019, the AC had 83
4 registrants, and for 2021 there were 169 (no data for June 2020 as that meeting was cancelled).
5 Registration for the I-22 Meeting had 115 registered attendees, which is a marked increase from
6 November 2021, where 106 registrations were received for the virtual event and 40 attended in
7 person. This is also a marked increase from the virtual November 2020 meeting, when 30
8 participants attended the Caucus event. At the November 2019 Interim meeting there were 101
9 registered participants for the LGBTQ+ Caucus event.

10
11 In 2022, the AC hosted educational events with high attendance and registration rates and
12 supported the AMA's commitment to embedding health equity. The topics and speakers selected at
13 both the 2022 Annual and Interim meetings were non-profit providers who support marginalized
14 LGBTQ+ communities. At the June meeting, the AIDS Foundation of Chicago (AFC) presented,
15 "Policy, Housing, Health Equity." The session relayed AFC's impact on reducing HIV-related
16 health disparities among Black, Indigenous, and people of color and LGBTQ+ communities
17 through housing, case management, policy and advocacy, and community engagement. For the
18 November Interim education session, Hawaii Health and Harm Reduction Center presented
19 "Knowing Your Place." Attendees of this session gained an increased understanding of western
20 concepts of LGBTQ+ identities; increased knowledge about the culture, history, and role of native
21 Hawaiian Mahu and of the impacts of colonialism on the native Hawaiian Mahu community; and
22 gained increased confidence to provide culturally appropriate health services to Native Hawaiian
23 LGBTQ+ communities.

24
25 *6. Accessibility - Provides opportunity for members of the constituency, who are otherwise under-*
26 *represented, to introduce issues of concern and to be able to participate in the policymaking*
27 *process within the HOD.*
28

29 Since its formation, the AC has been well-organized and engaged in the AMA, has a collegial and
30 supportive relationship with the BOT and is recognized as the forum for physicians and medical
31 students who identify as LGBTQ+ within the AMA. The Committee conducts their meetings and
32 policy discussions in alignment with the HOD as do the sections, which the AC engages with, e.g.,
33 the Integrated Physician Practice Section, MSS, RFS, Minority Affairs Section, Women Physicians
34 Section and more on a regular and consistent basis. The AC has engaged with AMA staff to
35 support the AMA business efforts addressing the needs of physicians and health care of the
36 LGBTQ+ community. While many AC members are delegates or alternates who are familiar with
37 the activities and policymaking processes of the House, it is common that reference committee
38 members, section leaders, various delegations or BOT members may ask the unofficial opinion of
39 the AC on items of business at the HOD, despite the AC having no official standing at the House.
40 However, Committee members have not had a consistently visible identified voice in the HOD.
41 Members of the AC believe all of this has prepared the AC to transition quickly and efficiently to
42 become a highly functioning and effective section and that the time has come to transition to
43 section status with a delegate who can voice the official opinion of an LGBTQ+ Section.

44
45 The LGBTQ+ Section would serve as an entry point to the HOD for most AMA resolutions
46 seeking to support physicians, medical students, and patient health of the LGBTQ+ community.
47 This section can help ensure resolutions brought to the HOD provide opportunities for LGBTQ+
48 members to engage in the AMA policymaking process. Section members will be notified prior to
49 meetings of resolution submission guidelines and deadlines. Members would submit resolutions to
50 the GC for consideration that would then review the submission and assist the author(s) with
51 modifications, if needed. Section members could submit comments or testimony to revise the

1 original resolution. The GC would discuss resolutions and reports that are germane to the section
2 during their meetings. Section membership would vote to support, oppose, or recommend other
3 directives for the resolutions and reports, and would also solicit and discuss timely issues for future
4 policymaking activities. The LGBTQ+ Section could provide a friendly forum for under-
5 represented LGBTQ+ physicians and medical students who have often felt marginalized to
6 introduce issues of concern and to participate in the AMA policymaking process.

7
8 CLRPD ASSESSMENT

9
10 Within the AMA, there are no component groups solely devoted to advocacy and education related
11 to issues that are specific to LGBTQ+ individuals. Given the limited opportunity of the AC to
12 present issues of concern specific to this group, the CLRPD believes it would be appropriate to
13 afford LGBTQ+ physicians and medical students with an opportunity for a focused voice. The
14 proposed LGBTQ+ Section would be dedicated to advocacy on policy issues, provide leadership
15 development and educational opportunities for medical students and physicians, and monitor trends
16 and issues that affect physicians, medical students and patients who identify as LGBTQ+.

17
18 The LGBTQ+ Section would generate projects relevant to physicians and physicians in training
19 who have an interest in LGBTQ+ issues. Improving outreach and creating new opportunities for
20 participation among physicians and trainees may incentivize non-members of this demographic to
21 become AMA members. The structure of the proposed LGBTQ+ Section is conducive to sharing
22 key concerns and identifying meaningful opportunities for physicians, which supports the
23 objectives of this group. In accordance with the AMA bylaws, sections are required to have an
24 elected GC from the voting members of the section and establish a business meeting that would be
25 open to its members. The AC presently has an established online forum, which could create an
26 avenue for a voting body to elect GC members.

27
28 LGBTQ+ physicians and medical students remain a substantial market segment for our AMA and
29 this section would represent over 1,000 AMA members. Since its inception, the AC has taken steps
30 to align its structure with the activities of the AMA. AC leadership has built a solid foundation for
31 the group, which would benefit from a delegate's voice to address LGBTQ+ issues in the HOD.
32 The AMA's policymaking process could be strengthened by ensuring that the perspectives of these
33 physicians, medical students and patients are represented.

34
35 The CLRPD finds that the application meets all six criteria as defined in bylaws.

36
37 RECOMMENDATIONS

38
39 The Council on Long Range Planning and Development recommends that the following
40 recommendations be adopted and the remainder of the report be filed:

- 41
42 1. That our American Medical Association transition the Advisory Committee on Lesbian, Gay,
43 Bisexual, Transgender and Queer (LGBTQ+) Issues to the LGBTQ+ Section as a delineated
44 section. (Directive to Take Action)
45
46 2. That our AMA develop bylaw language to recognize the LGBTQ+ Section. (Directive to Take
47 Action)

Fiscal Note: The Advisory Committee on LGBTQ+ Issues submitted a detailed fiscal note that projected incremental expenditures of \$16,000 per annum for the proposed section.

REPORT OF THE SPEAKERS

Speakers' Report 01-A-24

Subject: Report of the Resolution Modernization Task Force Update

Presented by: Lisa Bohman Egbert, MD, Speaker, and John H. Armstrong, MD, Vice Speaker

Referred to: Reference Committee F

1 BACKGROUND

2
3 At the 2023 Annual Meeting, resolution 604 was adopted. Resolution 604 states:

4
5 RESOLVED, That our American Medical Association form a Speakers Task Force on the
6 Resolution Process to review the entire process of handling resolutions for our AMA
7 House of Delegates, including but not limited to definitions of on time resolutions,
8 emergency resolutions, and late resolutions, deadlines for submission of resolutions by all
9 sections, processing and review of reference committee reports, and use of virtual meetings
10 so that all on time resolutions can be submitted by the same deadline (Directive to Take
11 Action); and be it further

12
13 RESOLVED, That our AMA Speakers Task Force on the Resolution Process report back
14 to our AMA House of Delegates by the 2024 Annual Meeting with recommendations
15 regarding the resolution process. (Directive to Take Action)

16
17 Pursuant to this policy, the Resolution Modernization Task Force (RMTF) was appointed by the
18 Speaker with a broad representation in the House. The RMTF includes following nine members:

- 19
20
- 21 ● David Henkes, MD, Chair, Texas
 - 22 ● Sarah Candler, MD, American College of Physicians
 - 23 ● Ronnie Dowling, MD, Arizona Medical Association
 - 24 ● Rachel Ekaireb, MD, Resident/Fellow Section, California
 - 25 ● Michael Hanak, MD, American Academy of Family Physicians
 - 26 ● Susan Hubbell, MD, American Academy of Physical Medicine and Rehabilitation
 - 27 ● Gary Pushkin, MD, The Maryland State Medical Society
 - 28 ● Kaylee Scarnati, Medical Student Section, Ohio
 - 29 ● Rachel Kylo, MD, American Society for Dermatologic Surgery
 - 30 ● Lisa Bohman Egbert, MD, Speaker, Ohio
 - 31 ● John H. Armstrong, MD, Vice Speaker, American College of Surgeons

32 The RMTF held their initial meeting on August 27, 2023, and developed an informational report,
33 Speakers' Report 01-I-23, which delineated issues with the resolutions process. This report was
34 used to guide the RMTF Open Forum which was held at the 2023 Interim Meeting to solicit input
35 from House of Delegates (HOD) and other AMA members attending the meeting. In addition, an
36 RMTF email box was established and announced during the open forum to enable members to
37 continue to submit comments after I-23 adjourned. There was robust discussion during the open

1 forum and many comments were received into the RMTF email box. The discussion topics at the
2 open forum included:

- 3
- 4 ● Unequal time for delegates to evaluate items for HOD business
- 5 ● Avoiding Redundancy with Existing Policy
- 6 ● Reference Committee Process
- 7 ● Reference Committee Hearings
- 8

9 The RMTF met again in early January 2024 to review comments received. As was stated at their
10 initial meeting, the task force, "...seeks to develop efficient processes that allow for all business
11 before the House to be equally reviewed by all delegates with the ultimate goal of the best policy
12 being developed for our AMA," and that remained their guiding principle in developing this report
13 and its recommendations.

14 15 DISCUSSION

16
17 Based on comments heard at the open forum, there was general consensus that the resolution
18 process is outdated, inefficient and requires modernization. The task force notes that the resolution
19 submission process and policies have not been changed since 2012; however, the HOD office has
20 begun significant technical improvements to PolicyFinder and to the procedures for submission and
21 processing of resolutions. Because these technical improvements are ongoing, the RMTF focused
22 on changes that would allow the consideration of HOD business to be more efficient, more
23 inclusive to members, and more equitable so that all items of business receive adequate and
24 equivalent consideration by the House. Therefore, the proposed recommendations address
25 resolution deadlines, the online forum, reference committee reports, and reaffirmation.

26 27 *Resolution Deadlines*

28
29 The resolution submission deadlines as stated in AMA Bylaws are as follows:

30
31 2.11.3.1 Resolutions. To be considered as regular business, each resolution must be
32 introduced by a delegate or organization represented in the House of Delegates and must
33 have been submitted to the AMA not later than 30 days prior to the commencement of the
34 meeting at which it is to be considered, with the following exceptions.

35
36 2.11.3.1.1 Exempted Resolutions. If any member organization's house of delegates
37 or primary policy making body, as defined by the organization, adjourns during the
38 5-week period preceding commencement of an AMA House of Delegates meeting,
39 the organization is allowed 7 days after the close of its meeting to submit
40 resolutions to the AMA. All such resolutions must be received by noon of the day
41 before the commencement of the AMA House of Delegates meeting. The presiding
42 officer of the organization shall certify that the resolution was adopted at its just
43 concluded meeting and that the body directed that the resolution be submitted to
44 the AMA House of Delegates.

45
46 2.11.3.1.2 AMA Sections. Resolutions presented from the business meetings of the
47 AMA Sections may be presented for consideration by the House of Delegates no
48 later than the recess of the House of Delegates opening session to be accepted as
49 regular business. Resolutions presented after the recess of the opening session of
50 the House of Delegates will be accepted in accordance with Bylaw 2.11.3.1.4.

1 2.11.3.1.3 Late Resolutions. Late resolutions may be presented by a delegate prior
2 to the recess of the opening session of the House of Delegates, and will be
3 accepted as business of the House of Delegates only upon two-thirds vote of
4 delegates present and voting.

5
6 2.11.3.1.4 Emergency Resolutions. Resolutions of an emergency nature may be
7 presented by a delegate any time after the opening session of the House of
8 Delegates is recessed. Emergency resolutions will be accepted as business only
9 upon a three-fourths vote of delegates present and voting, and if accepted shall be
10 presented to the House of Delegates without consideration by a reference
11 committee. A simple majority vote of the delegates present and voting shall be
12 required for adoption.
13

14 Currently, it is difficult for staff, delegations and members to review and fully vet all items of
15 business before the House due to the multiple exceptions to the "on-time" deadline as defined
16 above. These multiple exceptions mean that business is being processed in an ongoing fashion and
17 results in a fairly significant amount of "on-time" business being submitted after the 30-day
18 deadline through the closing of the HOD Opening Session. Although exempted resolutions are
19 posted on the website as soon as they are processed, they are not able to be included in the HOD
20 Delegate Handbook or the Online Member Forums (forums) and are often not seen by delegations
21 until the release of the "meeting tote" prior to the HOD Second Opening Session. These items of
22 business are not available to undergo the same consideration as those submitted before the 30-day
23 deadline. The inability to adequately review these late arriving "on-time" resolutions has been
24 identified as a major frustration by delegations. The short timeframe for review also limits
25 opportunities for collaboration and consensus building among delegations. Many suggestions to
26 rectify this problem were offered at the open forum and by email. The majority favored having one
27 set "on-time" deadline. Some delegates voiced concern for the Sections who meet and pass
28 resolutions just prior to the meeting. However, representatives from the MSS and RFS stated that
29 they have a very robust process for vetting their resolutions; by default, resolutions are deferred to
30 the following HOD meeting, and only those of an urgent nature are immediately forwarded. Given
31 that late resolutions are specifically reviewed for their timeliness and urgency, these resolutions
32 would be well positioned to be recommended for consideration if submitted as such.
33

34 Therefore, the RMTF recommends that the "on-time" deadline for resolutions be set at 45 days
35 prior to the commencement of the meeting at which it is to be considered. This recommendation
36 discontinues the exemptions for late society meetings and AMA Sections. Resolutions will be
37 considered "late" when received after the 45-day deadline and prior to the beginning of the HOD
38 Opening Session. Late resolutions will continue to be under the purview of the Rules and
39 Credentials Committee and the criteria for which late resolutions would be recommended for
40 consideration will continue to include the resolution's timeliness and the urgency of the topic.
41 Recommendations for consideration of late resolutions will continue to be included as a consent
42 calendar on the Rules and Credentials Report presented at the Second Opening Session and require
43 a two-thirds vote for consideration. The emergency resolution process would remain unchanged;
44 however, any resolution submitted after the HOD Opening Session begins will be treated as an
45 emergency resolution.
46

47 In summary, resolutions will fall into one of three categories: on time (45 days prior to the
48 meeting), late (after the on-time deadline and before the Opening Session begins), or emergency
49 (after the Opening Session begins). The Sections and organizations that hold their policy-making
50 meetings after the on-time deadline would be encouraged to review their resolutions for timeliness
51 and urgency and hold those not meeting this criteria for the next coming AMA meeting. Those

1 resolutions deemed timely and urgent could be submitted as late resolutions which will require a
2 two-thirds vote for consideration. These adjusted deadlines would allow staff to more easily
3 process items of business, prepare and post the HOD Delegate Handbook in its entirety, and post
4 the entire handbook on the Online Member Forums. In turn, this should allow delegations more
5 time to consider items of business without the scramble and frustration that the current process
6 produces. Overall, these changes will level the playing field so that all resolutions will be able to be
7 reviewed equally.

8
9 *Reference Committees Hearings and Reports*

10
11 The Online Member Forums were identified as an area ripe for improvement. Many commenters
12 noted experience from their own organizations in which a more robust virtual preliminary reference
13 committee process led to a more efficient in-person process and ultimately to policy that has been
14 more thoughtfully crafted and more thoroughly vetted. Additionally, Res. 606-I-21, established
15 policy D-600.956 which called for a two-year trial requiring that reference committees, prior to the
16 in-person reference committee hearing, produce a preliminary reference committee document
17 based on the written online testimony. An evaluation to determine if this procedure should be
18 continued is a directive of this policy. The RMTF was asked to conduct this evaluation as part of
19 their overall review to modernize the HOD.

20
21 Assessing the success of the trial of the Online Member Forums is difficult. As noted above, the
22 vast majority of the comments submitted to the RMTF suggested that these online forums should
23 be utilized in a much more robust and productive way to move the business of the HOD forward.
24 Polling of HOD delegates over a course of three meetings (A-22, I-22 and A-23), found that
25 consistently around 70% of delegates had viewed at least a few items on the forums. The
26 preliminary documents were found to be at least "somewhat helpful" by around 65% of those
27 responding. This would suggest that, although delegates find the forums to be a useful tool to
28 review items of business, they are currently being underutilized.

29
30 In their current state, the comments received on the forums are viewed by many to not carry the
31 same importance as in person testimony which is multifactorial in origin. A significant factor, as
32 discussed above, is that many "on-time" resolutions are not even posted on the forums. In addition,
33 the current process for developing a preliminary document, as defined in policy D-600.956, gives
34 very little insight into the direction of the reference committee's actions. By explicitly treating this
35 as an official reference committee hearing with a report, the RMTF believes this will drive greater
36 utilization of this valuable tool by elevating the importance of contributing to the online discussion.
37 This change would thus give equal weight to the testimony gathered online. In addition, there are
38 multiple advantages to online testimony which include:

- 39
40
- 41 ● The ability to submit amendments and/or supporting documentation with unlimited text
42 which allows for consideration and comment by other delegations.
 - 43 ● More time and opportunity for delegates and delegations to collaborate to improve
44 proposed resolutions.
 - 45 ● The opportunity for the entire AMA membership to submit comments, offering a wider
46 voice in the development of AMA policy.
 - 47 ● Increased inclusivity by allowing those unable or who prefer not to travel to meetings the
48 opportunity to participate.
 - 49 ● The opportunity for small delegations to provide input on all items of business by avoiding
the inherent difficulty of presenting at concurrent in-person reference committee hearings.

1 Therefore, the RMTF recommends that the Online Member Forums be renamed the Online
2 Reference Committee Hearings. These online ref coms will open 10 days following the 45-day
3 resolution submission deadline and be open for 21 days. As noted above, this 10-day window will
4 allow adequate time for staff processing of resolutions, the development of the HOD Handbook,
5 the review of the Resolution Committee for Interim, and the posting of resolutions on the Online
6 Reference Committees which currently is a lengthy process. This also extends the online ref coms
7 by one week beyond the current two-week window. For these reasons, the RMTF chose 45 days for
8 the "on-time" deadline. All items of business received by the resolution deadline will be included
9 in the Online Reference Committee Hearings.

10
11 The RMTF recommends that reference committees convene virtually after the online ref com 21-
12 day window closes, to develop a Preliminary Reference Committee Report. The task force further
13 recommends that the bylaws be amended so that the term for all committees of the House shall
14 commence upon their formation and shall continue throughout the meeting for which they were
15 appointed unless otherwise directed by the HOD, such as Reference Committee F.

16
17 The Preliminary Reference Committee Report will follow the same format as the reference
18 committee reports which are produced following the in-person hearings with the exception that
19 they shall not be consent calendars. The reports would include recommended actions by the
20 reference committee with items grouped by action, a summary of testimony to date, and a rationale
21 for the action recommended. The reports would be posted to the HOD website at least four days
22 prior to the opening of the HOD meeting for which they were submitted.

23
24 The in-person reference committee hearings will continue to hear testimony on each item before
25 the reference committee with the exception that the order of business would follow the order listed
26 on the Preliminary Reference Committee Report. Therefore, those items recommended for
27 adoption would go first followed by those recommended for adoption as amended and so forth,
28 with items for reaffirmation in lieu of being heard last. Although the preliminary reports will offer
29 recommendations for action for each item, this does not preclude discussion of the original item
30 and/or alternate actions or the submission of supporting documentation for the reference committee
31 to consider. Following the in-person hearing, the reference committees will convene to review the
32 in-person testimony and make necessary adjustments to their reports taking both online ref com
33 and in-person testimony into consideration. The final reference committee report to be considered
34 at the HOD will then be posted in the usual fashion.

35
36 In prior discussions of preliminary reports, concerns included that recommendations contained in
37 the report would be based on insufficient input or include recommendations that bias the outcome
38 of an item of business. However, those with experience with such a preliminary report with
39 recommendations noted that the inclusion of recommendations actually led to more robust online
40 discussions and thus more accurate initial recommendations. Additionally, as previously stated, the
41 recommendations included in the preliminary report are based on initial testimony only and would
42 be updated to reflect the totality of testimony from both the online and in-person testimony and that
43 stating a preliminary action does not preclude discussion of the original item or alternative actions
44 at the in-person hearing. Reference committee members should be trusted to incorporate in-person
45 testimony and change recommendations as warranted.

46
47 The task force believes this iterative process affords delegates and delegations the time to
48 collaborate on language and to fully review topics that are more complicated in nature and provides
49 the opportunity to perfect reference committee recommendations for their final report. Ultimately,
50 reference committee reports are not definitive until the House acts, and this process provides ample

1 opportunity to discuss each item of business to achieve the goal of developing the best possible
2 policy of our AMA.

3
4 *Reaffirmation*

5
6 The reaffirmation process was universally identified as a significant problem to be addressed and
7 was generally described as “broken.” This was highlighted at I-23 when all of the items placed on
8 the consent calendar were subsequently removed from it. In their discussions, the task force
9 identified some of the sources of items recommended for reaffirmation which include:

- 10
11 ● Policy exists but the authors are either not aware of the policy or current AMA activity to
12 achieve the goals of the existing policy.
13 ● Some delegations have a directive to their delegation from their parent organization to
14 submit all resolutions earmarked to go to the AMA for consideration, even when they are
15 aware that there is current existing policy.
16 ● There is current AMA policy on the subject, but authors are not satisfied with AMA
17 activity as a result of the existing policy.
18

19 The task force noted that many members consider reaffirmation a “defeat” of their resolution. On
20 the contrary the task force believes that reaffirmation should be seen as a “win” as it resets the
21 sunset clock and brings the issue back to the attention of our leadership and management team.
22

23 The RMTF spent significant time discussing the current process and potential improvements for it.
24 Ultimately, the task force decided that the current process of having resolutions placed on a
25 reaffirmation calendar should be discontinued and that the recommended firm on-time deadline
26 along with the implementation of the online ref coms with subsequent preliminary reports, would
27 be the best method to handle the identification of items for reaffirmation. As envisioned, the
28 process would be as follows: AMA content experts would continue to review submitted
29 resolutions and identify relevant current policy which is included as background information.
30 These policies would also be posted on the online reference committee hearing and, when
31 appropriate, a notation would be added that an identified policy may be reaffirmed in lieu of the
32 resolution. Online comments regarding these so identified items could then proceed regarding the
33 merits of reaffirmation along with the merits of the item itself. The reference committee will then
34 have the option to recommend “reaffirmation in lieu of” for these or any other item it deems
35 appropriate on its preliminary reference committee report. Further discussion of the handling of
36 these items will then be entertained at the in-person hearing.
37

38 **CONCLUSION:**

39
40 The RMTF recommends the establishment of a firm deadline of 45 days prior to the start of a
41 meeting for on-time resolutions with all resolutions received after this deadline and prior to the
42 start of the meeting considered late. This strict deadline will allow for all on-time resolutions to be
43 included in the Online Reference Committee Hearings (renamed from the Online Member Forums)
44 and for these online ref coms to remain open for 21 days rather than the current 14. The online ref
45 coms will produce Preliminary Reference Committee Reports which will include preliminary
46 recommendations. Recommendations regarding reaffirmation in lieu of a resolution will be
47 included in the Preliminary Reference Committee Report rather than a reaffirmation calendar so
48 that comments regarding reaffirmation can be made in the online ref coms and discussed further at
49 the in-person hearings. Delegations and Sections that meet after the 45 day on-time deadline will
50 have the opportunity to present late resolutions which they deem timely and urgent to the Rules and
51 Credentials Committee which will in turn recommend for or against consideration based on these

1 criteria. These changes will allow for equal consideration of all on-time resolutions as well as equal
2 application of the timeliness and urgency considerations for all late resolutions. It will eliminate the
3 current "broken" reaffirmation process and allow for open discussion of the merits of reaffirmation
4 on any given item.

5
6 The objective of the task force was to increase the efficiency of the resolution process but also
7 paramount was to maintain member input and the voice of the minority. The task force tried to
8 individually look at each of the issues identified at the town hall meeting and the email box but
9 found that the issues and solutions were integrated. Your task force believes that all of the proposed
10 recommendations work together to provide the fairest, most effective, and efficient manner to
11 develop the best policy for our AMA. The RMTF expresses the need for caution in that changes in
12 one recommendation may reduce the effectiveness of others and urges the House to accept the
13 proposed recommendations in aggregate to achieve these goals.

14
15 RECOMMENDATIONS:

16
17 The Resolution Modification Task Force recommends that the following be adopted to be
18 implemented for Interim 2024 and the remainder of the report be filed:

- 19
20 1. The bylaws be amended so that the resolution submission deadline be 45 days prior to the
21 opening session of the House of Delegates. (Directive to take Action)
22
- 23 2. The bylaws be amended so that the definition of a late resolution shall be all resolutions
24 submitted after the resolution submission deadline and prior to the beginning of the
25 Opening Session of the House of Delegates. (Directive to take Action)
26
- 27 3. The bylaws be amended so that the definition of an emergency resolution shall be all
28 resolutions submitted after the beginning of the Opening Session of the House of
29 Delegates. (Directive to take Action)
30
- 31 4. The bylaws be amended so that the term of committees of the House of Delegates shall
32 commence upon their formation and shall conclude at the end of the meeting for which
33 they were appointed, unless otherwise directed by the House of Delegates. (Directive to
34 take Action)
35
- 36 5. That our AMA will convene Online Reference Committee Hearings prior to each House of
37 Delegates meeting. These hearings shall open 10 days following the resolution submission
38 deadline and remain open for 21 days. This shall be accomplished in lieu of Policy G-
39 600.045. (New HOD Policy)
40
- 41 6. Prior to House of Delegates meetings, reference committees will convene after the close of
42 the Online Reference Committee Hearings to develop a Preliminary Reference Committee
43 Report. These reports shall include preliminary recommendations and will serve as the
44 agenda for the in-person reference committee hearing. This shall be accomplished in lieu of
45 Policy G-600.060(8). (New HOD Policy)
46
- 47 7. That Policy D-600.956 be rescinded. (Rescind HOD Policy)

1 **Relevant AMA Policy:**

2
3 **Increasing the Effectiveness of Online Reference Committee Testimony Policy D-600.956**

- 4 1. Our AMA will conduct a trial of two-years during which all reference committees, prior to the
5 in-person reference committee hearing, produce a preliminary reference committee document
6 based on the written online testimony.
7 2. The preliminary reference committee document will be used to inform the discussion at the in-
8 person reference committee.
9 3. There be an evaluation to determine if this procedure should continue.
10 4. The period for online testimony will be no longer than 14 days.
11 5. The trial established by Policy D-600.956 be continued through Annual 2024.
12

13 **Online Member Forums in the House of Delegates G-600.045**

- 14 1. Online member forums should be incorporated into every House of Delegates policymaking
15 meeting, using the following parameters: a. Each reference committee should participate in the
16 online member forum process; b. Each online member forum should cover as many items of
17 business as possible, including, at minimum, those items that appear in the initial compilation of
18 the Delegate Handbook; c. Comments submitted to an online member forum should be used to
19 prepare a summary report that reflects the comments received up to that point; d. Full, free and
20 complete testimony should be allowed in the onsite hearings; and e. The Speakers should
21 experiment with alternative procedures to enhance and improve the overall online member forum
22 process.
23 2. Our American Medical Association will form a Speakers Task Force on the Resolution Process
24 to review the entire process of handling resolutions for our AMA House of Delegates, including
25 but not limited to definitions of on time resolutions, emergency resolutions, and late resolutions,
26 deadlines for submission of resolutions by all sections, processing and review of reference
27 committee reports, and use of virtual meetings so that all on time resolutions can be submitted by
28 the same deadline.
29 3. Our AMA Speakers Task Force on the Resolution Process will report back to our AMA House
30 of Delegates by the 2024 Annual Meeting with recommendations regarding the resolution process.
31

32 **Introducing Business to the AMA House G-600.060**

33 AMA policy on introducing business to our AMA House includes the following:

- 34 1. Delegates submitting resolutions have a responsibility to review the Resolution checklist and
35 verify that the resolution is in compliance. The Resolution checklist shall be distributed to all
36 delegates and organizations in the HOD prior to each meeting, as well as be posted on the HOD
37 website.
38 2. An Information Statement can be used to bring an issue to the awareness of the HOD or the
39 public, draw attention to existing policy for purposes of emphasis, or simply make a statement.
40 Such items will be included in the section of the HOD Handbook for informational items and
41 include appropriate attribution but will not go through the reference committee process, be voted
42 on in the HOD or be incorporated into the Proceedings. If an information statement is extracted,
43 however, it will be managed by the Speaker in an appropriate manner, which may include a simple
44 editorial correction up to and including withdrawal of the information statement.
45 3. Required information on the budget will be provided to the HOD at a time and format more
46 relevant to the AMA budget process.
47 4. At the time the resolution is submitted, delegates introducing an item of business for
48 consideration of the House of Delegates must declare any commercial or financial conflict of
49 interest they have as individuals and any such conflict of interest must be noted on the resolution at
50 the time of its distribution.

- 1 5. The submission of resolutions calling for similar action to what is already existing AMA policy
2 is discouraged. Organizations represented in the House of Delegates are responsible to search for
3 alternative ways to obtain AMA action on established AMA policy, especially by communicating
4 with the Executive Vice President. The EVP will submit a report to the House detailing the items
5 of business received from organizations represented in the House which he or she considers
6 significant or when requested to do so by the organization, and the actions taken in response to
7 such contacts.
- 8 6. Our AMA will continue to safeguard the democratic process in our AMA House of Delegates
9 and ensure that individual delegates are not barred from submitting a resolution directly to the
10 House of Delegates.
- 11 7. Our AMA encourages organizations and Sections of the House of Delegates to exercise restraint
12 in submitting items on the day preceding the opening of the House.
- 13 8. Resolutions will be placed on the Reaffirmation Consent Calendar when they are identical or
14 substantially identical to existing AMA policy. For resolutions placed on the Reaffirmation
15 Consent Calendar, the pertinent existing policy will be clearly identified by reference to the Policy
16 Database identification number. When practical, the Reaffirmation Consent Calendar should also
17 include a listing of the actions that have been taken on the current AMA policies that are equivalent
18 to the resolutions listed. For resolutions on the Reaffirmation Consent Calendar which are not
19 extracted, the existing, pertinent AMA policy will be deemed to be reaffirmed in lieu of the
20 submitted resolution which resets the sunset clock for ten years.
- 21 9. Updates on referred resolutions are included in the chart entitled "Implementation of
22 Resolutions," which is made available to the House.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(A-24)

Introduced by: Medical Student Section

Subject: Annual Holocaust Remembrance Event

Referred to: Reference Committee F

1 Whereas, physicians played leading roles in the Holocaust and were a driving force behind
2 some of the worst atrocities perpetrated on Jewish and other marginalized communities,
3 demonstrating the negative impact physicians can have during political turmoil^{1,2,3}; and
4

5 Whereas, heinous medical experimentation took place during the Holocaust despite Germany's
6 pre-existing Guidelines for Human Experimentation, which at the time was one of the only codes
7 for ethical human experimentation in the world and which called for unambiguous informed
8 consent, demonstrating the potential for codes of ethics to be ignored or subverted if they are
9 not protected and supported⁴; and
10

11 Whereas, even with a code of ethics, Nazi physicians believed they were operating under
12 scientifically and ethically sound beliefs due to their prioritization of the national effort and
13 government agenda^{2,3}; and
14

15 Whereas, medical involvement in the Holocaust has profoundly influenced contemporary
16 medical ethics, and current thinking on medical ethical issues can be understood better by
17 learning about and reflecting on the legacy of medical involvement in the Holocaust^{2,3}; and
18

19 Whereas, in addition to the well-known Nazi medical experiments, German physicians created
20 and led Nazi programs such as forced sterilizations, child "euthanasia," and the T4 program to
21 murder institutionalized adults, which are critical aspects of medical history (and some of which
22 were directly influenced by American medical and racial policies), but these are much less
23 widely studied by students in medical school^{3,4}; and
24

25 Whereas, learning about and reflecting on the implications of physician involvement in the
26 Holocaust can not only help students understand contemporary medical ethics, but can also
27 help protect against future human rights abuses by physicians^{2,3,5}; and
28

29 Whereas, per the Liaison Committee for Medical Education (LCME) annual survey, only 16% of
30 US and Canadian medical schools devote any required curricular time to learning about the
31 roles of physicians in the Holocaust and contemporary implications^{5,6}; and
32

33 Whereas, abundant curricular resources on Holocaust education are available, relieving the
34 burden of medical schools having to create novel educational materials to support medical
35 student learning and reflection on this history and its contemporary relevance^{5,7}; and
36

37 Whereas, the AMA Code of Medical Ethics only mentions physicians' role in the Holocaust once
38 as an example of information obtained from unethical experiments (E-7.2.2); and

1 Whereas, the legacy of medical involvement in the Holocaust is increasingly recognized as
2 critical to understanding contemporary concerns around health equity and justice and the roles
3 of health professionals in either perpetuating or alleviating injustice^{5,8}; and
4

5 Whereas, experts in medical ethics education and professional identity formation are
6 increasingly calling for inclusion of these issues as part of the medical curriculum, including in
7 the *Lancet*, the *AMA Journal of Ethics*, and in a presentation held by the AAMC^{3,5,9}; and
8

9 Whereas, a single event on an annual basis, held on an internationally-recognized day of
10 remembrance, could present a valuable opportunity for student and faculty learning and
11 reflection about the legacy of health professional involvement in the Holocaust¹⁰, therefore be it
12

13 **RESOLVED**, that our American Medical Association host an annual event in support of
14 International Holocaust Remembrance Day (January 27) to provide education to medical
15 trainees about the role of physicians in the Holocaust. (Directive to Take Action)

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

Received: 4/19/2024

REFERENCES

1. Anderlini D. Cultivating awareness of the holocaust in medicine. *The Lancet*. 2020;395(10221):334-335. doi:10.1016/s0140-6736(19)32609-1
2. Baker R. How should students learn about contemporary implications of health professionals' roles in the Holocaust? *AMA Journal of Ethics*. 2021;23(1).doi:10.1001/amajethics.2021.31
3. Chelouche T, Wynia MK, Why does medical participation in the Holocaust still matter? *AMA Journal of Ethics*. 2021;23(1). doi:10.1001/amajethics.2021.3
4. Chelouche T. Teaching hard truths about medicine and the Holocaust. *AMA Journal of Ethics*. 2021;23(1). doi:10.1001/amajethics.2021.59
5. Silvers WS, Wynia MK, Levine MA, Himer M. Teaching health professions students about the Holocaust. *AMA Journal of Ethics*. 2021;23(1). doi:10.1001/amajethics.2021.26
6. Wynia MK, Silvers WS, Lazarus JA. How do U.S and Canadian Medical Schools Teach About the Role of Physicians in the Holocaust? *Academic Medicine*. 2015;90(6):699-700. doi:10.1097/acm.0000000000000724
7. Reis SP, Wald HS, Weindling P. The Holocaust, medicine and becoming a physician: The crucial role of Education. *Israel Journal of Health Policy Research*. 2019;8(1). doi:10.1186/s13584-019-0327-3
8. Roelcke V, Hildebrandt S, Reis S. Announcing The Lancet Commission on medicine and the holocaust: Historical evidence, implications for today, teaching for Tomorrow. *The Lancet*. 2021;397(10277):862-864. doi:10.1016/s0140-6736(21)00157-4
9. Horton R. Offline: Holocaust education—A medical imperative. *The Lancet*. 2020;396(10263):1619. doi:10.1016/s0140-6736(20)32468-5
10. Wynia MK, Silvers WS. A call to commemorate International Holocaust Remembrance Day, January 27, in all Health Science Schools. *AMA Journal of Ethics*. 2021;23(1). doi:10.1001/amajethics.2021.75

RELEVANT AMA Policy

H-295.961 Medicolegal, Political, Ethical and Economic Medical School Course

1. The AMA urge every medical school and residency program to teach the legal, political, ethical and economic issues which will affect physicians.
2. The AMA will work with state and county medical societies to identify and provide speakers, information sources, etc., to assist with the courses.
3. An assessment of professional and ethical behavior, such as exemplified in the AMA Principles of Medical Ethics, should be included in internal evaluations during medical school and residency training, and also in evaluations utilized for licensure and certification.
4. The Speaker of the HOD shall determine the most appropriate way for assembled physicians at the opening sessions of the AMA House of Delegates Annual and Interim Meetings to renew their commitment to the standards of conduct which define the essentials of honorable behavior for the physician, by reaffirming or reciting the seven Principles of Medical Ethics which constitute current AMA policy.
5. There should be attention to subject matter related to ethics and to the doctor-patient relationship at all levels of medical education: undergraduate, graduate, and continuing. Role modeling should be a key

element in helping medical students and resident physicians to develop and maintain professionalism and high ethical standards.

6. There should be exploration of the feasibility of improving an assessment of ethical qualities in the admissions process to medical school.

7. Our AMA pledges support to the concept that professional attitudes, values, and behaviors should form an integral part of medical education across the continuum of undergraduate, graduate, and continuing medical education. [Res. 189, A-90; Modified by CME Rep. 1, I-95; Appended: Res. 318, I-98; Reaffirmed: CME Rep. 2, A-08; Reaffirmed in lieu of Res. 902, I-13; Reaffirmation I-15]

E-7.2.2 Release of Data from Unethical Experiments

Research that violates the fundamental principle of respect for persons and basic standards of human dignity, such as Nazi experiments during World War II or from the US Public Health Service Tuskegee Syphilis Study, is unethical and of questionable scientific value. Data obtained from such cruel and inhumane experiments should virtually never be published. If data from unethical experiments can be replaced by data from ethically sound research and achieve the same ends, then such must be done. In the rare instances when ethically tainted data have been validated by rigorous scientific analysis, are the only data of such nature available, and human lives would certainly be lost without the knowledge obtained from the data, it may be permissible to use or publish findings from unethical experiments. Physicians who engage with data from unethical experiments as authors, peer reviewers, or editors of medical publications should:

(a) Disclose that the data derive from studies that do not meet contemporary standards for the ethical conduct of research.

(b) Clearly describe and acknowledge the unethical nature of the experiment(s) from which the data are derived.

(c) Provide ethically compelling reasons for which the data are being released or cited, such as the need to save human lives when no other relevant data are available.

(d) Pay respect to those who were the victims of the unethical experimentation. [Issued: 2016]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(A-24)

Introduced by: Young Physicians Section

Subject: Ranked Choice Voting

Referred to: Reference Committee F

1 Whereas, American Medical Association elections require run-off elections to elect candidates
2 by majority; and
3

4 Whereas, ranked-choice voting elections can be run more efficiently without the need for runoff
5 elections, while still ensuring the outcome preferred by a majority of voters; therefore be it
6

7 RESOLVED, that our American Medical Association study ranked-choice voting for all elections
8 within the House of Delegates. (Directive to Take Action)
9

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

Received: 4/8/2024

RELEVANT AMA POLICY

Elections. B-3.4

3.4.1 Time of Election. Officers of the AMA, except the Secretary, the medical student trustee, and the public trustee, shall be elected by the House of Delegates at the Annual Meeting, except as provided in Bylaws 3.6 and 3.7. The public trustee may be elected at any meeting of the House of Delegates at which the Selection Committee for the Public Trustee submits a nomination for approval by the House of Delegates. On recommendation of the Committee on Rules and Credentials, the House of Delegates shall set the day and hour of such election. The Medical Student Section shall elect the medical student trustee in accordance with Bylaw 3.5.6.

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

3.4.2.1 At-Large Trustees.

3.4.2.1.1 First Ballot. All nominees for the office of At-Large Trustee shall be listed alphabetically on a single ballot. Each elector shall have as many votes as the number of Trustees to be elected, and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer or more votes than the number of Trustees to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if he or she has received a vote on a majority of the legal ballots cast and is one of the nominees receiving the largest number of votes within the number of Trustees to be elected.

3.4.2.1.2 Runoff Ballot. A runoff election shall be held to fill any vacancy not filled because of a tie vote.

3.4.2.1.3 Subsequent Ballots. If all vacancies for Trustees are not filled on the first ballot and 3 or more Trustees are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and

eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. When 2 or fewer Trustees are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are Trustees yet to be elected, and must cast each vote for different nominees. This procedure shall be repeated until all vacancies have been filled.

3.4.2.2 All Other Officers, except the Medical Student Trustee and the Public Trustee. All other officers, except the medical student trustee and the public trustee, shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

3.4.2.3 Medical Student Trustee. The medical student trustee is elected by the Medical Student Section in accordance with Bylaw 3.5.6.

3.4.2.4 Public Trustee. The public trustee shall be elected separately. The nomination for the public trustee shall be submitted to the House of Delegates by the Selection Committee for the Public Trustee. Nominations from the floor shall not be accepted. A majority vote of delegates present and voting shall be necessary to elect.

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

6.8.1 Nomination and Election. Members of these Councils, except the medical student member, shall be elected by the House of Delegates. Nominations shall be made by the Board of Trustees and may also be made from the floor by a member of the House of Delegates.

6.8.1.1 Separate Election. The resident/fellow physician member of these Councils shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

6.8.1.2 Other Council Members. With reference to each such Council, all nominees for election shall be listed alphabetically on a single ballot. Each elector shall have as many votes as there are members to be elected, and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer votes or more votes than the number of members to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if he or she has received a vote on a majority of the legal ballots cast and is one of the nominees receiving the largest number of votes within the number of members to be elected.

6.8.1.3 Run-Off Ballot. A run-off election shall be held to fill any vacancy that cannot be filled because of a tie vote.

6.8.1.4 Subsequent Ballots. If all vacancies are not filled on the first ballot and 3 or more members of the Council are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest number of votes on the preceding ballot, except where there is a tie. When 2 or fewer members of the Council are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are members of the Council yet to be elected, and must cast each vote for a

different nominee. This procedure shall be repeated until all vacancies have been filled.

6.8.2 Medical Student Member. Medical student members of these Councils shall be appointed by the Governing Council of the Medical Student Section with the concurrence of the Board of Trustees.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(A-24)

Introduced by: Resident and Fellow Section, Medical Student Section
Subject: End Attacks on Health and Human Rights in Israel and Palestine
Referred to: Reference Committee F

1 Whereas, the attack on October 7th resulted in the death of over 1,100 Israelis, including
2 around 700 civilians, and the displacement of over 200,000 individuals^{1,2}; and
3
4 Whereas, the resultant escalating crisis in the Gaza Strip, home to over 2.3 million individuals
5 with half being children, has led to the loss of civilian life surpassing that of any conflict in this
6 region in the past 17 years and the displacement of 1.7 million civilians to already severely
7 overcrowded refugee camps^{1,3,4}; and
8
9 Whereas, attacks have resulted in the death of over 33,000 civilians across Gaza, the West
10 Bank, and Jerusalem, including over 13,000 children, with a further 75,000 wounded and at
11 least 10,000 people missing and believed to be buried under rubble, with an estimated 17,000
12 children unaccompanied or separated; further, the conflict has spilled over into neighboring
13 nations resulting in deaths of over 300 people in Lebanon and over 200 people in Syria^{1,4-12}; and
14
15 Whereas, the Geneva Conventions protect journalists, refugees, children, pregnant women and
16 mothers with infants, civilians, patients, physicians, and other medical personnel during times of
17 conflict¹³; and
18
19 Whereas, United Nations (UN) officials proclaim there is “no safe place in Gaza,” as shelters,
20 refugee camps, hospitals, ambulances, homes, bakeries, places of worship, toy stores, and UN-
21 funded schools, clinics and shelters have faced airstrikes, shootings, and have been flooded
22 with poisonous white phosphorous gasses¹⁴⁻¹⁶; and
23
24 Whereas, Attacks on over 99 health facilities, including 30 of the 36 hospitals in the Gaza Strip,
25 have resulted in the deaths of over 685 healthcare personnel, injured another 900, and
26 damaged 54 ambulances, 99 health facilities, including 30 hospitals^{1,5,17}; and
27
28 Whereas, physicians and other medical personnel have been forced to perform surgeries in
29 corridors and waiting rooms, conserve supplies due to a lack of basic medical supplies,
30 anesthetics, or painkillers, and utilize vinegar in place of antibiotics on open wounds¹⁸⁻²¹; and
31
32 Whereas, restrictions on the passage of fuel supplies and clean water have led to shutdowns of
33 medical equipment across hospitals, leaving critically ill patients at especially high risk and
34 increasing infectious disease outbreaks^{13,22}; and
35
36 Whereas, the destruction of homes and vital infrastructure, targeting of hospitals and refugee
37 camps, and depletion of medical resources in the setting of a complete blockade have led to a
38 critical humanitarian crisis and collapse of the Gazan healthcare system, leading the World
39 Health Organization (WHO) to proclaim on April 5 that “the systematic dismantling of healthcare
40 must end” as access to healthcare “has now become totally inadequate” in Gaza^{17,23}; and

1 Whereas, in April 2024, famine was confirmed in parts of Gaza, and the WHO Integrated Food
2 Security Phase Classification partnership has raised the alarm that “over a million people are
3 expected to face catastrophic hunger” unless the situation is addressed^{24,25}; and
4

5 Whereas, between 12.4–16.5% of children aged 5 years or younger in Gaza are already
6 suffering from severe malnutrition^{24,26}; and
7

8 Whereas, if a ceasefire is not achieved, the war in Gaza is projected to cause a further 58,260
9 to 66,720 excess deaths by August 2024²⁷; and
10

11 Whereas, the UN General Assembly, in a 153-10 vote, called for an immediate ceasefire in
12 December 2023, while the UN Security Council called for an immediate ceasefire for the month
13 of Ramadan, leading to a lasting ceasefire in March 2024^{28,29}; and
14

15 Whereas, a ceasefire is defined as a long-term suspension of fighting in the entire geographic
16 area that is agreed upon by all involved parties and would allow for the continuous flow of
17 humanitarian aid^{30,31}; and
18

19 Whereas, numerous leading healthcare advocacy and humanitarian organizations, including
20 Doctors Without Borders, Amnesty International, Human Rights Watch, the World Health
21 Organization, the UN Security Council, and the UN High Commissioner on Human Rights, have
22 called for an immediate ceasefire, safe transit of aid and Gaza's civilian population, and
23 protection of civilian infrastructure^{2,8,28,32-38}; and
24

25 Whereas, many organizations are diligently recruiting volunteers to aid the civilian population in
26 Gaza but they are often unable to enter due to the increasingly unsafe conditions³⁸⁻⁴³; and
27

28 Whereas, healthcare professionals and organizations are responsible for upholding medical
29 neutrality and condemning violence against healthcare infrastructure, hospitals, first responders,
30 patients, children, refugees, and the blockade of essential health supplies, water, and fuel,
31 including in times of war and siege^{2,14,30,44-47}; and
32

33 Whereas, our AMA President issued a statement condemning the October 7th attack on Israel,
34 and the AMA has previously released statements vocalizing solidarity with Ukraine, passed a
35 policy calling for continuous support of organizations providing humanitarian missions to
36 Ukrainian refugees, and contributed \$100,000 in humanitarian aid through the AMA Foundation
37 to Ukraine^{48,49}; and
38

39 Whereas, on November 9, 2023, our AMA Board of Trustees released a statement on the
40 humanitarian crisis in Israel and Palestine but did not address the pivotal and life-saving issue of
41 ceasefire⁵⁰; therefore be it
42

43 **RESOLVED**, that our American Medical Association supports a ceasefire in Israel and Palestine
44 in order to protect civilian lives and healthcare personnel. (New HOD Policy)

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

Received: 4/24/2024

REFERENCES:

1. Frankel J. Half a year into the war in Gaza, here's a look at the conflict by the numbers. Associated Press. April 6, 2024. Accessed April 22, 2024. <https://apnews.com/article/israel-hamas-gaza-war-statistics-95a6407fac94e9d589be234708cd5005>
2. These numbers show the staggering toll of the Israel-Hamas war. November 5, 2023. Accessed November 6, 2023. <https://apnews.com/article/israel-hamas-war-death-toll-numbers-injured-5c9dc40bec95a8408c83f3c2fb759da0>.
3. Occupied Palestinian Territory. UNFPA. April 2, 2024. Accessed April 6, 2024. <https://www.unfpa.org/occupied-palestinian-territory>
4. Leila Molana-Allen. Israeli airstrikes hit Gaza, the West Bank, Lebanon and Syria amid fears of widening war. October 22, 2023. Accessed November 7, 2023. <https://www.pbs.org/newshour/show/israeli-airstrikes-hit-gaza-the-west-bank-lebanon-and-syria>
5. Batrawy, Aya. Gaza's death toll now exceeds 30,000. Here's why it's an incomplete count. February 29, 2024. Accessed April 7, 2024. <https://www.npr.org/2024/02/29/1234159514/gaza-death-toll-30000-palestinians-israel-hamas-war>
6. Palestinian children killed in Israeli attacks in Gaza | Al Jazeera Newsfeed. Al Jazeera English. February 2, 2024. Accessed April 7, 2024. https://www.youtube.com/watch?v=NICzT9_YE9Y
7. The Latest | Gaza death toll tops 30,000 as over 100 killed in aid convoy violence. AP. February 29, 2024. Accessed April 7, 2024. <https://apnews.com/article/israel-hamas-war-latest-02-29-2024-ae3d114b28cafd3b1a806bfaa9f83cab>
8. STATEMENT OF THE COMMISSIONER-GENERAL OF UNRWA TO THE GENERAL ASSEMBLY. UNRWA. March 4, 2024. Accessed April 7, 2024. <https://www.unrwa.org/newsroom/official-statements/statement-commissioner-general-unrwa-general-assembly>
9. Israeli attacks wipe out entire families in Gaza. Amnesty International. October 23, 2023. Accessed November 5, 2023. <https://www.amnesty.org/en/latest/news/2023/10/damning-evidence-of-war-crimes-as-israeli-attacks-wipe-out-entire-families-in-gaza/>.
10. Israeli forces cut off north Gaza to isolate Hamas as an advance on the urban center looms. November 6, 2023. Accessed November 7, 2023. <https://apnews.com/article/israel-hamas-war-news-11-6-2023-51286d15d4dd77ae0dd7ea76ee52bc71>.
11. People from 35 countries killed, missing in Israel-Gaza war: What to know. October 11, 2023. Accessed November 7, 2023. <https://www.washingtonpost.com/world/2023/10/11/israel-hamas-war-foreign-nationals/>
12. Bassam Hatoum. Lebanese woman and her 3 granddaughters killed in Israeli strike laid to rest. November 7, 2023. Accessed November 7, 2023. <https://abcnews.go.com/International/wireStory/lebanese-woman-3-granddaughters-killed-israeli-strike-laid-104683802>
13. Convention (IV) relative to the Protection of Civilian Persons in Time of War. Geneva, 12 August 1949. IHL. Accessed November 5, 2023. <https://ihl-databases.icrc.org/en/ihl-treaties/gciv-1949>.
14. oPt EMERGENCY SITUATION REPORT - Issue 10. WHO Regional Office for the Eastern Mediterranean. November 1, 2023. Accessed November 6, 2023. https://www.emro.who.int/images/stories/palestine/WHO_oPt_Sitrep_10.pdf.
15. Ferguson S. No Place is Safe for Children in Gaza. UNICEF USA. October 24, 2023. Accessed November 5, 2023. <https://www.unicefusa.org/stories/no-place-safe-children-gaza>.
16. Israel: White phosphorus used in Gaza, Lebanon. Human Rights Watch. October 13, 2023. Accessed November 5, 2023. <https://www.hrw.org/news/2023/10/12/israel-white-phosphorus-used-gaza-lebanon>.
17. Mhawish MR. "We have nothing": Families seek safety from bombs inside Gaza hospitals. Al Jazeera. November 4, 2023. Accessed November 5, 2023. <https://www.aljazeera.com/news/2023/11/4/we-have-nothing-families-seek-safety-from-bombs-inside-gaza-hospitals>.
18. Al-Mughrabi N. Bodies Line Gaza Hospital Wall and surgeons operate in corridors. Reuters. October 31, 2023. Accessed November 5, 2023. <http://www.reuters.com/world/middle-east/gaza-surgeons-operate-corridors-israeli-bombs-fill-hospitals-2023-10-31/>.
19. Yazbek H, Zraick K. A doctor in Gaza describes "horrific scenes" after Israeli airstrikes. The New York Times. November 2, 2023. Accessed November 5, 2023. <https://www.nytimes.com/2023/11/02/world/middleeast/voices-airstrikes-jabaliya-hospital.html>.
20. Shurafa W, Magdy S, Kullab S. Dwindling fuel supplies for Gaza's hospital generators put premature babies in incubators at risk. AP News. October 23, 2023. Accessed November 5, 2023. <https://apnews.com/article/israel-gaza-hamas-babies-crisis-9ec2e404e16a132821dac644af110ef6>.
21. Shurafa W, Magdy S, Kullab S. Dozens of premature babies at risk of death as fuel supplies dwindle in Gaza, doctors say. PBS. October 23, 2023. Accessed November 6, 2023. <http://www.pbs.org/newshour/world/dozens-of-premature-babies-at-risk-of-death-as-fuel-supplies-dwindle-in-gaza-doctors-say>.
22. Lederer EM. Un agency in Gaza says urgent cease-fire is a matter of life and death for millions of Palestinians. AP News. October 31, 2023. Accessed November 6, 2023. <https://apnews.com/article/un-palestinian-israel-humanitarian-ceasefire-catastrophe-unrwa-a26629bbda0c6b2e2bc46a6896c944fe>.
23. Gaza: 'Systematic dismantling of healthcare must end' says WHO. UN News. April 6, 2024. Accessed April 22, 2024. <https://news.un.org/en/story/2024/04/1148316>
24. McKernan B. 'It's death there': babies and children hit hardest as famine tightens hold on Gaza. The Guardian. April 15, 2024. Accessed April 22, 2024. <https://www.theguardian.com/world/2024/apr/15/babies-children-gaza-famine>
25. Famine in Gaza is imminent, with immediate and long-term health consequences. World Health Organization. March 18, 2024. Accessed April 7, 2024. <https://www.who.int/news/item/18-03-2024-famine-in-gaza-is-imminent--with-immediate-and-long-term-health-consequences>
26. Gaza: Israel's Imposed Starvation Deadly for Children. Human Rights Watch. April 9, 2024. Accessed April 22, 2024. <https://www.hrw.org/news/2024/04/09/gaza-israels-imposed-starvation-deadly-children>
27. Lambert J. Even if there's a ceasefire, thousands of deaths projected in Gaza over next 6 months. NPR. March 1, 2024. Accessed April 22, 2024. <https://www.npr.org/sections/goatsandsoda/2024/03/01/1234993226/deaths-gaza-hamas-israel-war-projection>
28. Security Council Demands Immediate Ceasefire in Gaza for Month of Ramadan, Adopting Resolution 2728 (2024) with 14 Members Voting in Favour, United States Abstaining. United Nations Meetings Coverage and Press Releases. March 25, 2024. Accessed April 7, 2024. <https://press.un.org/en/2024/sc15641.doc.htm>
29. UN General Assembly votes by large majority for immediate humanitarian ceasefire during emergency session. UN News. December 12, 2023. Accessed April 22, 2024. <https://news.un.org/en/story/2023/12/1144717>

30. Glossary of humanitarian terms on pauses during conflict in Ukraine. United Nations. MRCH 14, 2022. Accessed November 6, 2023. <https://ukraine.un.org/en/174777-glossary-humanitarian-terms-pauses-during-conflict>.
31. IRC statement: What a "humanitarian ceasefire" means, and why it is necessary. The IRC. November 5, 2023. Accessed November 6, 2023. <https://www.rescue.org/press-release/irc-statement-what-humanitarian-ceasefire-means-and-why-it-is-necessary#:~:text=A%20halt%20to%20the%20fighting,make%20possible%20effective%20aid%20delivery>.
32. Statement by the members of the Governing Board of the International Federation of Red Cross and Red Crescent Societies: IFRC. IFRC. February 11, 2023. Accessed November 6, 2023. <https://www.ifrc.org/article/statement-members-governing-board-international-federation-red-cross-and-red-crescent>.
33. UN Security Council emergency briefing on "The situation in the Middle East, Including the Palestinian Question." UNRWA Newsroom. October 30, 2023. Accessed November 6, 2023. <https://www.unrwa.org/newsroom/official-statements/un-security-council-emergency-briefing-situation-middle-east>.
34. International Committee of the Red Cross. Israel and the Occupied Territories: Deescalate now to prevent further human suffering. International Committee of the Red Cross. November 2, 2023. Accessed November 6, 2023. <https://www.icrc.org/en/document/israel-and-occupied-territories-deescalate-now-prevent-further-human-suffering>.
35. Doctors without Borders calls for immediate ceasefire in Gaza. Doctors Without Borders - USA. October 26, 2023. Accessed November 6, 2023. <http://www.doctorswithoutborders.org/latest/doctors-without-borders-calls-immediate-ceasefire-gaza>.
36. Oxfam. Lack of food and water a major threat to people in Gaza. Oxfam. October 30, 2023. Accessed November 6, 2023. <http://www.oxfamamerica.org/explore/stories/lack-of-food-and-water-a-major-threat-to-people-in-gaza>.
37. Stroehlein A. Gaza needs water, food, electricity – and Justice. Human Rights Watch Daily Brief. October 30, 2023. Accessed November 6, 2023. <http://www.hrw.org/the-day-in-human-rights/2023/10/30>.
38. Gaza: 3,195 children killed in three weeks surpasses annual number of children killed in conflict zones since 2019. Save the Children. October 29, 2023. Accessed November 6, 2023. <http://www.savethechildren.org/us/about-us/media-and-news/2023-press-releases/gaza--3-195-children-killed-in-three-weeks>.
39. Gaza. International Medical Corps. October 24, 2023. Accessed November 6, 2023. <https://internationalmedicalcorps.org/country/gaza/>.
40. Gaza: Update on the movement of staff via Rafah Crossing. Doctors Without Borders - USA. November 1, 2023. Accessed November 6, 2023. <http://www.doctorswithoutborders.org/latest/gaza-update-movement-staff-rafah-crossing>.
41. SCCM: SCCM calls for volunteers. Society of Critical Care Medicine (SCCM). Accessed November 6, 2023. <https://www.sccm.org/Clinical-Resources/globalhealth/Crisis-Response/Calls-for-Volunteers>.
42. Palestine. Doctors of the World. Accessed November 6, 2023. <https://www.doctorsoftheworld.org.uk/our-work/uncategorised/palestine/>.
43. PAMA. Volunteer with PAMA. PAMA. Accessed November 6, 2023. <https://palestinian-ama.org/volunteer/create>.
44. Volunteer Medical Missions. PCRF. Accessed November 6, 2023. <https://www.pcrf.net/volunteer-medical-missions>.
45. WMA - The World Medical Association-The World Medical Association stands firmly for the principles of medical neutrality as defined by the Geneva Convention, and calls on all parties to respect international law and the integrity of unrelated civilian populations. WMA The World Medical Association. October 15, 2023. Accessed November 6, 2023. <http://www.wma.net/news-post/the-world-medical-association-stands-firmly-for-the-principles-of-medical-neutrality-as-defined-by-the-geneva-convention-and-calls-on-all-parties-to-respect-international-law-and-the-integrity-of-unr>.
46. Galea S. Physicians and the Health Consequences of War. *JAMA Health Forum*. 2022;3(3). doi:10.1001/jamahealthforum.2022.0845
47. Mansoor S. The harrowing work facing Gaza doctors in wartime. *Time*. October 25, 2023. Accessed November 6, 2023. <https://time.com/6328314/gaza-doctors-hospital-electricity-fuel/>.
48. Final 2022 impact report - amafoundation.org. Annual Report 2022. Accessed November 6, 2023. https://amafoundation.org/wp-content/uploads/2023/06/FINAL-2022-Impact-Report_62223.pdf.
49. Ehrenfeld, Jesse (@DoctorJesseMD). "The @AmerMedicalAssn joins the @medwma in condemning the attacks on #Israel. <http://spr.ly/6018uV6cs>". October 14, 2023. <https://x.com/DoctorJesseMD/status/1713201779792556252?s=20>
50. Statement from the AMA Board of Trustees. Released November 9, 2023. <https://www.ama-assn.org/press-center/press-releases/statement-ama-board-trustees#:~:text=The%20conflict%20unfolding%20in%20Israel,afflicting%20Israelis%2C%20Palestinians%20and%20others>

RELEVANT AMA POLICY

War Crimes as a Threat to Physicians' Humanitarian Responsibilities D-65.993

Our AMA will (1) implore all parties at all times to understand and minimize the health costs of war on civilian populations generally and the adverse effects of physician persecution in particular, (2) support the efforts of physicians around the world to practice medicine ethically in any and all circumstances, including during wartime, episodes of civil strife, or sanctions and condemn the military targeting of health care facilities and personnel and using denial of medical services as a weapon of war, by any party, wherever and whenever it occurs, and (3) advocate for the protection of physicians' rights to provide ethical care without fear of persecution. [BOT Action in response to referred for decision Res. 620, A-09 Modified: BOT Rep. 09, A-19 Modified: Res. 002, I-22]

Medical Neutrality H-520.998

Our AMA supports medical neutrality, under the principles of the Geneva Convention, for all health care workers and the sick and wounded in all countries. [Sub. Res. 72, I-81 Reaffirmed: CLRPD Rep. F, I-91 Reaffirmed: Sunset Report, I-01 Reaffirmed: CEJA Rep. 8, A-11 Reaffirmed in lieu of Res. 601, I-13 Reaffirmed: CEJA Rep. 05, A-23]

Humanitarian and Medical Aid Support to Ukraine D-65.984

Our AMA will advocate for: (1) continuous support of organizations providing humanitarian missions and medical care to Ukrainian refugees in Ukraine, at the Polish-Ukrainian border, in nearby countries, and/or in the US; (2) 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, pregnant women, and the elderly; and (3) educational measures to enhance the understanding of war-related trauma in war survivors and promote broad protective factors (e.g., financial, employment, housing, and food stability) that can improve adjustment and outcomes for war-affected people, particularly when applied to vulnerable categories of people. [Res. 017, A-22]

Protecting Physicians and Other Healthcare Workers in Society H-515.950

Our AMA: (1) acknowledges and will act to reduce the incidence of antagonistic actions against physicians as well as other health care workers including first responders and public health officials, outside as well as within the workplace, including physical violence, intimidating actions of word or deed, and cyber-attacks, particularly those which appear motivated simply by their identification as health care workers; (2) will educate the general public on the prevalence of violence and personal harassment against physicians as well as other health care workers including first responders, and public health officials, outside as well as within the workplace; and (3) will work with all interested stakeholders to improve safety of health care workers including first responders and public health officials and prevent violence to health care professionals. [Res. 413, I-20]

A Declaration of Professional Responsibility H-140.900

Our AMA adopts the Declaration of Professional Responsibility

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

Preamble

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

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to: (1) Respect human life and the dignity of every individual.

(2) Refrain from supporting or committing crimes against humanity and condemn any such acts.

(3) Treat the sick and injured with competence and compassion and without prejudice.

(4) Apply our knowledge and skills when needed, though doing so may put us at risk.

(5) Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.

(6) Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.

(7) Educate the public and polity about present and future threats to the health of humanity.

(8) Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.

(9) Teach and mentor those who follow us for they are the future of our caring profession.

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

[CEJA Rep. 5, I-01 Reaffirmation A-07 Reaffirmed: CEJA Rep. 04, A-17 Reaffirmed: Res. 215, A-23]

Condemning the Use of Children as Instruments of War H-520.987

Our AMA: (1) condemns the use of children as instruments of war; and (2) encourages evaluation, treatment, and follow-up for children who have been used as instruments of war. [Res. 411, I-01 Reaffirmed: CEJA Rep. 8, A-11 Reaffirmed: CEJA Rep. 1, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(A-24)

Introduced by: Senior Physicians Section

Subject: Confronting Ageism in Medicine

Referred to: Reference Committee F

1 Whereas, research has shown a strong link between ageism, in the form of negative
2 stereotypes, prejudice and discrimination, and risks for one's physical and mental health¹; and
3

4 Whereas, ageism refers to the stereotypes (how we think), prejudice (how we feel) and
5 discrimination (how we act) towards others or ourselves based on age. Structural ageism is the
6 way in which society and its institutions sustain ageist attitudes, actions or language in laws,
7 policies, practices or culture per the World Health Organization (WHO) and AGE Platform
8 Europe²; and
9

10 Whereas, ageism affects everyone by stereotyping and/or discriminating against, at both the
11 structural level (in which societal institutions reinforce systematic bias against older persons)
12 and individual level (in which older persons take in the negative views of aging of their culture)
13 especially when it exists in an environment of disproportionate power and privilege³; and
14

15 Whereas, ageism can be internalized by elders putting them at risk for diminished access to
16 physical and mental health care and/or suboptimal care; and
17

18 Whereas, ageism thereby negatively impacts health, longevity and well-being of elders while
19 having far-reaching economic consequences⁴; and
20

21 Whereas, the percentage of people worldwide aged 65 and over is projected to increase to
22 nearly 17 percent of the world's population by 2050⁵; and
23

24 Whereas, research has paid little attention to the intersectionality of aging and gender
25 influences whereby socio-economic inequalities can be vastly different for men versus women
26 over time⁶; and
27

28 Whereas, advocacy, beginning with education about and prevention of ageism by the AMA, can
29 help to prevent negative subconscious attitudes, i.e. stigmas, from developing or continuing;
30 therefore be it
31

32 RESOLVED, that our American Medical Association adopt the following definition of ageism
33 based on the World Health Organization (WHO) and AGE Platform Europe: "Ageism refers to
34 the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) towards
35 others or oneself based on age; structural ageism is the way in which society and its institutions
36 sustain ageist attitudes, actions or language in laws, policies, practices or culture" (New HOD
37 Policy); and be it further
38

39 RESOLVED, that our AMA establish a definition of "age equity," and consider adoption of the
40 AGE Platform Europe vision: "Age equity is an inclusive society, based on well-being for all,

1 solidarity between generations and full entitlement to enjoy life, participate in and contribute to
2 society. At the same time, each person's rights and responsibilities throughout their life course
3 have to be fully respected" (Directive to Take Action); and be it further
4

5 RESOLVED, that our AMA review all existing policy regarding discrimination, bias and
6 microaggressions, and add age or ageism if not already mentioned (Directive to Take Action);
7 and be it further
8

9 RESOLVED, that our AMA routinely incorporate intersectional approaches to ageism (Directive
10 to Take Action); and be it further
11

12 RESOLVED, that our AMA conduct ongoing (1) advocacy for hospital and regulatory policy
13 changes focused on individual physicians' care quality data rather than their age; and (2)
14 educational outreach to AMA members (i.e. starting with a Prioritizing Equity episode panel
15 discussion to be posted on Ed Hub™ for CME, as a video and podcast, and promoted through
16 the UCEP/GCEP channels) (Directive to Take Action); and be it further
17

18 RESOLVED, that our AMA work with the World Medical Association (WMA) and other interested
19 stakeholders to have AMA's work significantly inform the global health organization's work on
20 ageism. (Directive to Take Action)
21

Fiscal Note: \$47,934: Initial cost to review and report back on existing policy and develop
educational session for CME, plus annual costs for continued advocacy and education.

Received: 5/2/2024

REFERENCES

1. Burnes, D., Sheppard, C., Henderson Jr. C.R., Wassel, M., Cope, R., Barber, C., & Pillemer, K. (2019). Interventions to Reduce Ageism Against Older Adults: A Systematic Review and Meta-Analysis. *American Journal of Public Health*, 109 (8), E1-E9.
2. Europe, A. P. Age Platform Europe Position on Structural Ageism.(2016). (AGE_IntergenerationalSolidarity_Position_on_Structural_Ageism2016.pdf (age-platform.eu)
3. Europe, A. P. Age Platform Europe Position on Structural Ageism.(2016). (AGE_IntergenerationalSolidarity_Position_on_Structural_Ageism2016.pdf (age-platform.eu)
4. Levy, S. R., Lytle, A., & Macdonald, J. (2022). The worldwide ageism crisis. *Journal of Social Issues*, 78(4), 743-768.
5. NIH (2016, March 28) World's Older Population Grows Dramatically?National Institutes of Health (NIH) [Press Release]
6. Holman, D., Walker, A. Understanding unequal ageing: towards a synthesis of intersectionality and life course analyses. *Eur J Ageing* 18, 239–255 (2021). <https://doi.org/10.1007/s10433-020-00582-7>

RELEVANT AMA POLICY

H-65.951 Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions

Our AMA adopted the following guidelines for healthcare organizations and systems, including academic medical centers, to establish policies and an organizational culture to prevent and address systemic racism, explicit and implicit bias and microaggressions in the practice of medicine.

GUIDELINES TO PREVENT AND ADDRESS SYSTEMIC RACISM, EXPLICIT BIAS AND MICROAGGRESSIONS IN THE PRACTICE OF MEDICINE

Health care organizations and systems, including academic medical centers, should establish policies to prevent and address discrimination including systemic racism, explicit and implicit bias and microaggressions in their workplaces.

An effective healthcare anti-discrimination policy should:

- Clearly define discrimination, systemic racism, explicit and implicit bias and microaggressions in the healthcare setting.
- Ensure the policy is prominently displayed and easily accessible.
- Describe the management's commitment to providing a safe and healthy environment that

actively seeks to prevent and address systemic racism, explicit and implicit bias and microaggressions.

- Establish training requirements for systemic racism, explicit and implicit bias, and microaggressions for all members of the healthcare system.
- Prioritize safety in both reporting and corrective actions as they relate to discrimination, systemic racism, explicit and implicit bias and microaggressions.
- Create anti-discrimination policies that:
 - Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.).
 - Define expected and prohibited behavior.
 - Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and implicit bias and microaggressions.
 - Ensure privacy and confidentiality to the reporter.
 - Provide a confidential method for documenting and reporting incidents.
 - Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action.
- These policies should include:
 - Taking every complaint seriously.
 - Acting upon every complaint immediately.
 - Developing appropriate resources to resolve complaints.
 - Creating a procedure to ensure a healthy work environment is maintained for complainants and prohibit and penalize retaliation for reporting.
 - Communicating decisions and actions taken by the organization following a complaint to all affected parties.
 - Document training requirements to all the members of the healthcare system and establish clear expectations about the training objectives.

In addition to formal policies, organizations should promote a culture in which discrimination, including systemic racism, explicit and implicit bias and microaggressions are mitigated and prevented. Organized medical staff leaders should work with all stakeholders to ensure safe, discrimination-free work environments within their institutions.

Tactics to help create this type of organizational culture include:

- Surveying staff, trainees and medical students, anonymously and confidentially to assess:
 - Perceptions of the workplace culture and prevalence of discrimination, systemic racism, explicit and implicit bias and microaggressions.
 - Ideas about the impact of this behavior on themselves and patients.
- Integrating lessons learned from surveys into programs and policies.
- Encouraging safe, open discussions for staff and students to talk freely about problems and/or encounters with behavior that may constitute discrimination, including racism, bias or microaggressions.
- Establishing programs for staff, faculty, trainees and students, such as Employee Assistance programs, Faculty Assistance Programs, and Student Assistance Programs, that provide a place to confidentially address personal experiences of discrimination, systemic racism, explicit or implicit bias or microaggressions.
- Providing designated support person to confidentially accompany the person reporting an event through the process.

[Res. 003, A-21]

H-65.946 Towards Diversity and Inclusion: A Global Nondiscrimination Policy Statement and Benchmark for our AMA

Our AMA reaffirms its commitment to complying with all applicable laws, rules or regulations against discrimination on the basis of protected characteristics, including Title VII of the Civil Rights Act, The Age Discrimination in Employment Act, and the Americans with Disabilities Act, among other federal, state and local laws, and will provide updates on its comprehensive diversity and inclusion strategy as part of the annual Board report to the AMA House of Delegates on health equity.

[BOT Rep. 5, I-22]

H-65.965 Support of Human Rights and Freedom

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

[CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17; Modified: Res. 013, A-22; Reaffirmed: BOT Rep. 5, I-22]

H-25.996 Retirement and Hiring Practices

It is urged that physicians, individually and through their constituent, component, and specialty medical societies, continue to stress the need to reappraise policies calling for compulsory retirement and age discrimination in hiring from the standpoint of health among older people, and that they participate actively and lend medical weight in the efforts of other groups to create a new climate of opportunity for the older worker.

[Committee on Aging Report, I-62; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed CSAPH Rep. 2, A-08; Modified CCB Rep. 01, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 605
(A-24)

Introduced by: Senior Physicians Section
Subject: Walking the Walk of Climate Change
Referred to: Reference Committee F

- 1
2 Whereas, our American Medical Association has declared that climate change is an “urgent”
3 public health crisis per AMA Policy H-135.938, “Global Climate Change and Human Health”;
4 and
5
6 Whereas, our AMA “will protect patients by advocating for policies” that promote carbon
7 neutrality by the middle of this century in AMA Policy D-135.966, “Declaring Climate Change a
8 Public Health Crisis”; and
9
10 Whereas, our AMA has pledged to “incorporate principles of environmental sustainability within
11 its business operations” in AMA Policy, H-135.923, “AMA Advocacy for Environmental
12 Sustainability and Climate”; and
13
14 Whereas, there is considerable evidence that plant-based diets are more carbon friendly than
15 omnivorous or meat-heavy diets^{1,2}; and
16
17 Whereas, emissions from agriculture, made up largely of ruminant meat and dairy farming, will
18 still push the world past safe climate change targets even if fossil fuel emissions were
19 eliminated immediately, thereby creating a dietary pattern that reduces the risk of diet-related
20 disease is the same diet that mitigates climate change; and
21
22 Whereas, our AMA through its flagship journal, JAMA, has recently launched a series on
23 “Climate Change and Health” urging a commitment to actions that decrease greenhouse
24 emissions³; and
25
26 Whereas, BOT Report 17-A-23 discussed our AMA’s plan to address and mitigate the health
27 effects of climate change as well as its participation in the National Academy Action
28 Collaborative on Decarbonizing the U.S. Health Sector, it was silent on addressing these same
29 issues within the AMA itself; therefore be it
30
31 RESOLVED, that our American Medical Association Board of Trustees present to the House of
32 Delegates at Interim 2024 a detailed timeline as to when and how to achieve our organizational
33 carbon neutrality (Directive to Take Action); and be it further
34
35 RESOLVED, that our AMA staff study AMA-related corporate travel with respect to minimizing
36 carbon emissions and/or mitigating or off-setting such emissions (Directive to Take Action); and
37 be it further
38
39 RESOLVED, that our AMA adopt a policy for plant-based menus as the default option when
40 planning meeting venues with an opt-out alternative as appropriate. (Directive to Take Action)
41

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

Received: 5/2/2024

REFERENCES

1. Rosi, A., Mena, P., Pellegrini, N., Turrone, S., Neviani, E., Ferrocino, I., ... & Scazzina, F. (2017). Environmental impact of omnivorous, ovo-lacto-vegetarian, and vegan diet. *Scientific reports*, 7(1), 6105.
2. Scarborough, P., Clark, M., Cobiac, L., Papier, K., Knuppel, A., Lynch, J., ... & Springmann, M. (2023). Vegans, vegetarians, fish-eaters and meat-eaters in the UK show discrepant environmental impacts. *Nature Food*, 4(7), 565-574.
3. Ebi, K. L., & Hess, J. J. Introduction to JAMA Climate Change and Health Series. *JAMA*. 2024;331(5):436–437. doi:10.1001/jama.2023.25878

RELEVANT AMA POLICY

H-135.923 AMA Advocacy for Environmental Sustainability and Climate

Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities. [Citation: Res. 924, I-16; Reaffirmation:1-19]

H-135.938 Global Climate Change and Human Health

Our AMA: 1. Supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize 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.

2. Supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.

3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.

4. Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.

5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk.

6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.

7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training.

[CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed CSAPH Rep.04, A-19; Reaffirmation: I-19; Modified: Res. 424, A-22; Modified: CSAPH Rep. 2, I-22]

D-135.966 Declaring Climate Change a Public Health Crisis

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 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. [Res. 420, A-22; Appended: CSAPH Rep.02, I-22]

D-440.912 AMA Public Health Strategy

Our AMA will distribute evidence-based information on the relationship between climate change and human health through existing platforms and

communications channels, identify advocacy and leadership opportunities to elevate the voices of physicians on the public health crisis of climate change, and centralize our AMA's efforts towards environmental justice and an equitable transition to a net-zero carbon society by 2050.

2. Our AMA Board of Trustees will provide an update on loss of coverage and uninsurance rates following the return to regular Medicaid redeterminations and the end of the COVID-19 Public Health Emergency, the ensuing financial and administrative challenges experienced by physicians, physician practices, hospitals, and the healthcare system; and a report of actions taken by the AMA and recommendation for further action to address these issues at I-2023.

3. Our AMA Board of Trustees will provide a strategic plan or outline for the AMA's plan to address and combat the health effects of climate change at I-2023.

4. Our AMA Board of Trustees will provide an update on the efforts and initiatives of the AMA's gun violence task force at I-2023.

5. Our AMA will continue to support increased funding for public health infrastructure and workforce, which should include funding for preventative medicine related residency programs, to increase public health leadership in this country

[BOT Rep. 17, A-23; Modified: BOT Rep. 05, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 606
(A-24)

Introduced by: New England

Subject: Creation of an AMA Council with a Focus on Digital Health Technologies and AI

Referred to: Reference Committee F

1 Whereas, there is an unparalleled effort to apply emerging digital technologies to healthcare,
2 including but not limited to augmented/artificial intelligence (AI) systems¹⁻⁴, simulation and
3 virtual/augmented reality (VR/AR)^{5,6}, telehealth^{7,8}, and even quantum computing⁹; and
4

5 Whereas, emerging digital technologies including AI are being theorized (and even promoted)
6 as a disruptive threat to the practice, business, and teaching of medicine;¹⁰⁻¹³ and
7

8 Whereas, during the last major wave of digital health and informatics innovation, the AMA
9 lacked a policy-making body and expertise dedicated to such technology to help predict and
10 prevent the disruptions related to meaningful use, electronic medical record interoperability,
11 telehealth, etc.; and
12

13 Whereas, at the 2023 AMA Annual meeting, in addition to the resolutions in the Reference
14 Committee on Science & Technology (E), there were 8 resolutions involving innovative
15 technologies spread across various reference committees, with reports subsequently distributed
16 across multiple councils; and
17

18 Whereas, the rapid evolution of AI and digital technology within healthcare, as well as the
19 increasing volume of related House of Delegates (HOD) resolutions, reports, and advocacy
20 necessitates better coordination of HOD expertise and policymaking for the benefit of physicians
21 and patients alike; and
22

23 Whereas, our AMA has developed a variety of staff-driven responses to the proliferation of new
24 health technologies, such as the Office of Digital Health Innovation and Health2047, but there is
25 no dedicated body of the HOD focusing on this critical policy area; and
26

27 Whereas, policy regarding digital health technologies and AI requires relevant expertise in
28 multiple domains (practice, payment, liability, ethics, EHR integration, education, etc.)¹²⁻¹⁹ not
29 currently served by a single council, causing an inefficient distribution of these topics across
30 councils and severely limiting potential impact; and
31

32 Whereas, a new AMA council focused on digital health technologies, informatics, and AI would
33 benefit the HOD, Board of Trustees, and other Councils by organizing and cultivating precisely
34 this type of HOD staff expertise and physician leadership; therefore be it
35

36 RESOLVED, that our American Medical Association define and propose a new AMA council
37 focused on digital health, technology, informatics, and augmented/artificial intelligence, whose
38 members shall be elected by the House of Delegates, for presentation and constitution at the
39 2025 Annual Meeting. (Directive to Take Action)

Fiscal Note: To Be Determined

Received: 5/7/2024

REFERENCES

1. Haupt CE, Marks M. AI-Generated Medical Advice-GPT and Beyond. *JAMA*. 2023;329(16):1349-1350. DOI: 10.1001/jama.2023.5321. PMID: 36972070.
2. Kanjee Z, Crowe B, Rodman A. Accuracy of a Generative Artificial Intelligence Model in a Complex Diagnostic Challenge. *JAMA*. 2023;330(1):78-80. DOI: 10.1001/jama.2023.8288. PMID: 37318797.
3. Kulkarni PA, Singh H. Artificial Intelligence in Clinical Diagnosis Opportunities, Challenges, and Hype. *JAMA*. 2023;330(4):317-318. DOI: 10.1001/jama.2023.11440. PMID: 37410477.
4. "DAX Copilot: AI-automated clinical notes in seconds". Microsoft and Nuance Communications, Inc. Accessed: 4/16/2024 at <https://www.nuance.com/healthcare/campaign/ppc/dax-copilot.html>.
5. Azad TD, Warman A, Tracz JA, Hughes LP, Judy BF, Witham TF. Augmented reality in spine surgery – past, present, and future. *Spine J*. 2024;24(1):1-13. DOI: 10.1016/j.spinee.2023.08.015. PMID: 37660893.
6. Bhugaonkar K, Bhugaonkar R, Masne N. The Trend of Metaverse and Augmented & Virtual Reality Extending to the Healthcare System. *Cureus*. 2022;14(9):e29071. DOI: 10.7759/cureus.29071. PMID: 36258985.
7. Pool J, Indulska M, Sadiq S. Large language models and generative AI in telehealth: a responsible use lens. *J Am Med Inform Assoc*. Epub ahead of print: 2024 Mar 4. DOI: 10.1093/jamia/ocae035. PMID: 38441296.
8. Reed M, Huang J, Somers M, Hsueh L, Graetz I, Muelly E, Gopalan A. Telemedicine Versus In-Person Primary Care: Treatment and Follow-up Visits. *Ann Intern Med*. 2023;176(10):1349-1357. DOI: 10.7326/M23-1335. PMID: 37844311.
9. Shams M, Choudhari J, Reyes K, Prentzas S, Gapizov A, Shehryar A, Affaf M, Grezenko H, Gasim R, Naveed Mohsin S, Rehman A, Rehman S. The Quantum-Medical Nexus: Understanding the Impact of Quantum Technologies on Healthcare. *Cureus*. 2023;15(10):e48077. DOI: 10.7759/cureus.48077. PMID: 38046499.
10. Suran M, Hswen Y. How to Navigate the Pitfalls of AI Hype in Health Care. *JAMA*. 2024;331(4):273-276. DOI: 10.1001/jama.2023.23330. PMID: 38170492.
11. Elmahdy M, Sebros R. A snapshot of artificial intelligence research 2019-2021: is it replacing assisting physicians? *J Am Med Inform Assoc*. 2023;30(9):1552-1557. DOI: 10.1093/jamia/ocad094. PMID: 37279884.
12. Kung TH, Cheatham M, Medenilla A, Sillos C, De Leon L, Elepano C, Madriaga M, Aggabao R, Diaz-Dandido G, Maningo J, Tseng V. Performance of ChatGPT on USMLE: Potential for AI-assisted medical education using large language models. *PLOS Digital Health*. 2023;2(2):e0000198. DOI: 10.1371/journal.pdig.0000198. PMID: 36812645.
13. Kumah-Crystal Y, Mankowitz S, Embi P, Lehmann C. ChatGPT and the clinical informatics board examination: the end of unproctored maintenance of certification? *J Am Med Inform Assoc*. 2023;30(9):1558-1560.
14. Jindal JA, Lungren MP, Shah NH. Ensuring useful adoption of generative artificial intelligence in healthcare. *J Am Med Inform Assoc*. Epub ahead of print: 2024 Mar 7. DOI: 10.1093/jamia/ocae043. PMID: 38452298.
15. Evans RP, Bryant LD, Russell G, Absolom K. Trust and acceptability of data-driven clinical recommendations in everyday practice: A scoping review. *Int J Med Inform*. 2024;183:105342. DOI: 10.1016/j.ijmedinf.2024.105342. PMID: 38266426.
16. Reddy S, Allan S, Coghlan S, Cooper P. A governance model for the application of health care. *J Am Med Inform Assoc*. 2020;27(3):491-497.
17. Maurud S, Henni SH, Moen A. Health Equity in Clinical Research Informatics. *Yearb Med Inform*. 2023;31(1):138-145. DOI: 10.1055/s-0043-1768720. PMID: 37414033.
18. Chen F, Wang L, Hong J, Jiang J, Zhou L. Unmasking bias in artificial intelligence: a systematic review of bias detection and mitigation strategies in electronic health record-based models. *J Am Med Inform Assoc*. Epub ahead of print: 2024 Mar 23. DOI: 10.1093/jamia/ocae060. PMID: 38520723.
19. Economou-Zacanos NJ, Bessias S, Cary MP Jr, et al. Translating ethical and quality principles for the effective, safe and fair development, deployment and use of artificial intelligence technologies in healthcare. *J Am Med Inform Assoc*. 2024;31(3):705-713. DOI: 10.1093/jamia/ocad221. PMID: 38031481.

RELEVANT AMA POLICY**Responsibilities. B-6.0.1**

6.0.1.1 Information and Recommendations. All Councils have a continuing duty to provide information and to submit recommendations to the House of Delegates, through the Board of Trustees, on matters relating to the areas of responsibility assigned to them under the provisions of these Bylaws.

6.0.1.1.1 Method of Reporting. Councils, except the Council on Ethical and Judicial Affairs and the Council on Legislation shall submit their reports to the House of Delegates through the Board of Trustees. The Board of Trustees may make such non-binding recommendations regarding the reports to the Councils as it deems appropriate, prior to transmitting the reports to the House of Delegates without delay or modification by the Board. The Board may also submit written recommendations regarding the reports to the House of Delegates.

6.0.1.1.2 Method of Referral. Referrals from the House of Delegates to a Council shall be made through the Board of Trustees. The Board may, in addition, refer the matter to such other councils as it deems appropriate.

6.0.1.2 Strategic Planning. All Councils have a responsibility to participate in the strategic planning process with the Board of Trustees, other Councils, and other organizational units as may be appropriate.

6.0.1.3 Communications and Working Relationships. All Councils have a responsibility to communicate

and develop working relationships with the Board of Trustees, other Councils, the Sections, organizations represented within the House of Delegates and other organizational units as may be appropriate.

Medical Innovations H-480.978

It is the policy of the AMA to continue to publicly support adequate funding for the development and implementation of medical innovations, and that the reasoning behind this position be communicated to physicians, the public, and appropriate policymakers.

Sub. Res. 508, I-92 Reaffirmed: CSA Rep. 8, A-03 Modified: CSAPH Rep. 1, A-13 Reaffirmed: CSAPH Rep. 08, A-23

Evolving Impact of Telemedicine H-480.974

Our AMA:

- (1) will evaluate relevant federal legislation related to telemedicine;
- (2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;
- (3) urges professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;
- (4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;
- (5) encourages development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;
- (6) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;
- (7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine;
- (8) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries; and
- (9) will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association (www.americantelemed.org) to develop physician and patient specific content on the use of telemedicine services--encrypted and unencrypted.

CMS/CME Rep., A-94 Reaffirmation A-01 Reaffirmation A-11 Reaffirmed: CMS Rep. 7, A-11 Reaffirmed in lieu of Res. 805, I-12 Appended: BOT Rep. 26, A-13 Modified: BOT Rep. 22, A-13 Reaffirmed: CMS Rep. 7, A-14 Reaffirmed: CME Rep. 06, A-16 Reaffirmation: A-18

Augmented Intelligence in Health Care H-480.940

As a leader in American medicine, our American Medical Association has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.

To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
 - a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
 - b. is transparent;
 - c. conforms to leading standards for reproducibility;

- d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
 - e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4. 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.
 5. 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.
- BOT Rep. 41, A-18

Technology and the Practice of Medicine G-615.035

Our AMA encourages the collaboration of existing AMA Councils and working groups on matters of new and developing technology, particularly electronic medical records (EMR) and telemedicine.
Res. 606, A-14

Health Information Technology Principles H-478.981

Our AMA will promote the development of effective electronic health records (EHRs) in accordance with the following health information technology (HIT) principles. Effective HIT should:

1. Enhance physicians' ability to provide high quality patient care;
2. Support team-based care;
3. Promote care coordination;
4. Offer product modularity and configurability;
5. Reduce cognitive workload;
6. Promote data liquidity;
7. Facilitate digital and mobile patient engagement; and
8. Expedite user input into product design and post-implementation feedback.

Our AMA will utilize HIT principles to:

1. Work with vendors to foster the development of usable EHRs;
2. Advocate to federal and state policymakers to develop effective HIT policy;
3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;
4. Partner with researchers to advance our understanding of HIT usability;
5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care; and
6. Promote the elimination of "Information Blocking."

Our AMA policy is that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules.

BOT Rep. 19, A-18 Reaffirmation: A-19

Augmented Intelligence in Medical Education H-295.857

Our AMA encourages:

- (1) accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards;
- (2) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI;
- (3) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes;
- (4) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new

training modules;

(5) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems;

(6) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies;

(7) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients;

(8) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies;

(9) institutional leaders and academic deans to proactively accelerate the inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and

(10) close collaboration with and oversight by practicing physicians in the development of AI applications.
CME Rep. 04, A-19

National Agency for Technology Evaluations H-480.954

Our AMA advocates for active AMA input into any national agency whose role would be to evaluate technology for its value, to assist Medicare and other payors in making appropriate coverage decisions.
Res. 221, I-08Reaffirmed: CMS Rep. 01, A-18

Augmented Intelligence in Medical Education H-295.857

Our AMA encourages:

(1) accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards;

(2) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI;

(3) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes;

(4) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules;

(5) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems;

(6) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies;

(7) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients;

(8) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies;

(9) institutional leaders and academic deans to proactively accelerate the inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and

(10) close collaboration with and oversight by practicing physicians in the development of AI applications.
CME Rep. 04, A-19

Update on the Uses of Simulation in Medical Education D-295.330

Our AMA will:

1. continue to advocate for additional funding for research in curriculum development, pedagogy, and outcomes to further assess the effectiveness of simulation and to implement effective approaches to the use of simulation in both teaching and assessment;

2. continue to work with and review, at five-year intervals, the accreditation requirements of the Liaison Committee on Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), and the Accreditation Council for Continuing Medical Education (ACCME) to assure that program requirements reflect appropriate use and assessment of simulation in education programs;

3. encourage medical education institutions that do not have accessible resources for simulation-based teaching to use the resources available at off-site simulation centers, such as online simulated assessment tools and simulated program development assistance;

4. monitor the use of simulation in high-stakes examinations administered for licensure and certification as the use of new simulation technology expands;

5. further evaluate the appropriate use of simulation in interprofessional education and clinical team building; and

6. work with the LCME, the ACGME, and other stakeholder organizations and institutions to further identify appropriate uses for simulation resources in the medical curriculum.

CME Rep. 8, A-09Reaffirmed: CME Rep. 01, A-19

Redefine "Meaningful Use" of Electronic Health Records D-478.982

1. Our AMA will work with the federal government and the Department of Health and Human Services to: (A) set realistic targets for meaningful use of electronic health records such as percentage of computerized order entry, electronic prescribing, and percentage of inclusion of laboratory values; and (B) improve the electronic health records incentive program requirements to maximize physician participation.

2. Our AMA will continue to advocate that, within existing AMA policies, the Centers for Medicare & Medicaid Services suspend penalties to physicians and health care facilities for failure to meet Meaningful Use criteria.

Res. 222, A-10Reaffirmation I-10Reaffirmation A-14Appended: Res. 210, I-14Reaffirmed in lieu of Res. 203, I-15Reaffirmed in lieu of Res. 216, I-15Reaffirmed: Res. 211, I-16

Innovation to Improve Usability and Decrease Costs of Electronic Health Record Systems for Physicians D-478.976

1) Our AMA will: (A) advocate for CMS and the Office of the National Coordinator (ONC) to support collaboration between and among proprietary and open-source EHR developers to help drive innovation in the marketplace; (B) continue to advocate for research and physician education on EHR adoption and design best practices specifically concerning key features that can improve the quality, safety, and efficiency of health care regardless of proprietary or open-source status; and (C) through its partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs--open source and proprietary--to create more transparency and support more informed decision making in the selection of EHRs.

2) Our AMA will, through partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs--open source and proprietary--to create more transparency and formulate more formal decision making in the selection of EHRs.

3) Our AMA will work with AmericanEHR Partners to modify the current survey to better address the economics of EHR use by physicians including the impact of scribes.

4) Our AMA will make available the findings of the AmericanEHR Partners' survey and report back to the House of Delegates.

BOT Rep. 23, A-13BOT Rep. 24, A-13Reaffirmed: BOT Rep. 17, A-15Appended: Res. 603, I-16Modified: BOT Rep. 20, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 607
(A-24)

Introduced by: New Jersey

Subject: Appealing to our AMA to add clarity to its mission statement to better meet the need of physicians, the practice of medicine and the public health.

Referred to: Reference Committee F

1 Whereas, most leading national health organizations focus their mission statement on
2 empowering members to carry out the organizational mission; and
3

4 Whereas, physicians, while seeking to promote our AMA's mission, face significant challenges
5 such as loss of autonomy, scope creep or prior authorization that have contributed to poor
6 morale, high burn out rate, and an above average suicide rate among other professions; and
7

8 Whereas, despite our AMA's work to support physicians, most physicians fail to appreciate the
9 value of the AMA and less than 20 % of physicians are members of the AMA; and
10

11 Whereas, physicians are the primary stewards to carry out our AMA's mission statement; and,
12 the importance of a mission statement is to communicate an organization's values, priorities,
13 goals and serve as a moral compass that guides institutional decision making;
14 therefore be it
15

16 RESOLVED, that our American Medical Association amends its mission's statement from "to
17 promote the art and science of medicine and the betterment of public health" to "to empower
18 physicians to better care for their patients, advance the art and science of medicine, and
19 promote the betterment of physicians and the public health". (Directive to Take Action)
20

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

Received: 5/7/2024

REFERENCE

1. About Ana: Ana enterprise. ANA. (2017, October 14). <https://www.nursingworld.org/ana/aboutana/#:~:text=Fostering%20high%20standards%20of%20nursing,affect%20nurses%20and%20the%20public>
2. About the American Association of Nurse Practitioners® (AANP). American Association of Nurse Practitioners. (n.d.). <https://www.aanp.org/about/about-the-american-association-of-nurse-practitioners#aanp#:~:text=AANP%27s%20Mission,%2C%20advocacy%2C%20research%20and%20leadership>
3. About. Home. (n.d.). <https://www.pharmacist.com/who-we-are#:~:text=APhA%20Mission,based%2C%20patient%2Dcentered%20care>
4. Learn more about the American Academy of PAs - AAPA. AAPA. Published 2016. <https://www.aapa.org/about/>
5. Pompili M, Innamorati M, Narciso V, et al. Burnout, hopelessness and suicide risk in medical doctors. *La Clinica Terapeutica*. 2010;161(6):511-514. <https://pubmed.ncbi.nlm.nih.gov/21181078/>
6. Dutheil F, Aubert C, Pereira B, et al. Suicide among physicians and health-care workers: A systematic review and meta-analysis. *PLOS ONE*. Accessed January 4, 2024. <https://journals.plos.org/plosone/article?id=10.1371%2Fjournal.pone.0226361#sec028>.
7. Physician Stewardship of Health Care Resources. AMA. Accessed January 4, 2024. <https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-stewardshiphealth-care-resources>
8. Meacham J. What is the use of a mission statement? *Academe*. 2008;94(1):21-24
9. Pearson SD, Sabin J, Emanuel EJ. *No Margin, No Mission: Health Care Organizations and the Quest for Ethical Excellence*. New York, NY: Oxford University Press; 2003.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 608
(A-24)

Introduced by: Minority Affairs Section

Subject: The American Medical Association Diversity Mentorship Program

Referred to: Reference Committee F

1 Whereas, members of our American Medical Association have expressed interest in serving as
2 volunteer mentors to medical students, residents, and fellows; and
3
4 Whereas, volunteer mentorship programs have proven to be successful and cost-effective
5 platforms for addressing physician diversity gaps;¹ and
6
7 Whereas, our AMA has recognized the importance of supporting racial and ethnic populations
8 that are underrepresented in the medical profession relative to their numbers in the general
9 population; and
10
11 Whereas, alarming representation gaps still exist in medicine for American Indian & Alaska
12 Native, Hispanic, and Black Americans;² and
13
14 Whereas, our AMA carries the membership strength of over 270,000 dues-paying members;
15 and
16
17 Whereas, volunteer mentorship programs can help recruit and retain members through active
18 and rewarding engagement; and
19
20 Whereas, our AMA has outwardly emphasized the importance of mentorship via both accepted
21 policy and advocacy efforts, but has not enacted a successful internal platform; and
22
23 Whereas, our AMA is uniquely positioned to construct a first-in-class national mentorship
24 program through our strategic partners and extensive network of over 120 national medical
25 specialties and other societies;³ and
26
27 Whereas, mentorship has the powerful capacity to bring people together, share perspectives,
28 and promote a culture of togetherness; therefore be it
29
30 RESOLVED, that our American Medical Association establish a diversity mentorship program to
31 connect volunteer mentors with residents, fellows, and medical student mentees who are
32 underrepresented in medicine. (Directive to Take Action)

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

Received: 5/8/2024

REFERENCES

1. Yehia, B.R., Cronholm, P.F., Wilson, N. *et al.* Mentorship and pursuit of academic medicine careers: a mixed methods study of residents from diverse backgrounds. *BMC Med Educ* **14**, 26 (2014). <https://doi.org/10.1186/1472-6920-14-26>
2. 2022 Physician Specialty Data Report. Association of American Medical Colleges. <https://www.aamc.org/data-reports/data/2022-physician-specialty-data-report-executive-summary>
3. Member Organizations of the AMA House of Delegates. American Medical Association. Accessed May 1, 2024. <https://www.ama-assn.org/house-delegates/hod-organization/member-organizations-ama-house-delegates>

RELEVANT AMA Policy

Strategies for Enhancing Diversity in the Physician Workforce H-200.951

Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations. [CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16; Modified: Res. 009, A-21; Modified: CME Rep. 5, A-21]

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.

10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).

11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

12. Our AMA unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population.

13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs. [CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21; Modified: CME Rep. 02, I-22; Modified: Res. 320, A-23]

Continued Support for Diversity in Medical Education D-295.963

Our AMA will: (1) publicly state and reaffirm its support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; (5) directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education; (6) advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement; (7) investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty; (8) recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts; and (9) collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure. [Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13; Appended: CME Rep. 5, A-21; Modified: CME Rep. 02, I-22; Appended: Res. 319, A-22; Modified: Res. 319, A-23]

Diversity of AMA Delegations G-600.030

1. Our AMA encourages: (a) medical societies to develop methods for selecting AMA delegates that provide an exclusive role for AMA members; (b) state medical societies to collaborate more closely with state chapters of medical specialty societies, and to include representatives of these organizations in their AMA delegations whenever feasible; (c) state and specialty medical societies to adopt election procedures through which only AMA members may cast ballots for the state/specialty society's delegates to our AMA; (d) state medical associations and national medical specialty societies to review the composition of their AMA delegations with regard to enhancing diversity; (e) specialty and state societies to develop training and/or mentorship programs for their student, resident and fellow and young physician section representatives, and current HOD delegates for their future activities and representation of the delegation; (f) specialty and state societies to include in their delegations physicians who meet the criteria for membership in the Young Physicians Section; and (g) delegates and alternates who may be entitled to a dues exemption, because of age and retirement status, to demonstrate their full commitment to our AMA through payment of dues.

2. It is also suggested that each delegation have at least one member involved in the governance of the sponsoring organization. [CCB/CLRPD Rep. 3, A-12; Modified: CCB/CLRPD Rep. 1, A-22]

Racial and Ethnic Disparities in Health Care H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

2. The AMA emphasizes three approaches that it believes should be given high priority:

A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations. [CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21]

Enhancing the Cultural Competence of Physicians H-295.897

1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.

2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence and cultural humility, using existing mechanisms such as the annual medical education surveys.

3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.

4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.

5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.

6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.

7. Our AMA supports the development of national standards for cultural humility training in the medical school curricula. [CME Rep. 5, A-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-11; Appended: Res.

304, I-16; Modified: CME Rep. 01, A-17; Appended: Res. 320, A-17; Reaffirmed: CMS Rep. 02, I-17; Appended: Res. 315, A-18; Modified: Res. 322, A-22]

Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979

Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.

(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.

(3) Urging medical school and undergraduate admissions committees to proactively implement policies and procedures that operationalize race-conscious admission practices in admissions decisions, among other factors.

(4) Increasing the supply of minority health professionals.

(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.

(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.

(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.

(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.

(9) Recognizing the consideration of race in admissions is a necessary safeguard in creating a pipeline to an environment within medical education that will propagate the advancement of health equity through diversification of the physician workforce. [CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18; Modified: Res. 320, A-23; Appended: Res. 320, A-23]