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REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-I-24

Subject: AMA Efforts on Medicare Payment Reform

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

BACKGROUND

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

AMA ACTIVITIES ON MEDICARE PHYSICIAN PAYMENT REFORM

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

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

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

At the heart of the AMA's unwavering commitment to reforming the Medicare physician payment system lie four central pillars that underscore our strategic approach: legislative advocacy, regulatory advocacy, federation engagement, and grassroots, media, and outreach initiatives. Grounded in principles endorsed by a unified medical community, our legislative efforts drive the advancement of policies that foster payment stability and promote value-based care. We actively champion reform through regulatory channels, tirelessly engaging with crucial agencies such as the Centers for Medicare & Medicaid Services (CMS) and the White House to address impending challenges and ensure fair payment policies. Our federation engagement fosters unity and consensus

within the broader medical community, pooling resources and strategies to amplify our collective voice. Lastly, our continued grassroots, media, and outreach efforts bridge the gap between policymakers and the public, ensuring our mission is well-understood and supported from all quarters. Together, these pillars fortify our endeavors to achieve a more rational Medicare physician payment system that truly benefits all.

Legislative Advocacy

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

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

Summary of Recent AMA Advocacy Efforts in the 118th Congress

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

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

AMA and its Medicare Reform Workgroup finalized legislative language to reform MIPS in May of 2024; it was socialized with the Federation and has been circulated and discussed among key Committee and rank-and-file staff. The proposals are being incorporated into our messaging.

The new "Medicare Physician Data-Driven Performance Payment System" would: (1) simplify MIPS reporting and improve its clinical relevance; (2) reduce the potential severity of penalties (currently as much as -nine percent) for those scoring poorly under MIPS; (3) provide support to smaller practices that tend to score lower under the program; and (4) provide timely and meaningful performance feedback to physicians and expand the use of clinical data registries.

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

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

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

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

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

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

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

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

August Recess

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

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

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

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

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

These are well vetted, consensus reforms within the physician community. In addition to the Federation letter on MACRA reform, AMA advocacy staff are continuing to meet with the House and Senate leadership and committee staff to educate them on the importance of a permanent inflation-based update tied to the MEI, MIPs reform, Budget Neutrality reform, and the need for legislation modifying APMs in any end of year health care package.

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

Physician Call to Take Action

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

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

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

Grassroots, Media, and Outreach

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

community in the days ahead through various channels, including the Physicians Grassroots Network, requesting their timely engagement with Congress.

CONCLUSION

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

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

REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-I-24

Subject: Eliminating Eligibility Criteria for Sperm Donors Based on Sexual Orientation (Resolution 923-I-23)

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

INTRODUCTION

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

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

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

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

EXISTING AMA POLICY

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

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

AMA ACTIONS

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

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

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

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

CONCLUSION

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

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 17-I-24

Subject: Environmental Sustainability of AMA National Meetings (BOT Report 25-A-24, Rec. 3)

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

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

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

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

DISCUSSION

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

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

- Building Infrastructure
  - AMA headquarters updated HVAC systems and put in Merv-13 filtration on each floor, resulting in a 35 percent energy reduction.
  - Following the COVID-19 pandemic, AMA adjusted its physical footprint to align with occupancy rates, returning the 40th floor to the landlord in Q3 2023. This

consolidation led to a 20 percent reduction in storage space. AMA also created space usage guidelines, with staff onsite fewer than one day per week using new hoteling stations.

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

- Fifty percent of AMA Plaza's roof houses a green vegetable garden, which not only reduces carbon dioxide emissions but also slows the amount of rainfall runoff that goes to Chicago's sewer system. The roof at AMA Plaza is also home to a vegetable garden and bee program, which harvests honey twice a year.

- The AMA has tenancy in three locations (Chicago, DC, and Greenville) that have implemented varying sustainability best practices including LEED Green Certification, light sensors, recycling, etc. within their building guidelines. The AMA also instituted a requirement to contract exclusively with LEED-certified conference centers for Annual and Interim meetings in 2030.

- A re-landscaping project is on track for completion by August 2024. The project will use low-maintenance, synthetic plants, which are projected to reduce energy consumption from landscaping maintenance by 20%.

- Employee Commuter Benefits
  - AMA employees are encouraged to enroll in the commuter benefit program to use pre-tax payroll deductions towards public transit costs.

  - AMA's shuttlebus service, bike area, on-site Zipcars and scooter and hybrid vehicle parking reduced carbon emissions by nine metric tons. The shuttlebuses alone save an average of 65,000 pounds in carbon dioxide emissions per month.

- Building Operations and Amenities
  - AMA's HQ café sources local food and participates in the building's compost program, which repurposes 70 percent of waste.

  - AMA staff and visiting members/meeting attendees can charge their electronics using solar-powered benches in AMA plaza.

  - The AMA does not offer disposable hot cups in any of the breakrooms.

- AMA Events
  - Following COVID-19, AMA saw a surge in remote and hybrid meetings, prompting improvements in technology, workflows, vendor lists, licenses, guidelines, and training. Staff enhanced their skills in meeting accessibility and completed PCMA Event Accessibility certifications.
  - Catering practices:
    - AMA promotes the use of water stations vs plastic water bottles when catering.
    - AMA catering is equipped to compost waste from internal meetings.
    - AMA's top three vendors for catering all have a sustainability program.

- The AMA instituted a requirement to contract exclusively with LEED-certified conference centers for Annual and Interim meetings in 2030.
  - AMA has committed to Hyatt Regency Chicago, a LEED-certified building, for AMA's Annual meeting through 2029.
  - AMA's 2027, 2029 and 2031 Interim Meetings will be held at the Gaylord Pacific (currently under construction), designed to adhere to California's energy code Title 24, surpassing the standards set by LEED certified buildings.

Timeline of future efforts

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

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

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

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

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

4. **2026 to 2030: Leading by example within the Health Sector**
   a. Beginning in 2026, the AMA will launch an internal awareness campaign to inform and train employees on the new sustainability guidelines and improved

practices aimed at reducing emissions. The AMA will utilize the following channels:

i. Employee communications via email, SharePoint, and physical signage
ii. Programming via collaboration with Employee Resource Groups and local opportunities for volunteering with sustainability projects
iii. A digital course to educate employees on the sustainability guidelines

b. The AMA will continue to engage in the following consortiums and partnerships, not only to advance policies and interventions on climate change and health (BOT Report 17-A-23 Update on Climate Change and Health – AMA Activities) but also to share resources, information, and insights gained from the data collection, guideline development, implementation, and communication work above.
i. Medical Society Consortium on Climate Health
ii. National Academy of Medicine Action Collaborative on Decarbonizing the U.S. Health Sector
iii. The American Lung Association's Healthy Air Partners campaign
iv. American Public Health Association (APHA) Advisory Board on Climate, Health, and Equity

CONCLUSION

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

REFERENCES

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

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

REPORT OF THE BOARD OF TRUSTEES

B of T Report 19-I-24

Subject: Update on Climate Change and Health AMA Activities (BOT Report 03-I-23)

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

BACKGROUND

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

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

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

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

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

DISCUSSION

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

1. Educate physicians and trainees on the health effects of climate change.

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

CONCLUSION

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

Addressing the Public Health Crisis of Climate Change

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About the AMA

The American Medical Association is the powerful ally of and unifying voice for America's physicians, the patients they serve, and the promise of a healthier nation. The AMA attacks the dysfunction in health care by removing obstacles and burdens that interfere with patient care. It reimagines medical education, training, and lifelong learning for the digital age to help physicians grow at every stage of their careers, and it improves the health of the nation by confronting the increasing chronic disease burden. For more information, visit ama-assn.org.

Glossary of Terms

Term	Definition
Climate Change	Long-term shifts in temperatures and weather patterns.[1]
Greenhouse Gas Emissions (GHGs)	Gases that trap heat in the atmosphere are called greenhouse gases.[2]
Water Vapor	Water vapor is Earth's most abundant greenhouse gas. It is responsible for about half of Earth's greenhouse effect—the process that occurs when gases in Earth's atmosphere trap the Sun's heat. Greenhouse gases keep our planet livable. Without them, Earth's surface temperature would be about 59 degrees Fahrenheit (33 degrees Celsius) colder.[3]
Carbon Dioxide	Carbon dioxide enters the atmosphere through burning fossil fuels (coal, natural gas, and oil), solid waste, trees and other biological materials, and also as a result of certain chemical reactions (e.g., cement production).[1]
Methane	Methane is emitted during the production and transport of coal, natural gas, and oil. Methane emissions also result from livestock and other agricultural practices, land use, and by the decay of organic waste in municipal solid waste landfills.[2]
Nitrous Oxide	Nitrous oxide is emitted during agricultural, land use, and industrial activities; combustion of fossil fuels and solid waste; as well as during treatment of wastewater.[2]
Ozone	Ozone (O3) is a highly reactive gas composed of three oxygen atoms. It is both a natural and a man-made product that occurs in the Earth's upper atmosphere (the stratosphere) and lower atmosphere (the troposphere). Ozone contributes to what we typically experience as "smog" or haze, which still occurs most frequently in the summertime, but can occur throughout the year in some southern and mountain regions. Ozone absorbs UV light, reducing human exposure to harmful UV radiation that causes skin cancer and cataracts. When inhaled, it reacts chemically with many biological molecules in the respiratory tract, leading to many adverse health effects.[4]
Particulate Matter	Particle pollution — also called particulate matter (PM) — is made up of particles (tiny pieces) of solids or liquids that are in the air. Breathing in particle pollution can be harmful to your health.[5]
Renewable Energy	Renewable energy comes from unlimited, naturally replenished resources, such as the sun, tides, and wind. Renewable energy can be used for electricity generation, space and water heating and cooling, and transportation. Non-renewable energy, in contrast, comes from finite sources, such as coal, natural gas, and oil.[6]
Biofuels	Unlike other renewable energy sources, biomass can be converted directly into liquid fuels, called "biofuels," to help meet transportation fuel needs. The two most common types of biofuels in use today are ethanol and biodiesel, both of which represent the first generation of biofuel technology.[7]
Climate Justice	Climate justice connects the climate crisis to the social, racial and environmental issues in which it is deeply entangled. It recognizes the disproportionate impacts of climate change on low-income and BIPOC communities around the world, the people and places least responsible for the problem.[8]
Adaptation	Adaptation refers to adjustments in ecological, social or economic systems in response to actual or expected climatic stimuli and their effects. It refers to changes in processes, practices and structures to moderate potential damages or to benefit from opportunities associated with climate change.[9]
Decarbonization	Decarbonization is shorthand for finding alternative ways of living and working that reduce emissions and capture and store carbon in our soil and vegetation.[10]
IPCC	The intergovernmental panel on climate change is an intergovernmental body of the United Nations dedicated to advancing scientific knowledge about climate change. They are recognized as the global authority on climate science.[11]

Executive Summary

There is increasing evidence and near-universal consensus among the scientific community that human activities within the last 150 years are impacting the climate and causing increased global surface temperatures.[13] Even small increases in global surface temperatures can impact weather patterns, causing regional and seasonal temperature extremes, reducing snow cover and sea ice, and intensifying heavy rainfall.[12] Climate change has already caused irreversible damage, but climate change solutions can help prevent further temperature increases, provide health benefits, and mitigate negative impacts on health. The consequences of unmanaged climate change include droughts, water scarcity, rising sea levels and flooding, severe fires, melting polar ice, temperature extremes, declining biodiversity, increased vector-borne diseases, and catastrophic storms, all of which impact our health and safety.[1] Economically and socially marginalized groups are most vulnerable to climate change impacts due to structural determinants of health equity.[21]

From its inception in 1847, the American Medical Association (AMA) has been keenly aware that Americans' health was only as good as the environment they lived in, and has been actively engaged in environmental health research and policy. In 1989, the AMA issued its first report on the effects of global climate change and joined with governmental and other organizations to work on a comprehensive national policy and program to address the adverse effects of environmental pollution, including the "greenhouse effect". Within the last ten years, the AMA House of Delegates (HOD) has adopted a number of policies on climate change, air pollution, and sustainability. At the annual meeting in 2022, the AMA adopted policy declaring climate change a public health crisis that threatens the health and well-being of all individuals, with marginalized and disadvantaged populations expected to be disproportionately impacted by changing weather patterns.

To advance work in climate change and health, there are several organizational levers AMA can utilize, including education, advocacy, litigation, and collaborating with external partners. As such, the AMA has identified the following four strategic approaches to address climate change:

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

Section 1. Background and History

What is climate change?

Climate change refers to the long-term changes in temperature and weather patterns, primarily due to human behavior. Since the 1800s, burning fossil fuels such as coal, oil, and gas has generated greenhouse gas emissions (GHGs) that have trapped heat in the atmosphere and raised Earth's temperature by about 0.11 degrees Fahrenheit per decade.[1] However, the rate of warming has more than tripled since 1982, and in 2023, it was 2.12 degrees Fahrenheit above the 20th century average.[12] The impact of climate change does not end solely at temperature changes; climate change brings multiple weather-related changes, including intensified water cycles, increased flooding and drought in certain regions, rising sea levels, and increased rates of heat waves.[13] There is increasing evidence and near-universal consensus among the scientific community that human activities within the last 150 years are impacting the climate and causing increased global surface temperatures.[13] Even small increases in global surface temperatures can impact weather patterns, causing regional and seasonal temperature extremes, reducing snow cover and sea ice, and intensifying heavy rainfall.[12] Climate change has already caused irreversible damage, but climate change solutions can prevent further temperature increases, provide health benefits, and mitigate negative impacts on health.

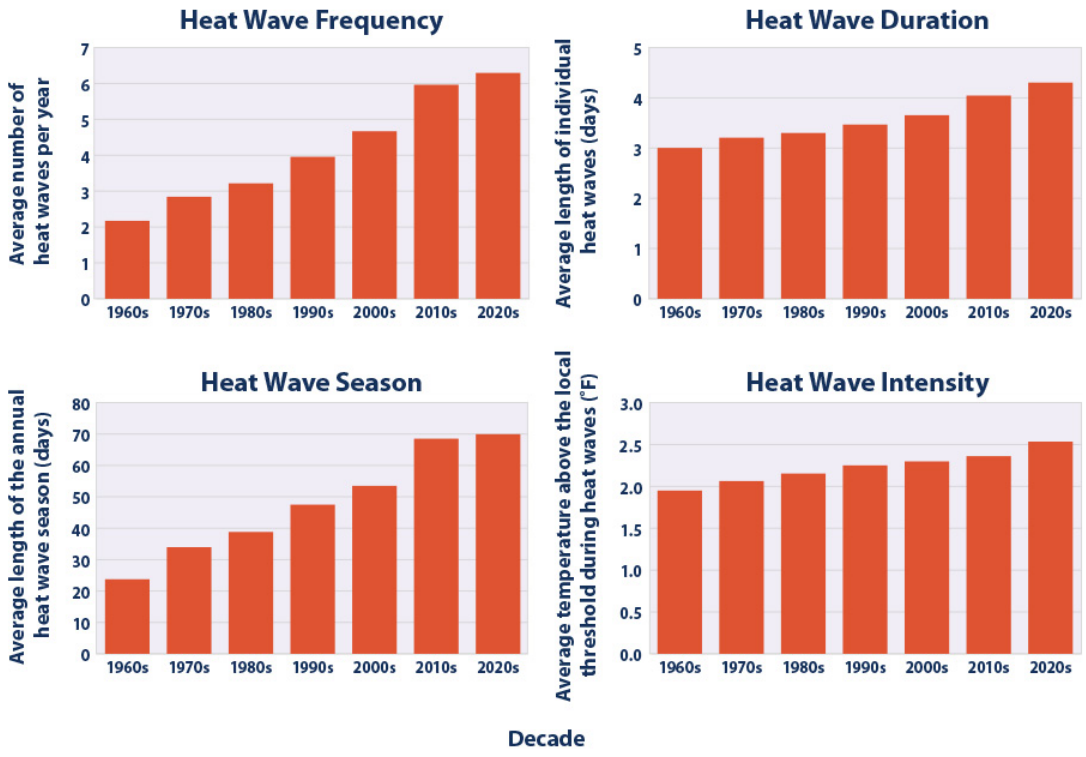
How does climate change impact health and equity?

The health impacts of climate change can be summarized as either direct or indirect **(Figure 1)**.[14]

Figure 1: Impact of climate change on health

The consequences of unmanaged climate change include droughts, water scarcity, rising sea levels and flooding, severe fires, melting polar ice, temperature extremes, declining biodiversity, and catastrophic storms, all of which impact our health and safety.[1] Heatwaves, for instance, can cause significant injury and mortality due to acute dehydration, heat exhaustion, and heat stroke, and studies have indicated that exposure to extreme heat can result in ischemic heart disease, heart failure, and arrhythmia.[15,16] Crucially, data from the United States Environmental Protection Agency (EPA) demonstrates that heat wave frequency, duration, and intensity are rising over time, and these trends are expected to continue and exacerbate health conditions for structurally vulnerable populations **(Figure 2)**.[17]

Figure 2: Heat wave trends in United States, 1961-2021



Data source: NOAA (National Oceanic and Atmospheric Administration). (2024). *Heat stress datasets and documentation* (provided to EPA by NOAA in April 2024) [Data set].

For more information, visit U.S. EPA's "Climate Change Indicators in the United States" at www.epa.gov/climate-indicators.

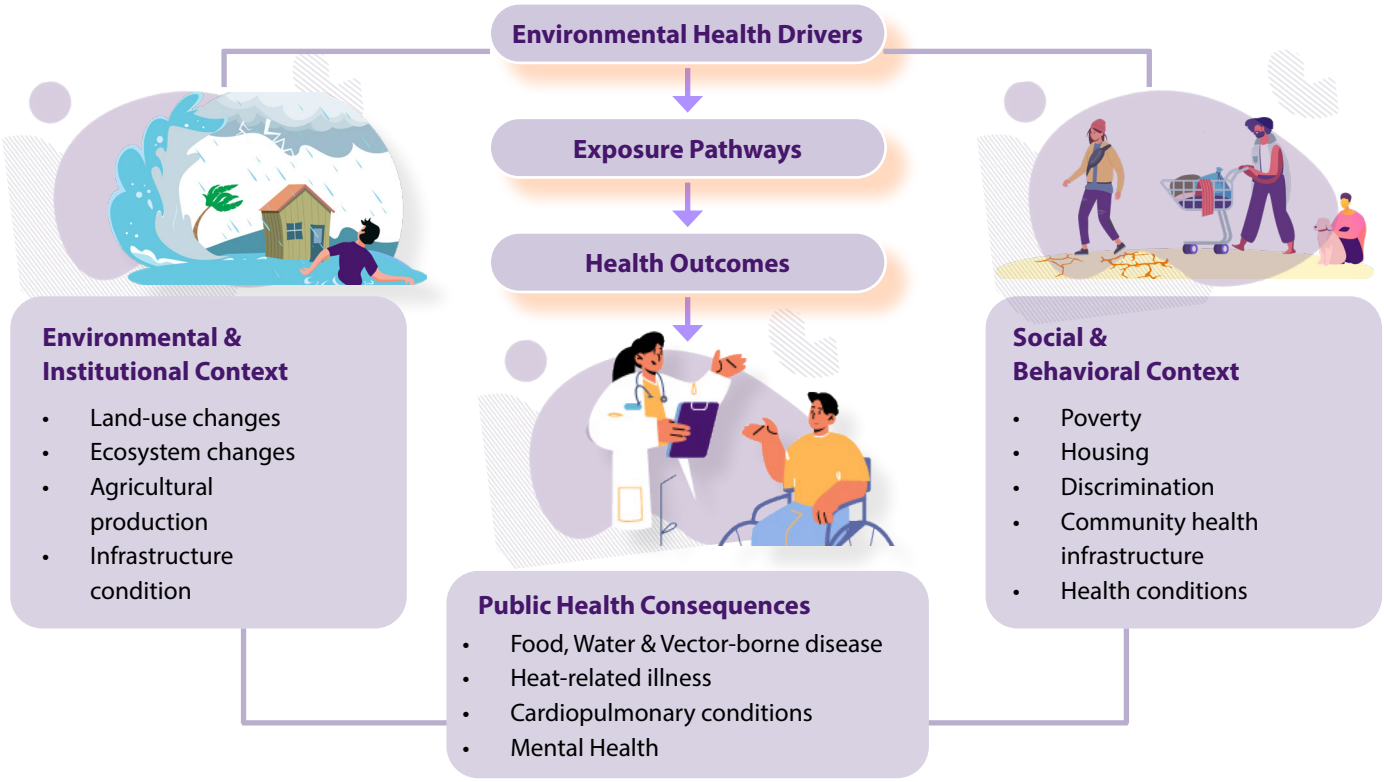
"I've seen this when I worked in hospitals in Florida, quite a bit. Obviously, one of our big things is heat, particularly in the summer months. And on those hot days, I have directly seen people coming to the ER who are in their early 20s, who are otherwise healthy and fit, no past medical history. And they're coming in with acute kidney injury because of dehydration, or heart failure or those people that have chronic illnesses. They're coming in when they hadn't been hospitalized in the two years prior or coming in with MI. Those are the direct effects of the heat for some of the patients." (Ankush Bansal, MD, FACP)

Evidence indicates that climate change impacts natural disasters, with observed changes in the intensity, frequency, and severity of extreme weather events such as monsoons, droughts, wildfires, and tropical cyclones.[13] These weather-related extreme events can cause death, destruction of people's homes, and hospitalizations due to traumatic injuries and can have lasting impacts on the environment through air and water quality.[18] Importantly, climate change impacts are not happening via one pathway, but rather, occur through various interconnected pathways across diverse social, environmental, and health contexts **(Figure 3)**. For example, nearly 4 in 10 people in the U.S., or 131.2 million people, already live in areas with unsuitable air quality.[19] Longer wildfire seasons will likely cause this number to increase, exacerbating population health inequities for people with asthma and other chronic respiratory conditions. The aftermath of these extreme events can also lead to displacement, homelessness, and post-traumatic stress disorder.[20] Economically and socially marginalized groups are most vulnerable to these poor outcomes due to structural determinants of health equity.[21]

Climate change continues to impact our food and water systems, which can indirectly worsen health outcomes by decreasing access to safe drinking water and healthy food. In 2022, 12.8 percent (17.0 million) of all households in the United States were food insecure, and in 2023, an estimated 2.2 million Americans lacked access to clean drinking water in their homes.[22]

Figure 3: Drivers of Exposure on Human Health

Climate change impacts human health through various interconnected pathways across social, environmental, and health contexts.



"I'd say we have definitely seen an increase in insect borne issues…from insects like ticks and mosquitoes. We've also seen changes with extremes of heat that negatively impact health and environmental resources…and I think that is problematic." (Maryanne Bombaugh MD, MSc, MBA, FACOG, CPE)

As climate change disrupts these systems further, it is expected that these numbers will grow. For example, IPCC models an additional 183 million people globally at risk of hunger if steps are not taken to mitigate climate change.[11] These disruptions will also increase food prices, decrease nutritional quality and food safety, and impact agricultural production levels. For individuals with less economic resources, shifts in food security could be a stress multiplier and lead to worsening health disparities and chronic disease rates.

Correspondingly, these changing weather patterns can indirectly impact health outcomes in numerous ways. Mental health experts note that the compounding factors of climate change can drastically impact mental health and increase the risk of psychiatric and neurological issues.[23] Many medications taken for managing mental health issues, except for benzodiazepines, can impair the body's ability to handle heat, raising the risk of heat exhaustion and heat stroke during extreme heat events.[24,25] Prior studies have found an association between increased temperatures and increased psychological distress, and another study identified increases in suicide deaths during wildfire events in rural America.[26, 27] While these results are not definitive and cannot establish causality, we know that climate change causes eco-anxiety and distress for 68 percent of adults, per a 2020 survey of over 2000 US adults conducted by the APA and The Harris Poll.[28] Additionally, in a global study of 10,000 children and young people, many respondents experienced at least moderate worry about climate change, and 75 percent reported feeling frightened about the future.[29] There is also evidence that children who were exposed in utero to natural disasters were significantly more likely to be diagnosed with a mood disorder or attention-deficit/disruptive behavioral disorder.[30] For many families, the stress and trauma of living through an extreme event can be substantial, long-lasting, and difficult to recover from as access to behavioral health treatment can be extremely limited.[31]

In 2023, over 200 medical journals, including the Journal of the American Medical Association (JAMA), coordinated the release of an editorial declaring climate change as a global health emergency, stating that vulnerable communities will bear the highest burden of changing climates.[32] Much like the COVID-19 pandemic, the climate crisis impacts communities of color, indigenous communities, and lower income communities at a greater scale. The legacy of systemic racism and structural violence (the social structures that put people in harm's way) means that marginalized communities face significant barriers in meeting their basic needs and accessing care.[33] For example, after Hurricane Katrina struck New Orleans in August 2005, data indicates that Black families faced significantly worse storm damages compared to white communities, with 272,000 Black individuals suffering displacement by flooding or storm damage, compared to 101,000 non-Black individuals.[34] Additionally, Louisiana autopsy data indicates that over 50 percent of storm casualties were non-Hispanic Black.[35]

"It's really looking at the dichotomy of how segregation, redlining, disinvestment in communities–and how climate plays a role in that, especially how stark the health effects are." (Joanna Bisgrove, MD)

We can uncover the root causes of these disparities using a structural violence lens: Black families in New Orleans faced wealth inequities due to intersecting systems of oppression that have prevented safety and economic resources, relegating families of color to poor, lower-lying areas without access to green space that might help absorb water.[36] Racial segregation, racism, and restrictive housing covenants ensured that Black homeowners were forced into undesirable, flood-prone areas.[37] Moreover, at the time of Hurricane Katrina, 84 percent of New Orlean's poor population was Black, making evacuation exceedingly difficult for these residents. In the end, the mortality rate for black individuals was potentially four times higher than whites; as such, scholars view racism as a primary driver in the risk of poor outcomes for such communities.[38,39] Many racial health disparities still exist today and have substantial implications on primary care, including exacerbated rates of heart disease, cancer, and new cases of HIV for Black residents of New Orleans.[40]

If action is not taken against climate change, these disparities will continue and are likely to worsen for historically marginalized communities and those at higher risk of climate-related health harms. Multiple studies in a 2022 scoping review found evidence that communities of color, including Black, Hispanic/Latinx, Native American, Pacific Islander, and Asian communities, face disproportionate impacts from climate change and extreme weather events, ranging from increased risk of stroke and cardiovascular disease during heat waves, higher risk of pregnancy complications for Hispanic women during Hurricane Sandy, and increased risk of infectious diseases such as gastrointestinal illness for American Indian and Black communities in the wake of Hurricane Florence.[41] Children and the elderly are especially vulnerable to climate disasters, as both have more limited ability to care for themselves and might be more susceptible to environmental hazards such as air pollution **(Figure 4)**.[42, 43] For Indigenous communities, climate change poses a substantial threat, as these groups often have a close relationship with the land and already face significant marginalization.[44]

The evidence is clear: Climate change is a fundamental threat to human health, and action must be taken to adapt and mitigate these impacts.

Figure 4: Climate Change and Vulnerable Populations

Impact on Children

Children are more vulnerable to the adverse health effects of climate change due to factors related to their developing physiology and metabolism, unique exposure pathways, biological sensitivities, and limits to their adaptive capacity (especially to extreme heat).

Impact on People with disabilities

Populations with mobility or cognitive disabilities are likely to experience greater vulnerability to adverse health impacts responding to, evacuating, and recovering from extreme weather events.

Impact on Older Adults

Older adults are more vulnerable during extreme events that cause power outages and/or require evacuation, as they may have limited mobility. Additionally, older adults are more likely to have other pre-existing conditions, such as hypertension, and other physiological factors that increase their risk of adverse impacts from climate change.

Impact on Communities of Color

As a result of structural and historical racism, communities of color are at increased risk from climate change due to the higher likelihood of living in risk-prone areas, areas with older or poorly maintained infrastructure, or areas with an increased burden of air pollution. Additionally, communities of color may face cumulative exposure to multiple pollutants and climate related health threats.

Impact on Low-Income Communities

Populations with limited income are more likely to live in risk-prone areas, such as urban heat islands, isolated rural areas, or coastal and other flood-prone areas. They are also more likely to have limited transportation options in the event of an evacuation and limited access to and use of health care.

The groups shown above do not represent a comprehensive list of communities that face increased climate vulnerability.
Other groups include members of the LGBTQ+ community, women, people who are incarcerated or without homes, particular occupational groups, immigrants, communities with limited English proficiency, and indigenous populations.

AMA and Environmental Health: The Historical Record

From its inception in 1847, the AMA has been keenly aware that Americans' health was only as good as the environment they lived in, evidenced by a report in 1856 on sanitation in cities that advocated for government intervention in controlling pollution of cities. While AMA's early work initially focused on air and water pollution, it soon came to encompass environmental health more broadly (see timeline of AMA environmental health policy in **Appendix A**). In the 1960s, AMA created a Committee on Environmental Health and recommended the federal government play a significant role in controlling air pollution. In 1989, four years after the discovery of a hole in the ozone layer, the AMA issued a report on the effects of global climate change and joined with governmental and other organizations to work on a comprehensive national policy and program to address the adverse effects of environmental pollution, including the "greenhouse effect". The AMA continued to advocate for restrictions on pollutants, but it was not until the early 2000's that policy was adopted calling for specific actions on climate change. In 2008, the AMA's Council on Science and Public Health (CSAPH) issued a report, *Global Climate Change and Human Health* that presented the (then) current scientific evidence on climate change, discussed predicted health effects, and provided policy recommendations, which were adopted (**See Policy H-135.938)**. Within the last ten years, the AMA HOD has adopted a number of policies on climate change, air pollution, and sustainability.

Recent AMA Policy on Climate Change

In 2016, policy was adopted in support of initiatives to promote environmental sustainability and other efforts to halt global climate change. In 2022, the AMA declared climate change a public health crisis that threatens the health and well-being of all individuals, with marginalized and disadvantaged populations expected to be disproportionately impacted by changing weather patterns. That same year, the AMA's CSAPH presented a council-initiated report on this topic "due to the significant public health threat that climate change represents and the impact on the health of patients, with marginalized populations expected to be disproportionately impacted." The CSAPH report called on the AMA to protect patients by advocating for policies that:

- Limit global warming to no more than 1.5 degrees Celsius (2.7 degrees Fahrenheit)
- Reduce US greenhouse gas emissions aimed at carbon neutrality by 2050
- Support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens

Section 2. Steps to Move AMA Forward

Levers for Change

From an organizational perspective, there are several avenues AMA can take to leverage its resources to engage in climate change and health work and address the public health crisis of climate change.

Education

Providing education is a critical component of AMA's mission to "promote the art and science of medicine," which it does as an accredited provider of continuing medical education (CME) and a driving force in the modernization of physician training. The AMA accomplishes this mission in several ways - through its online learning platform, the AMA Ed Hub™, and the publication of JAMA.

AMA's Ed Hub™ brings together almost 6,000 activities and over 2,000 CME articles, podcasts, videos, and interactive modules on a wide range of issues. There are currently over 70 resources available on the Ed Hub on the topic of climate change, which will continue to grow in the future. In the summer of 2024, the AMA released a 30-minute educational module on climate change and health. The focus of the module is to bring awareness to physicians about the impact of climate change on the nation's health and to empower physicians to begin conversations with their patients about how climate change is affecting their health and what they can do about it. Additionally, *JAMA* has announced a new Climate and Health series, intended to inform readers about the associations between climate change and health and "to stimulate improved knowledge and understanding of the health effects of climate change to help foster commitment to timely action to prevent adverse health events from climate change." Through multiple channels, AMA will continue to produce and disseminate high quality educational content on climate change and health to meet the needs of physicians and the healthcare workforce.

Advocacy

The AMA's Advocacy team has a long-standing commitment to advocating at the federal and state levels. As part of our advocacy efforts, the AMA participates in the American Lung Association's (ALA) Healthy Air Partners campaign, which is a coalition of 40 national public health, medical, nursing and health care organizations engaged in healthy air advocacy efforts. The Coalition is united in its calling for strong federal laws and policies to slash air pollution and address climate change, recognizing climate change can affect air quality, and certain air pollutants can affect climate change. AMA has participated in several comments letters as part of this coalition, which are not fully enumerated below, but a few notable cases are highlighted:

- In June 2023, AMA joined 13 other health organizations in a letter to Environmental Protection Agency (EPA) on their proposed ruling regarding Pollutant Emissions Standards for Model Years 2027 and Later Light-Duty and Medium-Duty Vehicles, urging them to pass the most stringent emission standards possible with existing technologies. In March 2024, the Biden Administration finalized this rule placing stricter limits on emissions from new cars. These new rules are a big win for public health and the planet. They will improve air quality and help prevent future health harms from climate change. The new standards will avoid more than 7 billion tons of carbon emissions and provide $13 billion of annual public health benefits due to improved air quality.
- In August 2023, AMA joined ALA and other health organizations in a letter to EPA on their proposed ruling in the Reconsideration of the National Ambient Air Quality Standards for Particulate Matter, calling for the most protective standards to protect the health of the most vulnerable populations. In February 2024, EPA finalized their particulate matter rule. While the new rule did not set particulate matter at the more protective standard as advocated for by the Coalition, the revised rule did address several of our comments and the new standards will result in significantly reduced particulate matter pollution in the future.

Through its engagement with partners and as needed on a case-by-case basis, the AMA will continue to support policy and regulatory changes that advance efforts to reduce U.S. greenhouse gas emissions and improve health.

Litigation

Through the AMA's litigation center, we work to represent the interests of the medical profession on this issue in the courts by providing support or becoming actively involved in litigation of importance to physicians. The Litigation Center has engaged in a number of issues important to public health including government interference in the physician-patient relationship, the regulation of tobacco products, and firearm violence. Recent court cases centered on climate change and health (e.g., Montana), as well as the government's role in regulating greenhouse gases, highlight an area where the AMA can potentially engage moving forward.

Collaboration with external partners

In addition to its collaboration with ALA's Healthy Air Coalition, AMA partners with several other external groups that focus on climate change and health. The AMA continues to engage in the Medical Society Consortium on Climate and Health (MSCCH), which brings together associations representing over 600,000 clinical practitioners. The AMA is represented on the executive committee of this group.

The AMA is also a sponsor of the NAM Action Collaborative on Decarbonizing the Health Sector as a member of the Steering Committee and co-lead of the Health Care Delivery Workgroup. The first phase (2021-2023) of the Action Collaborative's work was focused on identifying key opportunities and challenges to climate action, decarbonization, and building resiliency across the health sector and developing resources and tools to meet those needs. The collaborative, through the work of the members, has developed over thirty resources to accelerate climate action across the health sector. The second phase (2024-2025) is focused on accelerating a national climate and health movement, as well as advancing the successes of the existing working groups and launching an accelerator pilot program. The AMA has sent an invitation to the Federation of Medicine inviting groups to join us in accelerating the climate and health movement.

Lastly, the AMA is represented on the American Public Health Association's (APHA) Center for Climate, Health, and Equity Advisory Board. APHA's Center for Climate, Health and Equity leads public health efforts to inspire action on climate and health, advance policy and galvanize the field to address climate change. The Advisory Board assists in refining and implementing APHA's Center for Climate, Health, and Equity strategic plan.

Organizational sustainability efforts

The AMA is committed to improving its environmental sustainability and will continue to implement several ongoing initiatives but also expand upon them. AMA's Chicago headquarters are located in a LEED-Gold certified building and multiple upgrades in the building are making it even more energy efficient. The building has also implemented several water conservation programs and a composting program. AMA's robust telework policy and promotion of a hybrid working environment, utilization of a shuttlebus service, bike area, on-site Zipcars and scooter and hybrid vehicle parking contribute to carbon emission reductions. AMA has published updates on these environmental sustainability initiatives (BOT Report 25-A-24) and will do so again for the 2024 interim meeting of the AMA House of Delegates.

Strategic approaches to address climate change

The AMA's response to public health crises is typically focused on (1) ensuring physicians and trainees have the data and resources needed; (2) identifying evidence-based policies and interventions; (3) elevating the voices of physician leaders through AMA channels and platforms; and (4) convening and collaborating with stakeholders to advance priority policies and interventions. These strategic approaches overlap and dovetail well with the different levers of change identified above.

To ensure our climate change strategy is consistent with our other work on other public health crisis, the AMA has identified the following four strategic approaches to address climate change:

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

Measuring our effectiveness

We are committed to advancing our strategic priorities on this critical public health issue and will track our progress using several performance indicators for each of four strategic approaches. Performance measures for each of our strategic approaches will address:

1. How much did we do? (For example, the number of events and/or activities completed)
2. How well did we do it? (For example, the number of educational products or events that were of high quality)

To ensure transparency and accountability, regular updates on our progress will be provided to the House of Delegates in the AMA's annual public health strategy report.

Section 3. Key Accomplishments and Future Actions

Strategic Approach	Key Accomplishments (2022 – 2024)
Educate physicians and trainees on the health effects of climate change.	Made climate change education available via the Ed Hub™ from a variety of sources including the *AMA Journal of Ethics, JAMA*, the American Public Health Association (APHA), and UC Center for Climate, Health and Equity (Ongoing). *JAMA* announced new series on climate and health intended to inform readers about the associations between climate change and health (2024). AMA's Center for Health Equity released an episode as part of the Prioritizing Equity series featuring physicians and scholarly leaders advocating for equitable climate action to remedy the disproportionate burden of health harms climate crisis puts on historically marginalized communities (2024). AMA climate change and health module being developed to be disseminated via the AMA Ed Hub™ (Coming in 2024).
Identify and disseminate information to physicians on decarbonizing the health care sector, reducing GHG emissions, as well as improving adaptation and resilience efforts.	The Council on Science and Public Health (CSAPH) initiated a report on *Climate Change in Human Health* and resulting policy calling for a 50 percent reduction in emissions by 2030 and for the health sector to lead by example in committing to carbon neutrality by 2050 (2022). Hosted an educational session at I-23 entitled *The Climate Crisis: Pathways to Decarbonizing the U.S. Health Sector* in collaboration with the National Academy of Medicine (NAM) (2023). AMA Update episode featured Dr. Victor Dzau, President of the NAM, who discussed how the Action Collaborative on Decarbonizing the U.S. Health Sector is bringing together organizations across medicine to act on climate change (Nov. 2023). CSAPH Report on *Sustainability in the Operating Room* adopted at HOD I-23. Dissemination of materials and resources for implementation of the Inflation Reduction Act (IRA) through NAM Collaborative. CSAPH report on *Reducing Hydrofluorocarbon in Health Care* adopted at A-24. BOT report on Carbon Pricing developed for I-24.
Elevate the voices of physician leaders on the issue of climate change and health.	AMA Update video and podcast series featured Renee Salas, MD, MPH, MS, a climate and health expert and emergency medicine physician who discussed research on the intersection of health and the climate crisis (Jan. 2022). AMA Update video and podcast series featured Colin Cave, MD, medical director of external affairs, government relations and community health at Northwest Permanente who discussed the link between health and climate change, and how physicians and health systems can be a part of the solution (Aug 2022). AMA conducted listening sessions with physicians to gauge their level of knowledge on climate change and elicit feedback on AMA strategy moving forward (May 2023). AMA staff participated in a plenary panel session entitled, "Climate – Impact on Health and Health Care" at AcademyHealth's 2023 Annual Research Meeting (June 2023). AMA's Chief Health & Science Officer joined the PermanenteDocs Chat podcast on heat waves and health, with a focus on how physicians can adjust to prepare to care for heat-related conditions brought on by climate change (Aug. 2023). The AMA STEPS Forward® Podcast featured Dr. Jerry Abraham, who discussed the intersections between the social determinants of health and climate change impacts (Feb. 2024). AMA staff developed and distributed a survey to physicians to assess perceptions on climate change and health (2024).
Collaborate with stakeholders to advance policies and interventions with a unified voice.	Launched a dedicated page on the AMA website, *Advocacy in action: Combatting health effects of climate change,* to highlight AMA's position on this issue, how it is engaged, and resources for physicians (2023). Sponsored the NAM Action Collaborative on Decarbonizing the US Health Sector (2021-Present). Participated in the MSCCH, and the American Lung Association's Healthy Air Partners coalition. AMA staff member serves on APHA Climate, Health, and Equity Advisory Board. Signed three letters in support of EPA policy to reduce greenhouse gas emissions and air pollution. Joined the MSCCH and 34 other health care organizations in sending a letter to the House of Representatives Agriculture Committee on the U.S. Farm Bill reauthorization (March 2024).

Section 3. Key Accomplishments and Future Actions

Strategic Approach	Proposed Actions
Educate physicians and trainees on the health effects of climate change.	Seek funding and opportunities for collaboration to support additional educational content on climate change, environmental justice, and health. Release additional CME module or content on climate change and health.
Identify and disseminate information to physicians on decarbonizing the health care sector, reducing GHG emissions, as well as improving adaptation and resilience efforts.	Disseminate relevant resources produced by the NAM Action Collaborative to Decarbonize the Health Sector. Study issues relating to decarbonization, climate change, and environmental sustainability as requested by the HOD. Publish an updated Green Practice Guide to the AMA website. Identify additional methods of dissemination for AMA's climate-related policies and positions, such as fact sheets or podcasts.
Elevate the voices of physician leaders on the issue of climate change and health.	Disseminate results from the AMA climate change survey through peer-reviewed journal publication and/or conference presentations. Participate in relevant national meetings and elevate AMA's policies and positions on climate change. Feature physician leaders on AMA platforms addressing the topic of climate change and health.
Collaborate with stakeholders to advance policies and interventions with a unified voice.	Continue to participate in multiple coalitions on climate change and health. Advocate for laws and regulations consistent with AMA climate change policies. File amicus briefs determined to be aligned with AMA's climate change policies and of importance to physicians.

Appendix A. A History of AMA's Environmental Health Policy and Research (1856-1960)

1856

A report on sanitation of cities calls for government intervention in the pollution of cities (Report on the Sanitary Police of Cities, A-1856).

1875

AMA adopts policy calling on the chief officer of the Signal Service Corps to have the quantity of ozone in the atmosphere telegraphed and published in weather reports. At this time, scientists believed ozone was a healthy component of the environment (Minutes of the 26th Annual Meeting, A-1875).

1891

In calling for the creation of a cabinet appointment of a Secretary of Public Health, environmental protection initiatives are cited noted as being supported by such a position (Report of the Committee on the Question of a Cabinet Appointment of a Secretary of Public Health, A-1891).

1905

AMA committee on Medical Legislation notes the importance of doctors weighing in on legislation regarding the protection of streams from pollution, among other public health initiatives (Report of Committee on Medical Legislation, A-05).

1946

In an address before the HOD, Rear Admiral J.T. Boone of the US Navy decried the pollution in Appalachia caused by coal mining (Address of Rear Admiral J.T. Boone, I-46).

1949

AMA's Council on Industrial Health holds a panel on scientific developments in the field including atmospheric pollution, toxic chemical and other harmful biological exposures (Report of Council on Industrial Health, A-49).

1955

AMA supports the creation of grants intended to provide funding for research on air pollution (Report of Washington Office, I-55).

1960

The Environmental Medicine Division is formed to address socio-economic issues affecting health care. Later known as Environmental Medicine and Medical Services (EMMS), the division oversaw initiatives addressing public health and professional issues as diverse as air pollution, school health, fitness, international health, health care for jail inmates, physician placement, and practice development (BOT Report, I-60).

Appendix A. A History of AMA's Environmental Health Policy and Research (1962-1973)

1962

AMA forms a Committee on Environmental Health (Address of the President, A-62).

1963

AMA recommends the federal government play a significant role in controlling air pollution (BOT Report, A-63)

1964

AMA has its first Congress on Environmental Health Problems (BOT Report, I-64).

1965

- AMA officially recognizes the importance and complexity of air pollution and creates a medical basis for establishing standards and objectives for the guidance of groups such as government agencies, medical organizations, and industrial and private organizations (BOT Report, A-65);
- AMA's Committee on Environmental Health is elevated to the more permanent status of "council" (BOT Report, I-65).

1967

AMA supports the Air Quality Act of 1967, but advocates against the establishment of industry-wide pollution standards in favor of individualized standards depending on the location of the polluting facility (Legislative Department Annual Report, I-67).

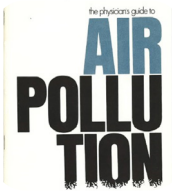
1969

AMA recognizes rapidly increasing air pollution hazards and calls on the medical profession to exert leadership in the search for effective solutions (Res. 55, I-69).

1971

AMA adopts policy calling for the Federal Environmental Protection Agency to have jurisdiction over all other federal agencies to set environmental quality standards and enforce compliance (Res. 60, I-71).

1973



AMA reaffirms support for the present levels and time schedules to reduce air pollution as promulgated by the Clean Air Act of 1970 (Res. 61, A-73).

Appendix A. A History of AMA's Environmental Health Policy and Research (1978-2009)

1978

AMA adopts policy on the hazards of nuclear, fossil, and alternative-energy generating sources. (Report of the Council on Scientific Affairs, A-78).

1989

- AMA issues a report on the effects of global climate change (Report of Council on Scientific Affairs, A-89).
- AMA joins with governmental and other organizations to achieve a comprehensive national policy and program to address the adverse effects of environmental pollution, including the "greenhouse effect". (Res. 43, A-89)
- AMA adopts policy on stewardship of the environment, calling on physicians to be spokespersons for environmental health (Report of Council on Scientific Affairs, I-89).

1992

AMA encourages physicians and environmental scientists to continue to incorporate concerns for human health into environmental research and public policy initiatives and encourages physician educators to devote more attention to environmental health issues (Report of Council on Long Range Planning and Development, I-92).

1995

AMA adopts policy calling for leadership and participation in a major education and prevention program to inform patients of the negative effects of air pollution on health (Res. 404, I-95).

2004

AMA adopts policy encouraging the Environmental Protection Agency (EPA) to finalize the most stringent feasible standards to control pollutant emissions from road engines (Res. 428, A-2004).

2008

- AMA encourages physicians to participate in regional and state decision-making regarding air pollution (Res. 408, A-2008);
- AMA supports green initiatives and anti-pollution programs (Report of the Council on Science and Public Health, I-2008);
- AMA issues a report on global climate change and concludes that human activity represents a significant contribution to the phenomenon. New policy is adopted educating the medical community on the potential adverse effects of climate change and supporting research to create evidence-based climate change policy decisions (Report of Council on Science and Public Health, I-2008).

2009

AMA issues a report on its efforts toward making the AMA "greener" (BOT Report, A-2009).

Appendix A. A History of AMA's Environmental Health Policy and Research (2010-2022)

2010

AMA policy supports the Environmental Protection Agency (EPA)'s effort to promulgate rules to regulate and control greenhouse gas emissions (Res. 925, I-2010).

2014

AMA formally supports the Environmental Protection Agency (EPA)'s regulation of carbon emissions (Res. 421, A-2014).

2015

AMA joins Royal Australasian College of Physicians Consensus Statement: Act now to reduce the damaging health impacts of climate change.

2016

- AMA adopts policy in support of initiatives to promote promote environmental sustainability and other efforts to halt global climate change (Res. 924, I-2016).
- AMA joins the Medical Society Consortium on Climate Change and Health.

2017

AMA adopts policy in support of evidence-based environmental statutes and regulations intended to regulate air and water pollution and reduce greenhouse gas emissions (Res. 523, A-2017).

2018

- AMA adopts policy to protect and maintain the Clean Air Act (Res. 917, I-2018);
-Policy calls on the AMA and its affiliated corporations to "work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships… with companies that generate the majority of their income from… fossil fuels" (BOT Report, A-2018).

2019

-AMA adopts policy in support of teaching about climate change in undergraduate, graduate, and continuing medical education (Res. 302, A-2019);
- AMA adopts policy in support of exploring environmentally sustainable practices for *JAMA* distribution (BOT Report, I-2019).
- AMA joins the U.S. Call to Action on Climate, Health, and Equity: A Policy Action Agenda that lists ten policy recommendations and strategies for simultaneously tackling climate change, health, and equity.

2020

AMA sends a letter to President Trump declaring "there is no single step that will do more for the health of all Americans than remaining in and meeting our obligations to the Paris Climate Agreement" (AMA Press Release, 1-10-2020).

2021

AMA joins National Academy of Medicine Action Collaborative on Decarbonizing the U.S. Health Sector.

2022

- AMA declares climate change a public health crisis (Res. 420, A-2022);
- AMA calls on the health care sector to take the lead in mitigating climate change by committing to carbon neutrality by 2050 (AMA Press Release, 11-15-2022).

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AMA
AMERICAN MEDICAL ASSOCIATION

REPORT 20 OF THE BOARD OF TRUSTEES (I-24)
2024 AMA Advocacy Efforts

EXECUTIVE SUMMARY

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

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

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

Physicians identify these issues as the most vital to establishing and maintaining thriving practices.

The AMA is also seeking to advance AMA policy on a host of other health care issues under consideration at the federal and state levels including physician-owned hospitals; physician workforce; non-compete agreements; Medicaid/CHIP; government intrusion into clinical care; firearm violence; maternal health; the overdose epidemic; climate change; and nutrition.

Updates on all these efforts are also included in this report. HOD members are also strongly encouraged to read Advocacy Update which comes out every other Friday and provides updates on AMA legislative, regulatory, and private sector efforts. Every HOD member should be receiving Advocacy Update, but if you are not, please sign up at this link.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 20-I-24

Subject: 2024 AMA Advocacy Efforts

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

BACKGROUND

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

DISCUSSION OF 2024 ADVOCACY EFFORTS

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

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

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

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

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

Medicare Payment Reform

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

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

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

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

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

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

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

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

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

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

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

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

- 90.9MM+ Impressions
- 1.5MM+ Engagements
- 2,000+ #FixMedicareNow Social Media Mentions
- 397k messages sent to Congress
- 504k+ FixMedicareNow.org Pageviews
- 423k+ FixMedicareNow.org Site Users
- 1000+ earned media stories on Medicare, including more than 50 placements giving voice to physician leaders and third parties – making the case for reforming the system and stopping/reversing the cuts. (These efforts have had an organic impact on thought leaders and policy analysts who are now beginning to express similar views independently.)

A good example of the campaign is a promotional series that the AMA is running at the Politico site and other influential web properties. Activities ramping-up in the summer will continue to intensify through the fall and in anticipation of a Congressional "lame duck" session that will tackle Medicare. These include engaging both patient and physician audiences during Congress' month-long August Recess, helping them identify opportunities to contact and meet with their federal legislators and staff equipped with 'action kits' (that include talking points, supportive

charts/data, and feedback forms) that reinforce medicine's position. Other tactics include aggressive paid promotion that hit lawmakers in Washington, D.C. and their home states/districts with a battery of messaging online, in print, radio, and TV/streaming services ensuring the issue is top-of-mind for them and their constituents ahead of critical elections in November. Additionally, the AMA will leverage earned media efforts, physician grasstops, and allied influencer engagement that brings together the most influential voices to put direct/public pressure on key legislators.

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

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

Prior Authorization

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

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

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

The AMA is also advocating for the "Improving Seniors' Timely Access to Care Act" in both the House and Senate to codify and expand on prior authorization reforms finalized by CMS. This bill is even more important and is needed to memorialize the CMS rule in light of the *Loper Bright Enterprises v. Raimondo* ruling which may limit agency regulatory authority. The AMA successfully sought the reintroduction of the "Getting Over Lengthy Delays in Care as Required by Doctors (GOLD CARD) Act," which would exempt qualifying physicians from Medicare Advantage plans' prior authorization requirements.

The AMA continues to work to provide medical societies with legislative language, talking points, data, and other resources to push for important prior authorization reforms in state legislatures. The AMA is also lobbying national policymaking organizations (e.g., the National Association of Insurance Commissioners) on the importance of reform and working closely with coalitions of other impacted organizations to make the case for important patient protections from payers' utilization management requirements.

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

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

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

Physician-Led Team-Based Care

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

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

So far in 2024, the AMA has worked with more than 35 state medical associations and national medical specialty societies on scope of practice, securing more than 50 wins and demonstrating the collective work of organized medicine. State medical associations deserve special gratitude since they are on the ground in the statehouses each day and serve as point on these campaigns.

- At least 12 states have defeated legislation that would remove physician supervision of or collaboration with nurse practitioners or advanced practice registered nurses (APRN), including two states, Oklahoma and Wisconsin, where the Governor vetoed APRN bills;
- Bills that would have allowed optometrists to perform surgery have been defeated in at least 10 states, including California, Idaho, Kansas, Minnesota, Missouri, Nebraska, New Hampshire, Utah, Vermont, and West Virginia;
- Nurse anesthetist bills have been defeated in at least eight states including: Florida, Georgia, Illinois, Kansas, Missouri, South Carolina, Utah, and Virginia;
- Arizona, California, Illinois, Mississippi, Oklahoma, South Carolina, and West Virginia stopped pharmacist test-to-treat legislation, while Washington State defeated a bill that would have given the Pharmacy Commission the authority to identify drugs and devices that a pharmacist could prescribe;
- Alaska, Colorado, Connecticut, Florida, Indiana, Kansas, Minnesota, Missouri, New Jersey, New York, and Washington defeated legislation that would have created a license for naturopaths, allowed naturopaths to prescribe medications and perform minor surgeries, or order and interpret diagnostic tests;
- Florida, Hawaii, New York, Oklahoma, and Washington defeated psychologist prescribing bills; and
- South Dakota State Medical Association achieved a "silent" victory as a physician assistant scope expansion bill was <u>not</u> introduced this year, likely because SDSMA defeated physician assistant scope bills three times in recent years. Unfortunately, however, two scope bills passed in South Dakota this year, an optometrist surgery bill and APRN Compact bill.

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

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

Physician Wellness

The AMA has made improving physician wellness/reducing physician burnout a cornerstone of its strategic work for more than a decade, working at the system-level to remove the common barriers that interfere with patient care and often lead to burnout and dissatisfaction. Following the passage

of the "Dr. Lorna Breen Health Care Provider Act" in 2022, a bill the AMA strongly supported, the AMA continued to push for regulatory, legislative, and other solutions to direct more funding and resources to support the mental health needs of physicians. The AMA is also seeking reauthorization of the legislation in 2024.

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

- 28 medicals boards: California, Connecticut, Georgia, Hawaii, Idaho, Illinois, Kansas, Louisiana, Massachusetts, Maine, Michigan, Minnesota, Missouri, Mississippi, Montana, Nebraska, New York, North Carolina, North Dakota, Ohio, Oregon, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, and Washington (the AMA is in the process of working directly with multiple other medical boards);
- More than 25 local, state and regional health systems, including Allegheny Health Network, Augusta Health, Bon Secours Mercy Health - Richmond, Centra Health, Envision, Children's Hospital of the King's Daughters, Geisinger Health, HCA Healthcare, Henry Ford Health System, Inova Health System, Mary Washington Health Care, Medstar Health, Northeastern Vermont Regional Hospital, Northwell Health, NYC Health + Hospitals, Sentara Health System, Sturdy Health, PacificSource Health Plans, UVA Health System, Valley Health System, Wooster Community Hospital, Wooster Community Hospital, Allina Health, and Fulton County Health Center. The AMA is working with more than 40 additional systems to audit and revise their credentialing applications;
- AMA advocacy efforts and partnerships also secured multiple organizations adopting policies and/or advocacy positions directly aligned with the AMA on these issues, including CDC/NIOSH, the National Association of Medical Staff Services, the Massachusetts Hospital Association, the American Dental Association, the American Society of Health System Pharmacists, and others;
- Minnesota and Virginia enacted legislation in 2024 restricting applications from having stigmatizing language and supporting "safe-haven" type programs; and
- AMA advocacy has led to the National Association of Medical Staff Services revising its Ideal Credentialing Standards to follow AMA policy. The AMA also successfully advocated for the National Center for Quality Assurance to align with AMA policy for credentialing applications to ask only about current impairment and not past diagnosis or treatment of a mental illness or substance use disorder.

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

Telehealth

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

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

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

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

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

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

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

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

Further, in a final rule, CMS announced it will maintain the waiver of geographic and originating site restrictions related to telehealth through the end of 2024. The waiver, which began during the COVID-19 pandemic, allows Medicare beneficiaries to connect with physicians anywhere in the

U.S. from home. This creates flexibility in patients' access to care. CMS also finalized extending payment for audio-only telehealth services, increasing remote patient monitoring capabilities.

Cybersecurity

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

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

The AMA appreciated that HHS and CMS responded to the urgency of this incident and the unprecedented disruptions to medical practices and access to care. Following the AMA's urging, HHS and CMS announced initial steps in March to support physicians experiencing financial hardships as a result of this ransomware attack. CMS announced that physicians impacted by the Change Healthcare service disruption could apply for advance Medicare payments. CMS also extended the 2023 MIPS data submission deadline to April 15.

HHS further responded to concerns from the AMA regarding difficulties physicians face in securing information and assistance from commercial health insurers in the aftermath of the Change Healthcare cybersecurity attack by releasing a resource that collates information and contacts across many health plans. The AMA submitted multiple statements for the record for congressional hearings on the Change Healthcare cyberattack. In addition, a letter cosigned by over 100 Federation groups and other stakeholders was sent in May, asking that HHS and the Office of Civil Rights publicly clarify that breach notifications are the responsibility of UnitedHealth Group and not individual physicians, hospitals, and other providers. Following this sign-on letter, the HHS Office of Civil Rights released updated FAQs specifying that covered entities can delegate to Change Healthcare the tasks of making the required Health Insurance Portability and Accountability Act breach notifications on their behalf.

The AMA also sent a letter to the National Association of Insurance Commissioners (NAIC) asking that it urge its members to take immediate action to protect physician practices from the widespread impact of the Change Healthcare cybersecurity breach. NAIC disseminated the letter to states, which have responded with their own actions. NAIC has also formed a steering committee to address this issue and has been in touch with the AMA to assess the ongoing impact on physicians. The AMA also advocated to the National Association of Medicaid Directors (NAMD) asking that it urge its members to take immediate action to assist physician practices impacted by the Change breach, including taking advantage of flexibilities provided by CMS related to state plan amendments to provide advance payments to physicians under Medicaid. NAMD responded

positively to the AMA outreach and welcomed ongoing discussions with the AMA on how the service disruption is interfering with care delivery.

The AMA has engaged with Congress, offering several recommendations to prevent or mitigate future cyber-attacks and the impact on physicians:

- Robust cybersecurity standards for health plans and health care clearinghouses;
- Federally funded cybersecurity support centers to assist physician offices and smaller health care providers with cybersecurity adoption, prevention, training, and education;
- Impacted payers and clearinghouses must provide emergency connection points to maintain business continuity with physicians' health IT systems; and
- Physicians should be explicitly exempt from any accountability, liability, or penalties if a breach of their patients' protected health information occurs without any fault on their part.

The AMA continues to closely monitor the situation and gather information on the impact of this breach and others affecting health systems and other health care stakeholders.

Augmented Intelligence

Augmented Intelligence (AI) technology holds the promise to radically transform health care for both physicians and patients. For AI to meet its potential to improve care delivery and health, the AMA has called for a whole government regulatory approach that engages the physician community to ensure necessary safeguards and protections are in place. The AMA released Principles for Augmented Intelligence Development, Deployment and Use in the fall of 2023 that will guide the organization's engagement with the administration, Congress, and industry stakeholders in discussions on the future of governance policies to regulate the development, deployment and use of health care AI. For example, transparency around health care AI design, development, and deployment processes should be mandated by law and physicians should be provided sufficient detail and information to make their own informed decisions about using AI. These principles build on existing AMA policies on AI that go back to 2018, which encourage a comprehensive government approach to AI governance policies to mitigate risks. The principles lay out an appropriate strategy for AI in health care, including:

- Above all else, health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, and transparent;
- Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient; and
- Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the potential overall or disparate harm and consequences the AI system might introduce.

More information on AMA AI efforts is included in Board Report 01-A-24.

Physician-Owned Hospitals

The AMA continues to be a strong proponent of lifting the existing ban on physician-owned hospitals. Representatives Michael Burgess, MD (R-TX), Tony Cardenas (D-CA), Morgan Griffith (R-VA), and Vicente Gonzalez (D-TX) introduced, H.R. 9001, "the Physician Led and Rural Access to Quality Care Act." This bipartisan legislation would permit the establishment of select

physician-owned hospitals that meet certain criteria. More specifically, the legislation defines a "covered rural hospital" as a physician-owned hospital that is located in a rural area and more than a 35-mile drive (or a 15-mile drive in mountainous terrain or areas with only secondary roads) from another hospital or critical access hospital. The legislation also only permits these hospitals that meet this narrow definition to expand existing physician-owned hospitals. If enacted, H.R. 9001 will help foster greater competition and provide better health care access, especially in rural areas.

Physician Workforce

To address the current and growing physician workforce crisis, the AMA is emphasizing a multi-pronged solution. This includes seeking additional Graduate Medical Education (GME) slots and funding so more physicians can be trained. Legislation on this recommendation, H.R. 2389, the "Resident Physician Shortage Reduction Act," currently has more than 170 bipartisan House cosponsors. The AMA is calling for additional funding in support of programs created through the "Dr. Lorna Breen Health Care Provider Protection Act" and more loan repayment and scholarship programs for physicians, such as through the National Health Service Corps. The AMA is also urging greater access for international medical graduates through expansion of the Conrad 30 program (H.R. 4922/S. 665) and reclaiming unused employment-based visas from the past 30 years (H.R. 6205/S. S. 3211).

Non-Compete Agreements

In April, the Federal Trade Commission (FTC) approved a final rule banning all non-competes except for current non-competes involving senior executives. The rule does permit other types of clauses such as typical confidentiality agreements, non-disclosure agreements, and training repayment agreements. It is likely that the final rule will not apply to some, and perhaps many, 501(c)(3) hospitals, health systems, and other 501(c)(3) health care organizations. This means that under the final rule, many non-profit hospitals may be able to continue using non-competes while for-profit physician practices could not. In June, a federal district court judge temporarily enjoined the enforcement of the FTC noncompete rule. The injunction only applies to the plaintiffs that filed the lawsuit, which includes the U.S. Chamber of Commerce, an accounting firm, and a couple Texas business groups. The AMA continues to watch this case closely and, regardless of the court's decision, expects the ruling to be appealed to higher courts. The AMA has developed and released to the Federation a comprehensive legislative template that provides an in-depth analysis of all state non-compete laws applicable to physicians as well as key non-compete cases involving physicians.

Aligned with new HOD-adopted policy, the AMA opposes all restrictive covenants between employers and physician employees and will regularly update its state restrictive covenant legislative template. The AMA will also continue assisting the Federation in developing strategies for physician employee retention. The AMA has helped several state medical associations enact laws limiting non-competes, including Pennsylvania.

Medicaid/Children's Health Insurance Program (CHIP)

On April 22, CMS finalized two major rules to strengthen access to high-quality medical care for Medicaid and Children's Health Insurance Program (CHIP) beneficiaries and advance transparency related to quality, access, and payment rates.

The "Managed Care Rule" establishes federal maximum appointment wait-time and other standards for the first time and requires public reporting of quality and payment data for key

services. The "Access Rule" requires states to publish Medicaid fee-for-service payment rates and compare them to Medicare rates for key services and prove that any plans to restructure plans or reduce rates will not result in sufficiently diminished or insufficient access.

The AMA strongly supported many of the provisions when both rules were proposed and welcomed the historic changes in a statement, noting that the AMA has long sought changes to Medicaid payment and coverage policies to overcome longstanding barriers to care for low-income patients and advance health equity. In a statement, then-AMA President Jesse M. Ehrenfeld, MD, MPH, underscored that the AMA looks forward to working with CMS to implement these reforms to advance patient access and quality of care while emphasizing the need for common-sense protections to ensure managed care plans do not unfairly pass the burden of compliance onto safety net practices.

The AMA also continues to work with state medical associations, federal agencies, and other stakeholders to protect Medicaid beneficiaries during the Medicaid "unwinding." At the national level, the AMA has been participating in the Connecting to Coverage Coalition (CCC), which holds weekly calls. In April, the CCC issued a press release commending administration renewal actions, which included a quote from then-President Jesse M. Ehrenfeld, MD, MPH. In addition, the AMA has continued to engage with administration officials about unwinding and provided feedback on state experiences with unwinding and best practices. At the state level, the AMA has been working with state medical associations to raise awareness of coverage disruptions and distribute resources aimed at both physicians and patients to mitigate coverage losses. Speakers at the 2023 AMA State Advocacy Roundtable and 2024 State Advocacy Summit also highlighted redetermination challenges and strategized on ways physician practices and medical associations could provide direct assistance to patients and advocate for supportive policy changes with state Medicaid agencies and state legislators.

The AMA continues to work with state medical associations to increase Medicaid reimbursement rates in order to ensure patients with low-income can access the care they need. The AMA also continues to support state medical associations as they push for Medicaid expansion, in states that have not yet opted to expand eligibility under the Affordable Care Act (ACA).

Protecting Against Government Intrusion into Clinical Care

The AMA strongly opposes government interference in the practice of medicine and strongly opposes laws that prohibit physicians from providing evidence-based medical care that is in the best interest of their patients.

Abortion

The AMA supports patients' access to the full spectrum of reproductive health care options, including abortion and contraception, as a right. Physicians have an ethical obligation to help patients choose the optimal course of treatment, through shared decision-making that is fully informed by medical science and shaped by patient autonomy. Anything less puts patients at risk and undermines both the practice of medicine and our nation's health.

The AMA spoke out forcefully against court actions that undermined the U.S. Food and Drug Administration (FDA) decision-making and threaten to impact the availability of mifepristone and potentially other drugs. The AMA has also filed briefs to inform U.S. Supreme Court deliberations. The court heard oral arguments in the mifepristone case on March 26 and issued a decision in June. The decision preserved access to medication abortion but did not resolve the issue on the merits.

The AMA supported the Administration's privacy guidance that makes it clear that physicians are not required to disclose private medical information to third parties and provides patients with tips on the use of personal cell phones and tablets.

Further, the AMA is working closely with state medical associations to make sense of confusing legal obligations in restrictive states, identifying strategies to mitigate harm, and advocating against new restrictive laws. In states where abortion remains legal, the AMA is working with state medical associations to enact additional legal and professional protections for physicians in those states. In 2024, two additional states, Maine and Rhode Island, enacted shield law protections, bringing the total number of states to 19, including the District of Columbia. The AMA supported both laws.

Finally, the AMA has convened a "Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," at the direction of the House of Delegates, to identify and create practice and advocacy resources and guide organized medicine's response to bans on abortion and gender-affirming care. Five AMA Councils, 11 national medical specialty associations, and seven state medical associations are represented on the Task Force. The Task Force will continue to meet over the next two years. More information on the Task Force's work can be found in Board Report 21-A-24.

In-Vitro Fertilization (IVF)

The AMA is deeply concerned about state activity to limit access to the full range of reproductive health services, including the Alabama Supreme Court decision earlier this year that included cryopreserved embryos created through in-vitro fertilization (IVF) in the legal definition of "children." The decision was unprecedented and the first time a court recognized embryos stored outside the human body as people. In response, the AMA HOD in June adopted policy to oppose legislation or ballot measures that could criminalize IVF. The AMA offered support to the Medical Association of the State of Alabama which played a key role in developing a legislative fix to allow IVF to continue in the state. The AMA is poised to assist other states when this issue arises.

Gender-Affirming Care

The AMA has advocated against state restrictions on evidence-based gender-affirming care in several states including Missouri, Montana, New Hampshire, and South Dakota and will continue to work closely with state medical associations across the country to oppose bans on evidence-based care. The AMA has also supported shield laws in several states, including Maine and Rhode Island in 2024, that provide legal and professional protections to physicians and other health care providers of gender-affirming care. The AMA has filed and joined briefs in multiple federal court cases supporting evidence-based gender-affirming care. The AMA is deeply concerned about increasingly hostile rhetoric and threats of violence directed at physicians who provide evidence-based gender-affirming care.

Firearm Violence

One of the AMA's top public health priorities is responding to public health crises impacting physicians, patients, and the public. Included within this bucket is preventing firearm injuries and deaths. At the 2016 Annual Meeting, following the Pulse nightclub shooting, policy was adopted declaring that "gun violence represents a public health crisis which requires a comprehensive public health response and solution." The AMA adopted policy in 2022 to establish a task force focused on firearm violence prevention, including firearm-involved suicide. The AMA has convened this task force with physician leaders and high-level staff from several national medical associations to increase collaboration on topics related to firearm safety. The AMA continues to

push lawmakers to adopt common-sense policies, broadly supported by the American public, to prevent avoidable deaths and injuries caused by firearm violence including banning assault weapons; high-capacity magazines; and other weapons of war. Our nation must also address the root causes that have fueled these mass murders and casualties. The AMA is working at the state level to encourage and assist states in implementing some of the new federal law's provisions, especially regarding passage of extreme risk protection order (ERPO) legislation. During the 2024 state legislative sessions, the AMA worked closely with state medical associations to craft ERPO legislation and to support community violence prevention strategies, as well as strengthening waiting period and background check requirements. With AMA support, two such bills—LD 2224 and LD 2238—were enacted in Maine.

The AMA has advocated for Congress to appropriate increased funding for research to prevent firearm violence. The AMA is working with national medical specialties societies, including the American Academy of Pediatrics (AAP), to support funding for the U.S. Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and the National Institute of Justice (NIJ) to conduct public health research on firearm morbidity and mortality prevention. The goal is to ensure at least level funding for next year; in the current environment, it is unlikely that funding will be increased but the coalition is advocating against any cuts. The AMA is also participating in the Health Professional Education and Advocacy/Policy committees of the Healthcare Coalition for Firearm Injury Prevention, (HCFIP) which is being led by American College of Physicians, with AAP, American College of Emergency Physicians, American College of Surgeons, and the Council of Medical Specialty Societies participating. HCFIP is focusing on safe storage and preventing suicide.

Maternal Health

To bolster federal and state efforts and provide recommendations to improve maternal health outcomes, the AMA has worked collaboratively over the last year with a variety of members of the Federation, including national medical societies, state medical associations, and physicians from rural areas. The AMA released a new set of concrete steps that the administration and Congress can take to improve maternal health outcomes in the U.S. The AMA also published a comprehensive document that provides extensive recommendations to policymakers and advocates. The AMA advocated for improvements to a new maternal health alternative payment model and urged CMS to consult with the AMA, the American College of Obstetricians and Gynecologists, and other interested parties prior to moving forward with an obstetrical services condition of participation. Additionally, the AMA submitted a Statement for the Record to the U.S. Senate Committee on Health, Education, Labor, and Pensions as part of the hearing entitled, "What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?"

Overdose Epidemic

Our nation's drug-overdose epidemic continues to kill more than 100,000 Americans each year, which is why the AMA continues to call on policymakers and other stakeholders—including health insurers, pharmacy benefit management companies, and national pharmacy chains—to remove barriers to evidence-based care for opioid use disorder and for pain and increase access to harm reduction initiatives, including decriminalizing fentanyl test strips, sterile needle and syringe exchange services, and piloting overdose prevention sites as well. The AMA's 2023 Overdose Epidemic Report, released in November, shows a nearly 50 percent decrease in opioid prescribing nationwide since 2012. At the same time, the country is facing a worsening drug-related overdose epidemic, fueled by a dramatic increase in use of illicit fentanyl and fentanyl analogs, as well as

methamphetamine and cocaine. State prescription drug monitoring programs were used more than 1.3 billion times in 2022.

AMA advocacy helped lead to FDA approving the first-ever over-the-counter naloxone product in 2023. The AMA has supported multiple bills at the state level to remove barriers to opioid therapy for patients with pain, including a new Minnesota law; bills to ensure that opioid litigation settlement funds from major distributors would go to public health and treatment; and language from AMA model legislation has been included in at least 10 new laws since 2022 that remove fentanyl test strips from state drug paraphernalia laws. The Federation of State Medical Boards (FSMB) recently adopted revisions to its recommendations relating to opioids and pain care at its April 2024 Annual Meeting. The AMA was part of the FSMB Workgroup on Opioid and Addiction Treatment that helped update the proposed "Strategies for Prescribing Opioids for the Management of Pain" over a two-year period.

Climate Change

At the 2022 Annual Meeting of the House of Delegates, policy was adopted declaring "climate change a public health crisis that threatens the health and well-being of all individuals." Concern has grown in recent decades about the connection of human activities to rapid climate change, such as the burning of fossil fuels and deforestation, and the impacts on health. Climate change is adversely affecting people's physical and mental health; however, climate-related risks are not distributed equally. The AMA recognizes that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change. The AMA has called for limiting global warming to no more than 1.5 degrees Celsius, as well as reducing U.S. greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050. The AMA is developing a formal strategy to address climate change and health, with an anticipated release at the AMA I-24 meeting.

The AMA participates in the American Lung Association's (ALA) Healthy Air Partners campaign, which is a coalition of 40 national public health, medical, nursing, and health care organizations engaged in healthy air advocacy efforts. The Coalition is united in calling for strong federal laws and policies to slash air pollution and address climate change, recognizing climate change can affect air quality, and certain air pollutants can affect climate change. In 2024, the AMA joined the Coalition on a letter to the Environmental Protection Agency (EPA) on their draft Revised Technical Guidance for Assessing Environmental Justice in Regulatory Analysis, which included the addition of climate change as a factor of vulnerability when conducting environmental justice analysis. The AMA also joined the Coalition on a letter to the EPA on Waste Emissions Charges for Petroleum and Natural Gas and on a letter on CMS' Decarbonization and Resilience Initiative. The AMA sent a letter providing comments to the EPA on National Primary Drinking Water Regulations for Lead and Copper: Improvements. In addition, the AMA continues to engage in the Medical Society Consortium on Climate and Health (MSCCH or Consortium), which brings together associations representing over a million clinical practitioners. The AMA sits on the executive committee of this group. The AMA was a sponsor of the MSCCH Annual Meeting held in February 2024 in Washington, DC. The AMA joined with MSCCH in sending a letter to Congress on the farm bill. The AMA is working with the Consortium and the ALA Coalition to draft comments on proposed regulations on heat standards issued by the Occupational Safety and Health Administration.

Nutrition

The AMA is committed to preventing and reducing the burden of chronic diseases and recognizes the critical link between diet and chronic disease in America. Moreover, we recognize that access to nutritious food is not equal, and that this inequity increases incidents of chronic diseases, such as diabetes and cardiovascular disease in historically marginalized communities. The AMA submitted a comprehensive statement to the U.S. Senate Committee on Health, Education, Labor and Pensions, Subcommittee on Primary Health & Retirement Security, on the hearing entitled, Feeding a Healthier America: Current Efforts and Potential Opportunities for Food is Medicine. The AMA also joined a sign-on letter to Congress, with over 75 societies and organizations, including the MSCCH, in support of farm policy that prioritizes both affordable and nutritious food and clean air and water.

AMA ADVOCACY ONGOING UPDATES AND MEETINGS

The AMA offers several ways to stay up to date on our advocacy efforts, and we urge the HOD to avail themselves of all of them to stay informed and advance our grassroots efforts:

- Sign up for AMA Advocacy Update a biweekly newsletter that provides updates on AMA legislative, regulatory, and private sector efforts. We try to make sure all HOD members are on the email list, but if you are not receiving AMA Advocacy Update, please subscribe and encourage your colleagues to do so as well. Subscribers can read stories from previous editions here.
- Join the Physicians Grassroots Network for updates on AMA calls to action on federal legislative issues. And if you have connections with members of Congress, or are interested in developing one, the Very Influential Physician (VIP) program can help grow these relationships.
- Connect with the Physicians Grassroots Network on Facebook, Twitter, and Instagram.

The AMA also encourages HOD members to attend the State Advocacy Summit and National Advocacy Conference. The 2025 State Advocacy Summit will take place on Jan. 9-11 at the Omni La Costa Resort & Spa in Carlsbad, California. The 2025 National Advocacy Conference will occur on Feb. 10-12 at the Grand Hyatt in Washington, D.C.

CONCLUSION

The AMA and the Federation of Medicine have faced numerous legislative and regulatory challenges in 2024. There has been progress on some issues, but others remain problematic. The keys for success on these issues moving forward will be maintaining a unified message and increasing engagement. Please continue to read Advocacy Update for the latest news, look for grassroots communications as they are released to our networks, and stay engaged with other AMA news sources. The AMA needs your help as the current 118th Congress is set to wrap up in the coming months, and organized medicine begins to plan for 2025 after the dust from the upcoming elections settles.

REPORT 21 OF THE BOARD OF TRUSTEES (I-24)
Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted

EXECUTIVE SUMMARY

American Medical Association (AMA) Policy G-605.009 entitled, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," instructs the AMA to establish a task force to, "help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources." AMA Policy D-5.998 entitled, "Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era," requires the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted (Task Force) to provide an annual report to the House of Delegates (HOD) at each Interim Meeting. Accordingly, this report highlights the Task Force's activities in the past year. (Note: Because of approval deadlines, this report was prepared in July and may not include more recent developments.)

In 2024, the Task Force formed and began work to carry out the directives adopted by the HOD. There are 29 physician members serving on the Task Force, 11 representing national medical specialty societies, 10 representing AMA Councils, seven representing state medical associations, and one representing the AMA Board of Trustees. Staff from the respective medical associations are also invited to support their assigned physician members in Task Force activities.

The Task Force held an introductory virtual meeting in May and its first in-person meeting in July of this year. The July meeting examined legal issues related to abortion care, including abortion-related litigation activity across the country, legal resources for physicians, the Emergency Medical Treatment and Active Labor Act, and shield law protections for abortion care providers. Task Force members discussed each issue and raised items for further action. In accordance with policy and in preparation for a new website that will serve as a resource hub for physicians and others navigating abortion restrictions, the Task Force also reviewed implementation-focused practice and advocacy resources on a range of issues, such as, health equity, practice management, medical education, privacy, and legal issues, as well as identified resource gaps and options to fill the gaps.

In accordance with the amendment to Policy G-605.009 adopted at the AMA 2023 Interim Meeting, the Task Force has formed a subcommittee to focus on payment and reimbursement issues in gender-affirming care and anticipates holding a meeting in February 2025 dedicated to those issues.

In accordance with Policy D-425.989 entitled, "Protecting Access to IVF Treatment," this report also provides an advocacy update on governmental efforts to restrict or interfere with assisted reproductive technology.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 21-I-24

Subject: Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

This report provides an update on the activities of the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted (Task Force) and a legislative update in accordance with Policies G-605.009, D-5.998, and D-425.989. (Note: Because of approval deadlines, this report was prepared in July and may not include more recent developments.)

BACKGROUND

American Medical Association (AMA) Policy G-605.009 entitled, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," was adopted at the 2022 Annual Meeting of the AMA House of Delegates (HOD). Policy G-605.009 instructs that:

1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
    a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;
    b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
    c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;
    d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;

e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;
f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and
g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.

Adopted during the AMA 2022 Interim Meeting, Policy D-5.998 entitled, "Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era," added a requirement for an annual report of the Task Force. Policy D-5.998(1) instructs that:

1. Our AMA Task Force developed under HOD Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," will publish a report with annual updates with recommendations including policies, strategies, and resources for physicians who are required by medical judgment and ethical standards of care to act against state and federal laws.

At the AMA 2023 Interim Meeting, the HOD amended Policy G-605.009 entitled, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," adding the creation of an ad hoc committee on payment and reimbursement issues in gender affirming care to the Task Force's directives. Specifically, the amendment instructs that:

3. Our American Medical Association will appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend d solutions to address these barriers to care.

Lastly, the HOD adopted Policy D-425.989 entitled, "Protecting Access to IVF Treatment," during the AMA 2024 Annual Meeting, directing the Task Force to report on legislation involving restrictions to assisted reproductive technology. Policy D-425.989 instructs that:

> Our AMA, through the AMA Task Force to Preserve the Patient-Physician Relationship, report back at I-24 on the status of, and AMA's activities surrounding, proposed ballot measures or legislation and pending court rulings, that (a) would equate gametes or embryos with children and/or (b) would otherwise restrict or interfere with evidence-based care for Assisted Reproductive Technology (ART).

DISCUSSION OF TASK FORCE ACTIVITIES

As directed by the HOD and in response to the U.S. Supreme Court's landmark 2022 decision in *Dobbs v. Jackson Women's Health Organization*, which held that the U.S. Constitution does not confer a constitutional right to abortion and returned the authority to regulate abortion to the states and the subsequent enactment of abortion bans in half the states, the AMA Board of Trustees'

(Board) formed the Task Force in June of 2023. With the formation of the Task Force and consistent with AMA Policies G-605.009 and D-5.998, as noted above, the Board envisioned that the Task Force would advise the Board of new and emerging threats to the provision of evidenced-based medical care and appropriate and innovative responses to protect access to care and to preserve the role of the patient-physician relationship as a central element in medical decision-making.

In accordance with the specific language of AMA Policies G-605.009 and D-5.998, in September 2023, the Chairs of the Councils on Legislation, Medical Service, Medical Education, Science and Public Health, and Ethics and Judicial Affairs each appointed two Council members to serve on the Task Force. As a result, 10 Council representatives serve on the Task Force. The then-Chair of the Board, Willie Underwood III, MD, MSc, MPH, appointed Madelyn E. Butler, MD, AMA Trustee, and Maryanne C. Bombaugh, MD, MBA, MSc, member of the Executive Committee for the AMA Council on Legislation, to serve as Co-Chairs of the Task Force.

In addition, and in accordance with underlying policy, in the spring of 2024, AMA invited 10 state medical associations and 13 national medical specialty societies to appoint a physician representative to serve on the Task Force. The organizations were selected based on their expertise, experience, and response to an AMA survey fielded in November 2022 (which was described in detail in the 2023 report on the Task Force) that asked about priorities and capacity to engage on the issues identified in AMA Policy G-605.009.

Seven state medical associations and 11 national medical specialty societies nominated a physician representative to serve on the Task Force. The participating national medical specialty societies include:

- American Academy of Child and Adolescent Psychiatry,
- American Academy of Dermatology,
- American Academy of Family Physicians,
- American Academy of Pediatrics,
- American College of Emergency Physicians,
- American College of Obstetricians & Gynecologists,
- American College of Physicians,
- American Psychiatric Association,
- American Society for Reproductive Medicine,
- American Society of Clinical Oncology, and
- The Endocrine Society.

The participating state medical associations include:

- California Medical Association,
- Idaho Medical Association,
- The Maryland State Medical Society (MedChi),
- Massachusetts Medical Society,
- Pennsylvania Medical Society,
- Texas Medical Association, and
- Medical Society of Virginia.

In total, there are 29 physician members of the Task Force.

Concurrently, staff across the AMA conducted environmental scans and gaps analyses of the issues identified in Policy G-605.009. These landscape analyses identify implementation-focused practice and advocacy resources on issues including health equity, practice management, medical education, privacy, and legal issues and identify potential resource gaps. The landscape analyses were presented to Council representatives, monthly, beginning in January of 2024 and concluding in May of 2024. The landscape analyses were used (and will continue to be used) to identify key topics of discussion for meetings of the Task Force and were distributed to all Task Force members prior to the first in-person meeting of the Task Force.

The Task Force held a virtual kick-off meeting on May 15, 2024, in which the Task Force Co-Chairs laid out the Task Force's scope, deliverables, and calendar for upcoming meetings.

The Task Force held its first in-person meeting on July 10, 2024, in Chicago. The in-person meeting focused on legal issues in abortion care and featured a range of speakers and presenters on topics all relating to legal issues in abortion care including, abortion-related litigation activity across the country, legal resources for physicians, the Emergency Medical Treatment and Active Labor Act (EMTALA), and shield law protections for abortion care providers.

Speakers included: Kyle Palazzolo, JD, Assistant General Counsel, AMA Office of General Counsel, who provided an update and analysis on recent important court decisions, including litigation impacting access to medication abortion, emergency care, state bans, and other issues; Rachel Rebouché, JD, LLM, Kean Family Dean and Peter J. Liacouras Professor of Law, Temple University Beasley School of Law, who discussed the landscape of state shield laws and protections afforded to abortion care providers under shield laws, as well as the potential impact of the Comstock Act on abortion access; Hannah Katch, Senior Advisor, Office of the Administrator, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, who presented the Administration's position and strategy regarding pregnant patients' rights during a medical emergency under EMTALA and the interaction of EMTALA with state abortion laws; and Brynn Weinstein, JD, Legal Defense Specialist, Resources for Abortion Delivery, who highlighted legal resources and services available to physicians providing abortion care through the Abortion Defense Network (ADN).

Following each presentation, Task Force members asked questions and discussed issues and concerns. During a working lunch, Task Force members were asked to strategize and identify resource gaps and potential deliverables for the Task Force regarding advocacy, health equity, medical education and workforce, legal issues, practice issues, and public health. The exercise generated numerous ideas for action. At the conclusions of the day, as directed by the Board and in accordance with Policies G-605.009 and D-5.998, which instruct the Task Force to identify and create implementation-focused practice and advocacy resources, the Task Force discussed existing resources and limitations of those resources, and identified gaps where resources need to be developed. Accordingly, AMA staff are in the process of developing a new website to serve as a resource hub for physicians and others navigating abortion restrictions. The website will exist separately from the AMA's website and will be available to the public. It will house resources created by the Task Force, as well as resources created and provided by Federation partners and other external organizations. Task Force members have been asked to share resources to be made available on the website.

In addition, the Task Force will host an informational session at the AMA 2024 Interim Meeting to engage AMA Delegates, Alternate Delegates, and representatives from AMA Sections, including but not limited to the Resident and Fellows Section, Medical Student Section, Women Physicians Section, Minority Affairs Section, and others. This session is an opportunity to elevate important

voices that are not members of the Task Force. Attendees of the informational session will hear about the activities of the Task Force and be asked to share their perspective on the issues being considered by the Task Force. As of the time of drafting this report, Task Force staff are working with AMA Section staff to ensure optimal engagement and the sharing of concerns and perspectives. The Board encourages all interested members to participate in this informational session in November.

In addition, and in accordance with the amendment to Policy G-605.009 adopted at the AMA 2023 Interim Meeting, the Task Force has formed a subcommittee to focus on payment and reimbursement issues in gender-affirming care. AMA staff has conducted a landscape analysis on payment and reimbursement issues that hinder access to gender-affirming care, which, like the landscape analyses on abortion, identified existing resources and gaps in those resources and will help inform discussion during in-person meetings. The Task Force anticipates holding an in-person meeting in February 2025 dedicated to these issues and as of the writing of this report in July 2024, was in the process of working with the subcommittee on an agenda.

Lastly, in addition to the Task Force meeting planned in February 2025 on gender-affirming care payment and reimbursement issues, the Task Force is planning to host an in-person meeting in July 2025 to discuss abortion-related issues in education, training, and workforce; an informational session at the 2025 Interim Meeting of the HOD; and a final, in-person meeting in February 2026 to discuss the intersection of abortion care and health equity.

LEGISLATIVE AND ADVOCACY UPDATE

Opposing third-party intrusion into the practice of medicine – including government interference with abortion, assisted reproductive technology (ART) and gender-affirming care – has long been a core priority for the AMA. The AMA continues to execute a multifaceted strategy, including engagement with policymakers at the state and federal levels, judicial advocacy, and more, to counter the deleterious impact of legislative efforts to criminalize the practice of medicine. The AMA continues to work extensively with state medical associations and national medical specialty societies, both publicly and behind-the-scenes, to oppose laws targeting reproductive health care services and evidence-based gender-affirming care.

Abortion

The AMA supports patients' access to the full spectrum of reproductive health care options, including abortion, as a right. Physicians have an ethical obligation to help patients choose the optimal course of treatment, through shared decision-making that is fully informed by medical science and shaped by patient autonomy. Anything less puts patients at risk and undermines both the practice of medicine and our nation's health.

As of the drafting of this report in July 2024, 14 states (Alabama, Arkansas, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, and West Virginia) prohibit the provision of nearly all abortions; four states (Florida, Georgia, Iowa, and South Carolina) prohibit abortion after fetal cardiac activity is detected around six weeks of pregnancy; two states (Nebraska and North Carolina) prohibit abortion after 12weeks of pregnancy; and five states (Arizona, Kansas, Ohio, Utah, and Wisconsin) between 15 and 22 weeks of pregnancy. Importantly, the status of state abortion laws is fluid. Legal challenges are ongoing and the legality of abortion in those states is subject to change.

In 2024, though dozens of new abortion restrictions were introduced in legislatures across the country, no new categorical bans on abortion were enacted. However, other troubling legislation was successful. Louisiana enacted Senate Bill (SB) 276 which reclassified mifepristone and misoprostol as Schedule IV controlled substances under the state's Uniform Controlled Dangerous Substances Law, making possession of the medication without a valid prescription a felony and increasing requirements on physicians and pharmacies that prescribe and dispense, respectively, the medications and chilling access to care. The law will take effect on October 1, 2024. Tennessee enacted SB 1971 which created the criminal offense of abortion trafficking, mirroring a law passed in Idaho in 2023 which has since been enjoined. The law prohibits an adult from recruiting, harboring, or transporting a minor for the purpose of obtaining an abortion in violation of the state's abortion ban or, if procured in another state, which would constitute a criminal abortion under the laws of Tennessee. The law took effect on July 1, 2024, and is being challenged in court. Kansas enacted House Bill (HB) 2749 which requires abortion providers and facilities to, among other things, ask patients to identify the reasons why they decided to seek an abortion and to report that information to the state. The Kansas law has been enjoined as of the writing of this report in July 2024. Given the sensitive political dynamics in these states, AMA staff provided background support to state medical associations as needed. The AMA continues to work closely with state medical associations in these and other states to make sense of confusing legal obligations, identify strategies to mitigate harm, and advocate against new restrictive laws.

In a victory for physicians and patients and thanks to the tremendous work of the Arizona Medical Association, state medical specialty associations, and other advocates in Arizona, the Arizona legislature repealed a near-total abortion ban following a decision by the Arizona Supreme Court that found the 1865 law enforceable. The state's 15-week ban, however, remains in effect.

Additionally, in 2024, two states, Maine and Rhode Island, enacted shield laws to protect abortion care providers (and providers of gender-affirming care) from extraterritorial enforcement of abortion bans in restrictive states, bringing the total number of states with shield laws to 19, including the District of Columbia. These laws protect health care professionals who provide abortion care (and gender-affirming care) from out-of-state civil, criminal, professional and other forms of liability. AMA has assisted state medical associations in supporting shield laws in many states, including providing technical assistance on both the Maine and Rhode Island bills. The AMA also sent a letter of support to Rhode Island legislators.

In November, voters in at least six states (Colorado, Florida, Maryland, Nevada, New York, and South Dakota) will decide whether to adopt state constitutional amendments to protect abortion rights in their states. As of the writing of this report, four additional ballot measures (in Arizona, Missouri, Montana, and Nebraska) to protect abortion rights are currently pending. One ballot initiative in Arkansas has been disqualified, though proponents are challenging the decision. Ballot measures to restrict abortion rights are pending in two states (Nebraska and Pennsylvania.) The AMA is closely monitoring this activity.

In addition to state advocacy, the AMA continues to fight for access to reproductive care at the federal level and in the courts. The AMA supported the Administration's privacy guidance that makes it clear that physicians are not required to disclose private medical information to third parties and provides patients with tips on the use of personal cell phones and tablets and continues to advocate to the Administration to preserve patient access to abortion care. Often through the AMA's Litigation Center, the AMA has joined dozens of court filings in state and federal courts around the country, including the United States Supreme Court, to articulate and support relevant AMA policies. The AMA spoke out forcefully against court actions that undermined the U.S. Food and Drug Administration decision-making and threaten to impact the availability of mifepristone

and potentially other drugs. The court heard oral arguments in the mifepristone case on March 26 and issued a decision in June that preserved access to medication abortion but did not resolve the issue on the merits. The AMA also urged the Supreme Court to confirm that patients in every state are entitled to prompt, complete, and unbiased emergency health care that is medically and scientifically sound and provided in compliance with EMTALA. In an opinion issued in June, the Court reinstated a pause on parts of Idaho's abortion ban, but again did not resolve the issue on the merits.

Currently, AMA litigation-related resources and activities are devoted to challenging the laws, regulations, and other barriers that interfere with the patient-physician relationship and a physician's medical judgment and ethical standards, rather than supporting the violation of those laws. In accordance with Policy D-5.998, which calls on the Task Force to identify "policies, strategies, and resources for physicians who are required by medical judgment and ethical standards of care to act against state and federal laws," the Task Force wishes to draw attention to the resources available through ADN and Resources for Abortion Delivery (RAD) which were presented to the Task Force during its meeting on July 10. ADN is a network of law firms, legal organizations, and attorneys that offer legal advice, representation, and funding to reproductive health care clinics, providers, and staff. After submitting a form on www.abortiondefensenetwork.org, physicians will be connected with an organization or law firm that can assist with legal issues on a pro bono basis. ADN also creates and shares resources for abortion providers, supporters, and seekers. State-specific guides to help medical professionals navigate their state's laws are available at www.abortiondefensenetwork.org/resources/providers. Additionally, the RAD Abortion Provider Legal Defense Fund covers legal defense costs for independent abortion providers subject to legal action for providing regulated abortion services to someone from or in a restricted state.

Assisted Reproductive Technology

The AMA supports patients' access to the full spectrum of reproductive health care options, including fertility services, as a right. The AMA was deeply concerned when, in February 2024, the Alabama Supreme Court found cryopreserved embryos created through in vitro fertilization (IVF) to be "extrauterine children" and therefore included in the definition of "minor child" under the Alabama Wrongful Death of a Minor Act. The ruling was unprecedented and the first time a court recognized embryos stored outside of the human body as people. The decision greatly increased the liability risks for clinics and physicians who provide in vitro fertilization (IVF) services in Alabama, and, in response to the court's decision, fertility clinics around the state paused services.

Following the decision, the AMA was in close communication with the Medical Association of the State of Alabama (the Medical Association) to offer assistance and coordinate the AMA's advocacy activities. As a result of the tremendous advocacy efforts of the Medical Association and others, legislation (SB 159) to protect IVF was enacted less than three weeks after the Supreme Court's decision. The legislation grants "civil and criminal immunity for death or damage to an embryo to any individual or entity when providing or receiving services related to in vitro fertilization" and provides "criminal immunity and damage calculations for death or damage to an embryo against manufacturers of goods used to facilitate the in vitro fertilization process." Following enactment of SB 159, fertility clinics in the state resumed services, though clinics still feel the impact of the Alabama Supreme Court decision.

As of the writing of this report in July 2024, no other state expressly recognizes personhood rights of cryopreserved embryos or criminalizes IVF. Following the controversy in Alabama, legislation in other states that may have threatened access to IVF was defeated, including, notably, in Iowa

(HF 2575) and Florida (HB 651). However, bills to protect IVF, including in Missouri, Kentucky, and Kansas also failed.

Many states recognize the rights of fetuses, often through laws authorizing criminal charges for fetal homicide, protecting children from abuse, neglect, or endangerment, or prohibiting abortion, for example. Some of these do not create liability for providing ART services. Laws in Alaska, Georgia, and Wyoming, for example, recognize the rights of a fetus "who is carried in the womb" and Arizona's law—which was enjoined in 2022—bars civil action against a person who performs IVF. It is unclear, however, whether courts can or will interpret other laws to restrict or prohibit IVF, though the developments in Alabama demonstrate that fetal personhood laws can have far-reaching consequences. Further, lawmakers continue to pursue fetal personhood laws and, in 2024, introduced legislation in 13 states, though none were enacted.

Despite the existence of fetal personhood laws in many states, IVF services continue, and the question remains whether the laws granting fetuses personhood rights could threaten the status of IVF. The AMA continues to closely monitor developments in this space and stands ready to work with state medical associations in legislatures and courts to protect physicians and preserve access to ART.

Gender-Affirming Care

As of the drafting of this report in July 2024, four states (New Hampshire, Ohio, South Carolina, and Wyoming) enacted bans on gender affirming care in 2024. These actions bring the total count of states to 26 (Alabama, Arizona, Arkansas, Florida, Georgia, Iowa, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Montana, Missouri, North Carolina, North Dakota, Nebraska, New Hampshire, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, and Wyoming) that have enacted laws that prohibit the provision of gender-affirming care to minor patients, including medications to delay puberty, hormonal therapy, and surgeries. Three of those states (Arizona, Nebraska, and New Hampshire) prohibit surgical interventions on patients younger than 18 years of age but do not ban non-surgical interventions. Due to legal challenges, laws in Arkansas, Florida, Montana, and Ohio are enjoined, in whole or part.

Some, but not all, states impose criminal penalties for violations. In other states, violations are subject to professional discipline, including, in some places, mandatory revocation of the health care professional's license. Several state laws also authorize patients and their families to bring civil suits against health care professionals for decades after the care was provided.

The AMA has advocated against state restrictions on evidence-based gender-affirming care in several states including Missouri, Montana, New Hampshire, and South Dakota and will continue to work closely with state medical associations across the country to oppose bans on evidence-based care. Due to political dynamics in many states, much of the AMA's advocacy is conducted through state medical associations behind-the-scenes. The AMA has also assisted state medical associations in supporting shield laws in many states that are supportive of access to gender-affirming care, including in Maine and Rhode Island, both of which enacted shield laws in 2024. Additionally, the AMA has filed and joined briefs in multiple federal court cases supporting evidence-based gender-affirming care. The AMA and other Federation members have also been the subject of subpoenas on issues related to the patient-physician relationship, notably with respect to policies and resources around gender-affirming care. The AMA is also deeply concerned about increasingly hostile rhetoric and threats of violence directed at physicians who provide evidence-based gender-affirming care.

CONCLUSION

The Board, through the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted, will continue to implement Policies G-605.009, D-5.998, and D-425.989, monitor and prepare for new and emerging threats to the provision of evidenced-based medical care, and work to protect access to care and preserve the role of the patient-physician relationship as a central element in medical decision-making.

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 1-I-24

Subject: Research Handling of De-Identified Patient Data

Presented by: Jeremy A. Lazarus, MD, Chair

INTRODUCTION

At the 2024 Annual Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-A-24, "Research Handling of De-Identified Patient Data." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

E-3.3.4 Research Handling of De-Identified Patient Data

Within health care systems, identifiable private health information, initially derived from and used in the care and treatment of individual patients, has led to the creation of massive de-identified datasets. As aggregate datasets, clinical data takes on a secondary promising use as a means for quality improvement and innovation that can be used for the benefit of future patients and patient populations. While de-identification of data is meant to protect the privacy of patients, there remains a risk of re-identification, so while patient anonymity can be safeguarded it cannot be guaranteed. In handling patient data, individual physicians thus strive to balance supporting and respecting patient privacy while also upholding ethical obligations to the betterment of public health.

When clinical data are de-identified and aggregated, their potential use for societal benefits through research and development is an emergent, secondary use of electronic health records that goes beyond individual benefit. Such data, due to their potential to benefit public health, should thus be treated as a form of public good, and the ethical standards and values of health care should follow the data and be upheld and maintained even if the data are sold to entities outside of health care. The medical profession's responsibility to protect patient privacy as well as to society to improve future health care should be recognized as inherently tied to these datasets, such that all entities granted access to the data become data stewards with a duty to uphold the ethical values of health care in which the data were produced.

As individuals or members of health care institutions, physicians should:

(a) Follow existing and emerging regulatory safety measures to protect patient privacy.

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(b) Practice good data intake, including collecting patient data equitably to reduce bias in datasets.

(c) Answer any patient questions about data use in an honest and transparent manner to the best of their ability in accordance with current federal and state legal standards.

Health care entities, in interacting with patients, should adopt policies and practices that provide patients with transparent information regarding:

(d) The high value that health care institutions place on protecting patient data.

(e) The reality that no data can be guaranteed to be permanently anonymized, and that risk of re-identification does exist.

(f) How patient data may be used.

(g) The importance of de-identified aggregated data for improving the care of future patients.

Health care entities managing de-identified datasets, as health data stewards, should:

(h) Ensure appropriate data collection methods and practices that meet industry standards to support the creation of high-quality datasets.

(i) Ensure proper oversight of patient data is in place, including Data Use/Data Sharing Agreements for the use of de-identified datasets that may be shared, sold, or resold.

(j) Develop models for the ethical use of de-identified datasets when such provisions do not exist, such as establishing and contractually requiring independent data ethics review boards free of conflicts of interest and verifiable data audits, to evaluate the use, sale, and potential resale of clinically derived datasets.

(k) Take appropriate cyber security measures to seek to ensure the highest level of protection is provided to patients and patient data.

(l) Develop proactive post-compromise planning strategies for use in the event of a data breach to minimize additional harm to patients.

(m) Advocate that health- and non-health entities using any health data adopt the strongest protections and seek to uphold the ethical values of the medical profession.

There is an inherent tension between the potential benefits and burdens of de-identified datasets as both sources for quality improvement to care as well as risks to patient privacy. Re-identification of data may be permissible, or even obligatory, in rare circumstances when done in the interest of the health of individual patients. Re-identification of aggregated patient data for other purposes without obtaining patients' express consent, by anyone outside or inside of health care, is impermissible. (IV)

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 2-I-24

Subject: Amendment to E-2.1.1, "Informed Consent"

Presented by: Jeremy A. Lazarus, MD, Chair

INTRODUCTION

At the 2024 Annual Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-A-24, "Research Handling of De-Identified Patient Data." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

E-2.1.1 Informed Consent

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making. Transparency with patients regarding all medically appropriate options of treatment is critical to fostering trust and should extend to any discussions regarding who has access to patients' health data and how data may be used.

The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:

(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.

(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:

(i) the diagnosis (when known);

(ii) the nature and purpose of recommended interventions;

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(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.

(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.

In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines. (I, II, V, VIII)

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 3-I-24

Subject: Amendment to E-3.1.1, "Privacy in Health Care"

Presented by: Jeremy A. Lazarus, MD, Chair

INTRODUCTION

At the 2024 Annual Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-A-24, "Research Handling of De-Identified Patient Data." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

E-3.1.1 Privacy in Health Care

Protecting information gathered in association with the care of the patient is a core value in health care. However, respecting patient privacy in other forms is also fundamental, as an expression of respect for patient autonomy and a prerequisite for trust.
Patient privacy encompasses a number of aspects, including personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).

Physicians must seek to protect patient privacy in all settings to the greatest extent possible and should:

(a) Minimize intrusion on privacy when the patient's privacy must be balanced against other factors.

(b) Inform the patient when there has been a significant infringement on privacy of which the patient would otherwise not be aware.

(c) Be mindful that individual patients may have special concerns about privacy in any or all of these areas.

(d) Be transparent with any inquiry about existing privacy safeguards for patient data but acknowledge that anonymity cannot be guaranteed and that breaches can occur notwithstanding best data safety practices. (I, IV)

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OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 4-I-24

Subject: Amendment to E-3.2.4 "Access to Medical Records by Data Collection Companies"

Presented by: Jeremy A. Lazarus, MD, Chair

INTRODUCTION

At the 2024 Annual Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-A-24, "Research Handling of De-Identified Patient Data." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

E-3.2.4 Access to Medical Records by Data Collection Companies

Information contained in patients' medical records about physicians' prescribing practices or other treatment decisions can serve many valuable purposes, such as improving quality of care. However, ethical concerns arise when access to such information is sought for marketing purposes on behalf of commercial entities that have financial interests in physicians' treatment recommendations, such as pharmaceutical or medical device companies.

Information gathered and recorded in association with the care of a patient is confidential. Patients are entitled to expect that the sensitive personal information they divulge will be used solely to enable their physician to most effectively provide needed services. Disclosing information to third parties for commercial purposes without consent undermines trust, violates principles of informed consent and confidentiality, and may harm the integrity of the patient-physician relationship.

Physicians who propose to permit third-party access to specific patient information for commercial purposes should:

(a) Only provide data that has been de-identified.

(b) Fully inform each patient whose record would be involved (or the patient's authorized surrogate when the individual lacks decision-making capacity) about the purpose(s) for which access would be granted.

Physicians who propose to permit third parties to access the patient's full medical record should:

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(c) Obtain the consent of the patient (or authorized surrogate) to permit access to the patient's medical record.

(d) Prohibit access to or decline to provide information from individual medical records for which consent has not been given.

(e) Decline incentives that constitute ethically inappropriate gifts, in keeping with ethics guidance.

Because de-identified datasets are derived from patient data as a secondary source of data for the public good, health care professionals and/or institutions who propose to permit third-party access to such information have a responsibility to establish that any use of data derived from health care adhere to the ethical standards of the medical profession. (I, II, IV)

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 5-I-24

Subject: Amendment to E-3.3.2, "Confidentiality and Electronic Medical Records"

Presented by: Jeremy A. Lazarus, MD, Chair

INTRODUCTION

At the 2024 Annual Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-A-24, "Research Handling of De-Identified Patient Data." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

E-3.3.2, Confidentiality and Electronic Medical Records

Information gathered and recorded in association with the care of a patient is confidential, regardless of the form in which it is collected or stored.

Physicians who collect or store patient information electronically, whether on stand-alone systems in their own practice or through contracts with service providers, must:

(a) Choose a system that conforms to acceptable industry practices and standards with respect to:

(i) restriction of data entry and access to authorized personnel;

(ii) capacity to routinely monitor/audit access to records;

(iii) measures to ensure data security and integrity;

(iv) policies and practices to address record retrieval, data sharing, third-party access and release of information, and disposition of records (when outdated or on termination of the service relationship) in keeping with ethics guidance.

(b) Describe how the confidentiality and integrity of information is protected if the patient requests.

(c) Release patient information only in keeping with ethics guidance for confidentiality and privacy. (V)

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OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 6-I-24

Subject: Physicians' Use of Social Media for Product Promotion and Compensation

Presented by: Jeremy A. Lazarus, MD, Chair

INTRODUCTION

At the 2024 Annual Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 4-A-24, "A Physicians' Use of Social Media for Product Promotion and Compensation." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

E-2.3.2– Physicians' Use of Social Media for Product Promotion and Compensation

Social media—internet-enabled communication platforms—enable individual medical students and physicians to have both a personal and a professional presence online. Social media can foster collegiality and camaraderie within the profession as well as provide opportunities to widely disseminate public health messages and other health communications. However, use of social media by medical professionals can also undermine trust and damage the integrity of patient-physician relationships and the profession as a whole, especially when medical students and physicians use their social media presence to promote personal interests.

Physicians and medical students should be aware that they cannot realistically separate their personal and professional personas entirely online and should curate their social media presence accordingly. Physicians and medical students therefore should:

(a) When publishing any content, consider that even personal social media posts have the potential to damage their professional reputation or even impugn the integrity of the profession.

(b) Respect professional standards of patient privacy and confidentiality and refrain from publishing patient information online without appropriate consent.

(c) Maintain appropriate boundaries of the patient-physician relationship in accordance with ethics guidance if they interact with their patients through social media, just as they would in any other context.

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(d) Use privacy settings to safeguard personal information and content, but be aware that once on the Internet, content is likely there permanently. They should routinely monitor their social media presence to ensure that their personal and professional information and content published about them by others is accurate and appropriate.

(e) Publicly disclose any financial interests related to their social media content, including, but not limited to, paid partnerships and corporate sponsorships.

(f) When using social media platforms to disseminate medical health care information, ensure that such information is useful and accurate based on professional medical judgment. (I, II, IV)

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 7-I-24

Subject: Short-Term Global Health Clinical Encounters

Presented by: Jeremy A. Lazarus, MD, Chair

INTRODUCTION

At the 2024 Annual Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 1-A- 24, "Short-Term Global Health Clinical Encounters." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

E-8.1.4 Short-Term Global Health Clinical Encounters

Short-term global health clinical encounters, which send physicians and physicians in training from wealthier communities to provide care in under-resourced settings for a period of days or weeks, have been promoted as a strategy to provide needed care to individual patients and, increasingly, as a means to address global health inequities. To the extent that such encounters also provide training and educational opportunities, they may offer benefit both to the host communities and the medical professionals and trainees who volunteer their time and clinical skills.

Short-term global health clinical encounters typically take place in contexts of scarce resources and in the shadow of colonial histories. These realities define fundamental ethical responsibilities for participants, sponsors, and hosts to jointly prioritize activities to meet mutually agreed-on goals; navigate day-to-day collaboration across differences of culture, language, and history; and fairly allocate resources. Participants and sponsors must focus not only on enabling good health outcomes for individual patients, but on promoting justice and sustainability, minimizing burdens on host communities, and respecting persons and local cultures. Responsibly carrying out short-term global health clinical encounters requires diligent preparation on the part of participants and sponsors in collaboration with host communities.

Physicians and trainees who are involved with short-term global health clinical encounters should ensure that the trips with which they are associated:

(a) Focus prominently on promoting justice and sustainability by collaborating with the host community to define project parameters, including identifying community needs, project goals, and how the visiting medical team will integrate with local health care

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professionals and the local health care system. In collaboration with the host community, short-term global health clinical encounters should prioritize efforts to support the community in building health care capacity. Trips that also serve secondary goals, such as providing educational opportunities for trainees, should prioritize benefits as defined by the host community over benefits to members of the visiting medical team or the sponsoring organization.

(b) Seek to proactively identify and minimize burdens the trip places on the host community, including not only direct, material costs of hosting participants, but also possible adverse effects the presence of participants could have for beneficial local practices and local practitioners. Sponsors and participants should ensure that team members practice only within their skill sets and experience.

(c) Provide resources that help them become broadly knowledgeable about the communities in which they will work and to cultivate the cultural sensitivity they will need to provide safe, respectful, patient-centered care in the context of the specific host community. Members of the visiting medical team are expected to uphold the ethics standards of their profession and participants should insist that strategies are in place to address ethical dilemmas as they arise. In cases of irreducible conflict with local norms, participants may withdraw from care of an individual patient or from the project after careful consideration of the effect that will have on the patient, the medical team, and the project overall, in keeping with ethics guidance on the exercise of conscience. Participants should be clear that they may be ethically required to decline requests for treatment that cannot be provided safely and effectively due to resource constraints.

(d) Are organized by sponsors that embrace a mission to promote justice, patient-centered care, community welfare, and professional integrity. Physicians, as influential members of their health care systems, are well positioned to influence the selection, planning and preparation for short term encounters in global health. In addition, they can take key roles in mentoring learners and others on teams to be deployed. Physicians can also offer guidance regarding the evaluation process of the experience, in an effort to enhance and improve the outcomes of future encounters.

Sponsors of short-term global health clinical encounters should:

(e) Ensure that resources needed to meet the defined goals of the trip will be in place, particularly resources that cannot be assured locally. This includes arranging for local mentors, translation services, and participants' personal health needs. It should not be assumed that host communities can absorb additional costs, even on a temporary basis.

(f) Proactively define appropriate roles and permissible range of practice for members of the visiting medical team, so that they can provide safe, high-quality care in the host community. Team members should practice only within the limits of their training and skills in keeping with professional standards they would deem acceptable in their ordinary clinical practice, even if the host community's standards are more flexible or less rigorously enforced.

(g) Ensure appropriate supervision of trainees, consistent with their training in their home communities, and make certain that they are only permitted to practice independently in ways commensurate with their level of experience in under-resourced settings.

(h) Ensure a mechanism for meaningful data collection is in place, consistent with recognized standards for the conduct of health services research and quality improvement activities in the sponsor's country. (I, V, VII, IX)

REPORT OF THE SPEAKERS

Speakers' Report 2-I-24

Subject:	Recommendations for Policy Reconciliation
Presented by:	Lisa Bohman Egbert, MD, Speaker; and John H. Armstrong, MD, Vice Speaker

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Policy G-600.111, "Consolidation and Reconciliation of AMA Policy," calls on your Speakers to "present one or more reconciliation reports for action by the House of Delegates relating to newly passed policies from recent meetings that caused one or more existing policies to be redundant and/or obsolete." Should other policies be identified that require updates, please email suggestions to your Speakers at hod@ama-assn.org. These will be addressed in future reconciliation reports.

Where changes to policy language will be made, additions are shown with underscore and deletions are shown with strikethrough in red font. Given the length of many of the policies, only the affected portions are reproduced.

RECOMMENDED RECONCILIATIONS

Policies to be modified

1. Through their work with the Election Task Force 2 and the Resolution Modernization Task Force, your Speakers identified policies that required corrections which would not change the intent of the policy but would update the language. The first removes a reference to a specific nationality, and the second refers to a tool that is no longer in use in our House policy making process.

   - G-610.090, "AMA Election Rules and Guiding Principles," Section V, Item 3:
     Each participant in ~~G~~group dinners, if attended by an announced candidate in a currently contested election, must ~~be "Dutch treat" - each participant~~ pay~~s~~ their own share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. Gatherings of 4 or fewer delegates or alternates are exempt from this rule.

   - G-600.055, "Options for Informational Reports Submitted to the House of Delegates," Item 1:
     Informational reports will be included in the AMA House of Delegates Online ~~Member Forums~~Reference Committees.

2. AMA policy H-65.942 states, "our American Medical Association will recognize the importance of using gender-neutral language such as gender neutral pronouns, terms, imagery, and symbols in respecting the spectrum of gender identity." The policy further states that policy will be amended prospectively by way of the reaffirmation and sunset processes. In addition, policy D-65.977 directs your Speakers to "review and update the language used in AMA policy and other resources and communications to ensure that the language used to describe families

and persons in need of obstetric and gynecologic care is inclusive of all genders and family structures."

In response to the House's request, your Speakers completed a policy search for the following terms: obstetric, pregnant, pregnancy, mother, father, he, she, him, her, his, man, men, woman, and women and have recommended appropriate alternate language for these terms. Ongoing review of gendered language should continue prospectively as policy states.

- Appendix A includes relevant portions of policies that contain gendered language and the recommended gender neutral alternative language.

- Appendix B contains other policies with gendered language that is relevant to the intent of the policy and would substantively change the policy if replaced with gender neutral language. Therefore, your Speakers are recommending the following policies be retained as written.

Recommended policy changes do not reset the sunset clock and will be implemented when this report is filed.

Fiscal Note: Minimal

Appendix A - Recommendations for gender neutral language

Policy Number	Title	Policy Language
D-65.984	Humanitarian and Medical Aid Support to Ukraine	2. Our AMA will advocate for an early implementation of mental health measures, including suicide prevention efforts, and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian refugees with special attention to vulnerable populations including but not limited to young children, ~~mothers~~**their parents**, pregnant ~~women~~**people**, and the elderly.
D-95.956	Cannabis Product Safety	Our American Medical Association will draft state model legislation to help states implement the provisions of AMA policies H-95.924, Cannabis Legalization for Adult Use and H-95.936, Cannabis Warnings for Pregnant and Breastfeeding ~~Women~~**People** that currently do not have such model language, including regulation of retail sales, marketing and promotion (especially those aimed at children), misleading health claims, and product labeling regarding dangers of use during pregnancy and breastfeeding.
D-290.982	State Children's Health Insurance Program Reauthorization (SCHIP)	2. Our AMA will lobby Congress to: c. Allow states to explicitly use SCHIP funding to cover eligible pregnant ~~women~~**people**. d. Allow states the flexibility to cover all eligible children residing in the United States and pregnant ~~women~~**people** through the SCHIP program without a mandatory waiting period.
D-310.950	Protecting Trainees' Breastfeeding Rights	Our AMA will: (2) work with appropriate bodies, such as the LCME, ACGME, and Association of American Medical Colleges (AAMC), to include language related to the learning and work environments for breastfeeding ~~mothers~~**people** in regular program reviews.
D-315.971	Physician Access to Their Medical and Billing Records	(2) that, where physician possession of all ~~his or her~~ billing records is not already required by state law, the employment or other contractual arrangement between a physician and entity submitting claims on behalf of the physician should specify that the physician is entitled to copies of ~~his or her~~ billing records subsequent to the termination of employment or contractual arrangement, when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician; (3) for legislation or regulation to eliminate contractual language that bars or limits the treating physician's access to ~~his or her~~ billing records and associated medical records, such as treating these records as trade secrets or proprietary.
D-383.989	Physician Freedom to Collectively Negotiate with Managed Care Plans and Health Insuring Organizations	Our AMA will: (4) speak forcefully to its membership that no member should feel compelled to sign any contractual agreement that harms ~~his/her~~ **their** ability to provide compassionate and quality care to ~~his/her~~ **their** patients; and
D-420.990	Pain Management Following Caesarean Birth	(3) supports counseling of ~~women~~**patients** who are prescribed opioid analgesics following caesarean birth about the risk of central nervous system depression in the ~~woman~~**patient** and the breastfed infant.

D-420.991	Improving Treatment and Diagnosis of ~~Maternal~~Peripartum Depression Through Screening and State-Based Care Coordination	Our AMA: (1) will work with stakeholders to encourage the implementation of a routine protocol for depression screening in pregnant and postpartum ~~women~~people presenting alone or with their child during prenatal, postnatal, pediatric, or emergency room visits; (2) encourages the development of training materials related to ~~maternal~~peripartum depression to advise providers on appropriate treatment and referral pathways; and (3) encourages the development of state-based care coordination programs (e.g., staffing a psychiatrist and care coordinator) to assure appropriate referral, treatment and access to follow-up ~~maternal~~peripartum-mental health care.
D-420.992	Research into Preterm Birth and Related Cardiovascular and Cerebrovascular Risks in ~~Women~~Pregnant People	Our AMA will advocate for more research on ways to identify risk factors linking preterm birth to cardiovascular or cerebrovascular disease in pregnant ~~women~~people.
D-440.930	Enhanced Zika Virus Public Health Action	3. Our AMA will consider collaboration with other educational and promotional entities (e.g., the AMA Alliance) to promote family-directed and community-directed strategies that minimize the transmission of Zika virus to potentially pregnant ~~women~~people.
G-600.031	Roles and Responsibilities of AMA Delegates and Alternate Delegates	(2) The roles and responsibilities of delegates and alternate delegates are as follows: (a) regularly communicate AMA policy, information, activities, and programs to constituents so ~~he/she~~they will be recognized as the representative of the AMA;
G-600.060	Introducing Business to the AMA House	5. The submission of resolutions calling for similar action to what is already existing AMA policy is discouraged. Organizations represented in the House of Delegates are responsible to search for alternative ways to obtain AMA action on established AMA policy, especially by communicating with the Executive Vice President. The EVP will submit a report to the House detailing the items of business received from organizations represented in the House which ~~he or she~~they consider~~s~~ significant or when requested to do so by the organization, and the actions taken in response to such contacts.
G-630.010	Executive Vice President	The office of the Executive Vice President shall be filled, if possible, by a Doctor of Medicine or Osteopathy who is an active member of our AMA at the time of ~~his~~their appointment and who possesses the necessary managerial qualifications.
H-5.989	Freedom of Communication Between Physicians and Patients	1. to strongly condemn any interference by the government or other third parties that causes a physician to compromise ~~his or her~~their medical judgment as to what information or treatment is in the best interest of the patient.
H-20.905	HIV/AIDS Research	(1) Information on the HIV Epidemic Our AMA: b) Requests the Secretary of the Department of Health and Human Services to make available information on HIV expenditures, services, programs, projects, and research of agencies under ~~his/her~~their jurisdiction and, to the extent possible, of all other federal agencies for purposes of study, analysis, and comment. The compilation should be sufficiently detailed that the nature of the expenditures can be readily determined;

H-20.906	Health and Disability Coverage for Health Care Workers at Risk for HIV and Other Serious Infectious Diseases	2. Disability Coverage a. each health care worker should consider the risks of exposure to infectious agents posed by ~~his/her~~**their** type of practice and the likely consequences of infection in terms of changes needed in that practice mode and select disability insurance coverage accordingly. The policy selected should contain a reasonable definition of "sickness" or "disability," an own-occupation clause, and guaranteed renewability, future insurability, and partial disability provisions; c. since there are a variety of disability insurance coverages available and a diversity of practice modes, each health care professional should individually assess ~~his/her~~**their** risk of infection and that of ~~his/her~~**their** employees and select disability coverage accordingly.
H-20.907	Financing Care for HIV/AIDS Patients	4. Our AMA supports government funding of all medical services that are deemed appropriate by both the patient and physician for pregnant seropositive ~~women~~**people** lacking other sources of funding.
H-20.910	HIV-Infected Children	2. Our AMA encourages the physician responsible for care of an HIV-infected child in a day-care, preschool, or school setting to receive information from the school on other infectious diseases in the environment and temporarily remove the HIV-infected child from a setting that might pose a threat to ~~his/her~~**their** health.
H-20.915	HIV/AIDS Reporting, Confidentiality, and Notification	(3) Contact Tracing and Partner Notification Our AMA: d) Promulgates the standard that a physician attempt to persuade an HIV-infected patient to cease all activities that endanger unsuspecting others and to inform those whom ~~he/she~~**they** might have infected. If such persuasion fails, the physician should pursue notification through means other than by reliance on the patient, such as by the Public Health Department or by the physician directly.
H-20.917	Neonatal Screening for HIV Infection	2. Our AMA favors giving consideration to rapid HIV testing of newborns, with ~~maternal~~ consent of the gestational parent, when the individual's HIV status has not been determined during pregnancy or labor.
H-20.918	Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV Transmission	In view of the significance of the finding that treatment of HIV-infected pregnant ~~women~~**people** with appropriate antiretroviral therapy can reduce the risk of transmission of HIV to their infants, our AMA recommends the following statements: (1) Given the prevalence and distribution of HIV infection among ~~women~~**individuals** in the United States, the potential for effective early treatment of HIV infection ~~in both women and their infants~~, and the significant reduction in perinatal HIV transmission with treatment of pregnant ~~women~~**people** with appropriate antiretroviral therapy, routine education about HIV infection and testing should be part of a comprehensive health care program for all ~~women~~**individuals**. The ideal would be for all ~~women~~**people** to know their HIV status before considering pregnancy. (2) Universal HIV testing of all pregnant ~~women~~**people**, with patient notification of the right of refusal, should be a routine component of perinatal care. Basic counseling on HIV prevention and treatment should also be provided to the patient, consistent with the principles of informed consent. (3) The final decision about accepting HIV testing is the responsibility of the ~~woman~~**patient**. The decision to consent to or refuse an HIV test should be voluntary. When the choice is to reject testing, the patient's refusal should be recorded. Test results should be confidential within the limits of existing law and the need to provide appropriate medical care for ~~the woman~~**patients** and ~~her~~**their** infant. (4) To assure that the intended results are being achieved, the proportion of pregnant ~~women~~**people** who have accepted or rejected HIV testing and

		follow-up care should be monitored and reviewed periodically at the appropriate practice, program or institutional level. Programs in which the proportion of ~~women~~patients accepting HIV testing is low should evaluate their methods to determine how they can achieve greater success. (5) ~~Women~~Pregnant people who are not seen by a health care professional for prenatal care until late in pregnancy or after the onset of labor should be offered HIV testing at the earliest practical time, but not later than during the immediate postpartum period. (6) When HIV infection is documented in a pregnant ~~woman~~person, proper post-test counseling should be provided. The patient should be given an appropriate medical evaluation of the stage of infection and full information about the recommended management plan for ~~her~~their own health. Information should be provided about the potential for reducing the risk of perinatal transmission of HIV infection to ~~her~~the infant through the use of antiretroviral therapy, and about the potential but unknown long-term risks to ~~herself~~the patient and ~~her~~the infant from the treatment course. The final decision to accept or reject antiretroviral treatment recommended for ~~herself~~the patient and ~~her~~their infant is the right and responsibility of the ~~woman~~patient. When the ~~woman's~~ serostatus is either unknown or known to be positive, appropriate counseling should also be given regarding the risks associated with breastfeeding for both her own disease progression and disease transmission to the infant. (7) Appropriate medical treatment for HIV-infected pregnant ~~women~~people should be determined on an individual basis using the latest published Centers for Disease Control and Prevention recommendations. The most appropriate care should be available regardless of the stage of HIV infection or the time during gestation at which the ~~woman~~patient presents for prenatal or intrapartum care. (8) To facilitate optimal medical care for ~~women~~pregnant people and the~~ir~~ infants, HIV test results (both positive and negative) and associated management information should be available to the physicians taking care of both ~~mother and infant~~individuals. Ideally, this information will be included in the confidential medical records. Physicians providing care for a ~~woman~~pregnant person or ~~her~~their infant should obtain the appropriate consent and should notify the other involved physicians of the HIV status of and management information about the ~~mother~~pregnant person and their infant, consistent with applicable state law. (9) Continued research into new interventions is essential to further reduce the perinatal transmission of HIV, particularly the use of rapid HIV testing for ~~women~~patients presenting in labor and ~~for women~~those presenting in the prenatal setting who may not return for test results. The long-term effects of antiretroviral therapy during pregnancy and the intrapartum period for both ~~women~~pregnant patients and their infants also must be evaluated. For both infected and uninfected infants exposed to perinatal antiretroviral treatment, long-term follow-up studies are needed to assess potential complications such as organ system toxicity, neurodevelopmental problems, pubertal development problems, reproductive capacity, and development of neoplasms. (10) Health care professionals should be educated about the benefits of universal HIV testing, with patient notification of the right of refusal, as a routine component of prenatal care, and barriers that may prevent implementation of universal HIV testing as a routine component of prenatal care should be addressed and removed. Federal funding for efforts to prevent perinatal HIV transmission, including both prenatal testing and appropriate care of HIV-infected ~~women~~pregnant people, should be maintained.

H-20.920	HIV Testing	(2) Informed Consent Before HIV Testing b) Informed consent should include the following information: (i) patient option to receive more information and/or counseling before deciding whether or not to be tested and (ii) the patient should not be denied treatment if ~~he or she~~they refuse~~s~~ HIV testing, unless knowledge of HIV status is vital to provide appropriate treatment; in this instance, the physician may refer the patient to another physician for care; (10) Counseling and Testing of Pregnant ~~Women~~People for HIV Our AMA supports the position that there should be universal HIV testing of all pregnant ~~women~~people, with patient notification of the right of refusal, as a routine component of perinatal care, and that such testing should be accompanied by basic counseling and awareness of appropriate treatment, if necessary. Patient notification should be consistent with the principles of informed consent.
H-30.940	AMA Policy Consolidation: Labeling Advertising, and Promotion of Alcoholic Beverages	3. Our AMA a. recommends that health education labels be used on all alcoholic beverage containers and in all alcoholic beverage advertising (with the messages focusing on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant ~~women~~people, as well as the dangers of irresponsible use to all sectors of the populace).
H-35.989	Physician Assistants	2. A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of ~~his or her~~their practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which: 4. While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly responsible as the attending physician for the patient care services delegated to ~~his~~their physician assistant.

H-50.996	Blood for Medical Use	(1) Blood transfusions and the use of other bodily tissues or substances or biological substances in rendering medical care to patients are often essential to save the life of a patient or to protect ~~his~~**their** health. Protecting the welfare of patients requires that blood for transfusions and bodily tissues or substances and biological substances be available and that use when needed be encouraged and not burdened with unreasonable restrictions and increased costs.
H-60.918	Lead Contamination in Municipal Water Systems as Exemplified by Flint, Michigan	3. Our AMA will advocate for appropriate nutritional support for all people exposed to lead contaminated water with resulting elevated blood lead levels, but especially exposed pregnant ~~women~~**people**, lactating ~~mothers~~**people** and exposed children. Support should include Vitamin C, green leafy vegetables and other calcium resources so that their bodies will not be forced to substitute lead for missing calcium as the children grow.
H-60.924	Reducing Lead Poisoning	2. Our AMA will call on the United States government to establish national goals to: (b) eliminate lead exposures to pregnant ~~women~~**people** and children, so that by 2030, no child would have a blood lead level >1 µg/dL (10 ppb). 3. Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals: a. adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant ~~women~~**people** and children from lead toxicity and neurodevelopmental impairment; f. establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant ~~women~~**people** and children, defined as blood lead levels above 1 µg/dL (10 ppb).
H-65.965	Support of Human Rights and Freedom	1. Our American Medical Association continues to support the dignity of the individual, human rights and the sanctity of human life, 2. Our AMA reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with ~~his or her~~ individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age.
H-85.955	Hospice Care	4. Our AMA believes that each patient admitted to a hospice program should have ~~his or her~~**their** designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program.
H-85.961	Accuracy, Importance, and Application of Data from the US Vital Statistics System	Our American Medical Association encourages physicians to provide complete and accurate information on prenatal care and hospital patient records of the ~~mother~~**birthing patient** and **their** infant, as this information is the basis for the health and medical information on birth certificates.
H-85.968	Patient Self Determination Act	(1) lend its administrative, legislative, and public relations support to assuring that the specific wishes of the individual patient as specified in ~~his or her~~**their** advance directive be strictly honored in or out of the hospital setting; (3) promote efforts to develop a national system to assist emergency medical personnel to rapidly ascertain a person's wishes with regard to resuscitation, regardless of ~~his or her~~**their** state of location.

H-95.912	Involuntary Civic Commitment for Substance Use Disorder	Our American Medical Association opposes civil commitment proceedings for patients with a substance use disorder unless: b. Judicial oversight is present to ensure that the patient can exercise ~~his or her~~their right to oppose the civil commitment. c. The patient will be treated in a medical or other health care facility that is staffed with medical professionals with training in mental illness and addiction, including medications to help with withdrawal and other symptoms as prescribed by ~~his or her~~their physician.
H-95.924	Cannabis Legalization for Adult Use (commonly referred to as recreational use)	3. Our AMA discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant ~~women~~people, and ~~women~~people who are breastfeeding. 10. Our AMA will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among ~~women~~people who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving.
H-95.952	Cannabis and Cannabinoid Research	4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant ~~women~~people, and ~~women~~people who are breastfeeding.
H-95.967	Harmful Substance Use	Our AMA encourages every physician to make a commitment to join ~~his/her~~their community in attempting to reduce harmful substance use and that said commitment encourage involvement in at least one of the following roles:
H-95.976	Addiction and Unhealthy Substance Use	(2) encourages the development of addiction treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant ~~women~~people and ~~women~~parents with infant children through a comprehensive array of essential services; (3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant ~~women~~people, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals; (7) affirms the concept that addiction is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the ~~mother~~pregnant person, the fetus and resultant offspring; and (8) calls for better coordination of research, prevention, and intervention services for ~~women~~pregnant people and infants at risk for both HIV infection and perinatal addiction.
H-100.951	Medication Brown Bagging	2. Our AMA affirms that "brown bagged" pharmaceuticals be accepted for in-office or hospital administration only after the physician responsible for administering these medications determines that the individual patient, or ~~his or her~~their agent, is fully capable of safely handling and transporting the medication.
H-115.974	Prescription Labeling	(1) That when a physician desires to prescribe a brand name drug product, ~~he or she~~they do so by designating the brand name drug product and the phrase "Do Not Substitute" (or comparable phrase or designation, as required by state law or regulation) on the prescription; and when a physician desires to prescribe a generic drug product, ~~he or she~~they do so by designating the USAN-assigned generic name of the drug on the prescription.

H-130.937	Delivery of Health Care by Good Samaritans	3. Where there is no conflict with state or local jurisdiction protocol, policy, or regulation on this topic, our AMA supports the following basic guidelines to apply in those instances where a bystander physician happens upon the scene of an emergency and desires to assist and render medical assistance. For the purpose of this policy, "bystander physicians" shall refer to those physicians rendering assistance voluntarily, in the absence of pre-existing patient-physician relationships, to those in need of medical assistance, in a service area in which the physician would not ordinarily respond to requests for emergency assistance. e. Where voice communication is not available, the bystander physician may sign appropriate documentation indicating that ~~he/she~~they will take responsibility for the patient(s), including provision of care during transportation to a medical facility. Medical oversight systems lacking voice communications capability should consider the addition of such communication linkages to further strengthen their potential in this area. f. The bystander physician should avoid involvement in resuscitative measures that exceed ~~his or her~~their level of training or experience.
H-130.978	Billing Procedures for Emergency Care	(2) In the interest of high quality care, patients who seek medical attention on an emergency basis should have the benefit of an immediate evaluation of any indicated diagnostic studies. The physician who provides such evaluation is entitled to adequate compensation for ~~his or her~~their services. When such evaluations are provided as an integral part of and in conjunction with other routine services rendered by the emergency physician, ideally an inclusive charge, commensurate with the services provided, should be made. Where the carrier collapses or eliminates CPT-4 coding for payment purposes, the physician may be left with no realistic alternative other than to itemize. Such an itemized bill should not be higher than the amount which would be paid if the appropriate inclusive charge were recognized. The interpretation of diagnostic procedures by a consulting specialist, as a separate and independent service provided the emergency patient, is equally important to good patient care. Physicians who provide such interpretations are also entitled to adequate compensation for their services
H-140.951	Professionalism in Medicine	Our AMA believes that the primary mission of the physician is to use ~~his~~ best efforts and skill in the care of ~~his~~ patients and to be mindful of those forces in society that would erode fundamental ethical medical practice. The AMA affirms that the medical profession is solely responsible for establishing and maintaining standards of professional medical ethics and that the state neither legislate ethical standards nor excuse physicians from their ethical obligations. The AMA House of Delegates, Board of Trustees, staff, and membership rededicate themselves to professionalism such that it permeates all activities and is the defining characteristic of the AMA's identity.
H-140.970	Decisions to Forgo Life-Sustaining Treatment for Incompetent Patients	(1) Advance directives (living wills and durable powers of attorney for health care) are the best insurance for individuals that their interests will be promoted in the event that they become incompetent. Generally, it is most effective if the individual designates a proxy decisionmaker and discusses with the proxy ~~his or her~~their values regarding decisions about life support.
H-140.984	Physicians' Involvement in Commercial Ventures	Our AMA opposes an across-the-board ban on self-referrals because of benefits to patients including increased access and competition, but proposes a list of standards to ensure ethical and acceptable financial arrangements: (3) Patient Referral Requirement - No investor in the medical facility can be required or coerced in any manner to refer patients to the facility. No investor can be required to divest ~~his or her~~ investment for failure to refer patients. No investor can be required to divest because ~~he or she~~they move~~s~~ from the area or ceases practicing medicine. (5) Disclosure of Ownership Interest - A physician or other health care

		professional or provider with an ownership interest in a medical or other health care facility or service to which the physician refers patients must disclose to the patients this ownership interest. A general disclosure can be made in a manner which is appropriate to ~~his or her~~their practice situation. (6) Request for Care - Each patient of a physician with an ownership interest (or whose immediate family member has an interest) must be provided with a physician's request for ancillary care to enable the patient to select a facility for such care. However, in accordance with the physician's ethical responsibility to provide the best care for the patient, the physician must be free to recommend what in the physician's judgment is the most appropriate facility, including ~~his or her~~their own facility. (7) Notification of Ownership Interest to Payer - If the physician (or immediate family member) has an ownership interest in a medical or health care facility or service to which ~~he or she~~they refer~~s~~ patients who are Medicare beneficiaries, this physician should identify the ownership interest on the Medicare claim form. If the Medicare carrier detects a pattern suggesting inappropriate utilization, the matter could be referred to the PRO for follow-up pursuant to the existing PRO review process. Such PRO review would have to be conducted in a uniformly fair, open-minded manner.
H-140.989	Informed Consent and Decision-Making in Health Care	(6) A patient should have access to the information in ~~his or her~~their health record, except for that information which, in the opinion of the health care professional, would cause harm to the patient or to other people.
H-150.989	Weight Loss Programs	1. Our AMA encourages any person considering participation in a weight loss program to first consult ~~his or her~~their regular attending physician, or any other independent physician, for a physical examination and an objective professional evaluation of the proposed weight loss program as it relates to the individual's physical condition.
H-160.888	Urgent Care Centers	1. Our American Medical Association supports that any individual, company, or other entity that establishes and/or operates urgent care centers (UCCs) adhere to the following principles: b. UCCs must transfer a patient's medical records to ~~his or her~~their primary care physician and to other health care providers, with the patient's consent, including offering transfer in an electronic format if the receiving physician is capable of receiving it.
H-160.912	The Structure and Function of Interprofessional Health Care Teams	2. Our AMA will advocate that the physician leader of a physician-led interprofessional health care team be empowered to perform the full range of medical interventions that ~~she or he is~~they are trained to perform.
H-160.921	Retail Clinics	4. Our AMA supports that any individual, company, or other entity that establishes and/or operates retail health clinics adhere to the following principles: b. Retail health clinics must use electronic health records to transfer a patient's medical records to ~~his or her~~their primary care physician and to other health care providers, with the patient's consent;

H-160.942	Evidence-Based Principles of Discharge and Discharge Criteria	(7) The AMA endorses the following principles in the development of evidence-based discharge criteria and an organized discharge process: (c) The discharge process includes, but is not limited to: (iv) Responsibility/Accountability: Responsibility/accountability for an appropriate transition from one setting to another rests with the attending physician. If that physician will not be following the patient in the new setting, ~~he or she is~~they are responsible for contacting the physician who will be accepting the care of the patient before transfer and ensuring that the new physician is fully informed about the patient's illness, course, prognosis, and needs for continuing care. If there is no physician able and willing to care for the patient in the new setting, the patient should not be discharged. Notwithstanding the attending physician's responsibility for continuity of patient care, the health care setting in which the patient is receiving care is also responsible for evaluating the patient's needs and assuring that those needs can be met in the setting to which the patient is to be transferred.
H-160.947	Physician Assistants and Nurse Practitioners	10. The physician is responsible for clarifying and familiarizing the physician assistant with ~~his/her~~their supervising methods and style of delegating patient care.
H-165.856	Health Insurance Market Regulation	4. Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine ~~his or her~~their premium.
H-165.877	Increasing Coverage for Children	Our AMA: (1) supports appropriate legislation that will provide health coverage for the greatest number of children, adolescents, and pregnant ~~women~~people;
H-165.920	Individual Health Insurance	(3) actively supports the principle of the individual's right to select ~~his/her~~a health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. (6) supports the individual's right to select ~~his/her~~a health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;
H-180.960	Insurance Company Medical Test Disclosures	AMA policy is that insurance companies must inform insurance applicants of any abnormal results that are found during an insurance health evaluation; that insurance companies should inform an applicant that if ~~he or she~~they receive~~s~~ information concerning an evaluation that has an abnormal result, ~~he or she~~they should send the results to ~~his or her~~their physician for further consultation; and that all insurance applicants should be made aware that all health information obtained from insurance evaluations is available upon an applicant's request.
H-210.996	Providing Cost Estimate with Home Health Care Order Authorization	The AMA urges physicians to request home health care providers to provide a cost estimate with the physician authorization form, when the form is sent to the physician for ~~his/her~~ signature.
H-210.998	Home Health Service Abuse	(3) urges physicians not to authorize the provision post-acute or long-term care to any patient with whom ~~he or she is~~they are not professionally involved in providing care.

H-220.977	Chief Executive Officer at Medical Staff Executive Committee	The AMA reaffirms its support for amending The Joint Commission Medical Staff Standard MS.02.01.01, Element of Performance 2, to read as follows: "That the Chief Executive Officer of the hospital or ~~his or her~~their designee may be invited to attend meetings of the Executive Committee of the medical staff."
H-225.942	Physician and Medical Staff Member Bill of Rights	IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to ~~his or her~~their patients, the medical staff, and the health care organization:
H-225.946	Preserving Physician/Patient Relationships During Hospitalizations	1. Our AMA advocates that hospital admission processes should include: a determination of whether the patient has an existing relationship with an actively treating primary care or specialty physician; where the patient does not object, prompt notification of such actively treating physician(s) of the patient's hospitalization and the reason for inpatient admission or observation status; to the extent possible, timely communication of the patient's medical history and relevant clinical information by the patient's primary care or specialty physician(s) to the hospital-based physician; notice to the patient that ~~he/she~~they may request admission and treatment by such actively treating physician(s) if the physician has the relevant clinical privileges at the hospital; honoring requests by patients to be treated by their physician(s) of choice; and allowing actively treating physicians to treat to the full extent of their hospital privileges.
H-225.950	AMA Principles for Physician Employment	1. Addressing Conflicts of Interest d. A physician's paramount responsibility is to ~~his or her~~their patients. Additionally, given that an employed physician occupies a position of significant trust, ~~he or she~~they owe~~s~~ a duty of loyalty to ~~his or her~~their employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address. i. No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to ~~his/her~~their religious beliefs or moral convictions. ii. No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because ~~he/she~~they either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates ~~his/her~~their religious beliefs or moral convictions. 3. Contracting c. When a physician's compensation is related to the revenue ~~he or she~~they generate~~s~~, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based. d. Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under ~~his/her~~their care. When a physician's employment status is unilaterally terminated by an employer, the physician and ~~his or her~~their employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in ~~his or her~~their new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee.

		Where physician possession of all medical records of ~~his or her~~**their** patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician. 5. Peer Review and Performance Evaluations f. Upon termination of employment with or without cause, an employed physician generally should not be required to resign ~~his or her~~**their** hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
H-225.952	The Physician's Right to Exercise Independent Judgement in All Organized Medical Staff Affairs	Our American Medical Association supports the unfettered right of a physician to exercise ~~his/her~~ personal and professional judgment in voting, speaking and advocating on any matter regarding: vi. not to be deemed in breach of ~~his/her~~**their** employment or independent contractor agreement for asserting the foregoing enumerated rights; and vii. not to be retaliated against by ~~his/her~~**their** employer in any way, including, but not limited to, termination of ~~his/her~~ employment or independent contractor agreement, commencement of any disciplinary action, or any other adverse action against ~~him/her~~**them** based on the exercise of the foregoing rights.
H-225.992	Right to Relevant Information	1. The AMA advocates "timely notice" and "opportunity to rebut" any adverse entry in the medical staff member's credential file, believes that any health care organization file on a physician should be opened to ~~him or her~~**them** for inspection, and supports inclusion of these provisions in hospital medical staff bylaws. 6. The investigating individual or body shall interview the practitioner, unless the practitioner waives ~~his/her~~**their** right to be heard, to evaluate the potential charges and explore alternative courses of action before proceeding to the formal peer review process.
H-225.997	Physician-Hospital Relationships	9. Both hospitals and hospital-associated medical specialists have an obligation to serve the needs of patients and the medical staff. The primary responsibility for determining the services needed adequately to care for the needs of individual patients should be that of the attending physician subject to review by ~~his~~**their**-peers.
H-230.954	Privileging Physicians with Low Volume Hospital Activity	3. Hospitals and medical staffs should use data and references, if available, from another hospital at which the applicant physician may be active as an additional method to verify ~~his/her~~**their** competency within the hospital environment.
H-230.956	Hospital, Ambulatory Surgery Facility, Nursing Home, or Other Health Care Facility Closure: Physician Credentialing Records	1. AMA policy regarding the appropriate disposition of physician credentialing records following the closure of hospitals, ambulatory surgery facilities, nursing homes and other health care facilities, where in accordance with state law and regulations is as follows: C. Documentation of Physician Credentials: The governing body shall make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of ~~his/her~~**their** credentials, clinical privileges, CME information, and medical staff status.

H-235.961	Employment Status and Eligibility for Election or Appointment to Medical Staff Leadership Positions	1. Our American Medical Association adopted as policy the principle that a medical staff member's personal or financial affiliations or relationships, including employment or contractual relationships with any hospital or health care delivery system, should not affect ~~his or her~~ eligibility for election or appointment to medical staff leadership positions, provided that such interests are disclosed prior to the member's election or appointment and in a manner consistent with the requirements of the medical staff bylaws. 2. Our AMA will draft model medical staff bylaws provisions supporting the principle that a medical staff member's personal or financial affiliations or relationships, including employment or contractual relationships with any hospital or health care delivery system, should not affect ~~his or her~~ eligibility for election or appointment to medical staff leadership positions, provided that such interests are disclosed prior to the member's election or appointment and in a manner consistent with the requirements of the medical staff bylaws.
H-235.967	Medical Staff Legal Counsel and Conflict of Interest	There is an inherent conflict of interest when an attorney represents the hospital and the organized medical staff. Organized medical staffs should require that the following disclosures be made prior to retaining separate legal counsel to avoid any real or perceived conflicts of interest on the counsel's part and to assure ~~his or her~~**their** loyalty: (1) whether the lawyer or the firm in which ~~he or she is~~**they are** associated or employed has ever represented the hospital as a client and received payment from the hospital or another party on behalf of the hospital for the legal services provided; (2) whether the hospital has paid legal fees to the lawyer or the law firm with which ~~he or she is~~**they are** associated or employed for legal opinions or advice on matters pending before the hospital governing board and/or hospital administration; and (3) whether the lawyer or the firm with which ~~he or she is~~**they are** associated or employed has represented or provided legal opinions and advice to other hospitals in the community or to a local or state hospital association.
H-245.986	Infant Mortality in the United States	It is the policy of the AMA: (1) to continue to address the problems that contribute to infant mortality within its ongoing health of the public activities. In particular, the special needs of adolescents and the problem of teen pregnancy should continue to be addressed by the adolescent health initiative; and (2) to be particularly aware of the special health access needs of pregnant ~~women~~**people** and infants, especially racial and ethnic minority group populations, in its advocacy on behalf of its patients.
H-265.989	FDA Conflict of Interest	2. It is the position of the AMA that the FDA should undertake an evaluation of pay-later conflicts of interest (e.g., where a FDA advisory committee member develops a financial conflict of interest only after ~~his or her~~**their** initial appointment on the advisory committee has expired) to assess whether these undermine the independence of advisory committee member recommendations and whether policies should be adopted to address this issue.
H-265.994	Expert Witness Testimony	(3) Existing policy regarding the competency of expert witnesses and their fee arrangements (BOT Rep. SS, A-89) is reaffirmed, as follows: (c) The AMA supports the right to cross examine physician expert witnesses on the following issues: (iv) the frequency with which ~~he or she~~**they** testified for either plaintiffs or defendants. The AMA supports laws consistent with its model legislation on expert witness testimony.

H-265.997	AMA-ABA Statement on Interprofessional Relations for Physicians and Attorneys	(1) Medical Reports: Physicians, upon proper authorization, should promptly furnish the attorney with a complete medical report, and should realize that delays in providing medical information may prejudice the opportunity of the patient either to settle ~~his~~their claim or suit, delay the trial of a case, or cause additional expense or the loss of important testimony. The attorney should give the physician reasonable notice of the need for a report and clearly specify the medical information which he seeks. (3) Subpoena for Medical Witness: Because of conditions in a particular case or jurisdiction or because of the necessity for protecting ~~himself~~themselves or ~~his~~their client, the attorney is sometimes required to subpoena the physician as a witness. Although the physician should not take offense at being subpoenaed, the attorney should not cause the subpoena to be issued without prior notification to the physician. The duty of the physician is the same as that of any other person to respond to judicial process. (4) Arrangements for Court Appearances: While it is recognized that the conduct of the business of the courts cannot depend upon the convenience of litigants, lawyers or witnesses, arrangements can and should be made for the attendance of the physician as a witness which take into consideration the professional demands upon ~~his~~their time. Such arrangements contemplate reasonable notice to the physician of the intention to call ~~him~~them as a witness and to advise ~~him~~them by telephone after the trial has commenced of the approximate time of ~~his~~their required attendance. The attorney should make every effort to conserve the time of the physician. (5) Physician Called as Witness: The attorney and the physician should treat one another with dignity and respect in the courtroom. The physician should testify solely as to the medical facts in the case and should frankly state ~~his~~their medical opinion. He should never be an advocate and should realize that ~~his~~their testimony is intended to enlighten rather than to impress or prejudice the court or the jury. It is improper for the attorney to abuse a medical witness or to seek to influence ~~his~~their medical opinion. Established rules of evidence afford ample opportunity to test the qualifications, competence, and credibility of a medical witness, and it is always improper and unnecessary for the attorney to embarrass or harass the physician. (7) Payment of Medical Fees: The attorney should do everything possible to assure payment for services rendered by the physician for ~~himself~~themselves or ~~his~~their client. When the physician has not been fully paid, the attorney should request permission of the patient to pay the physician from any recovery which the attorney may receive in behalf of the patient.
H-265.998	Guidelines for Due Process	(1) The physician should be provided with a statement, or a specific listing, of the charges made against ~~him or her~~them. (5) The physician against whom the charges are made should have the opportunity to be present at the hearing and hear all of the evidence against ~~him or her~~them. (6) The physician is entitled to the opportunity to present a defense to the charges against ~~him or her~~them.

H-275.937	Patient/Physician Relationship and Medical Licensing Boards	(1) Without regard to whether an act or failure to act is entirely determined by a physician, or is the result of a contractual or other relationship with a health care entity, the relationship between a physician and a patient must be based on trust and must be considered inviolable. Included among the elements of such a relationship of trust are: (a) Open and honest communication between the physician and the patient, including disclosure of all information necessary for the patient to be an informed participant in ~~his or her~~their care. (5) A (name of state) physician has both medical-legal and ethical obligations to ~~his or her~~their patients. These are well established in both law and professional tradition. Some models of medical practice may result in an inappropriate restriction of the physician's ability to practice quality medicine. This may create negative consequences for the public. It is incumbent that physicians take those actions they consider necessary to assure that medical practice models do not adversely affect the care that they render to their patients.
H-275.953	The Grading Policy for Medical Licensure Examinations	2. Our AMA adopts the following policy on NBME or USMLE examination scoring: b. Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of ~~his or her~~their numerical scores.
H-275.994	Physician Participation in Third Party Payer Programs	The AMA opposes state laws making a physician's licensure contingent upon ~~his~~ providing services to Medicaid beneficiaries or any other specific category of patients should be opposed.
H-275.998	Physician Competence	6. Our AMA urges state medical licensing boards to report all disciplinary actions promptly to the Federation of State Medical Boards and to the AMA Physician Masterfile. (Failure to do so simply allows the incompetent or impaired physician to migrate to another state, even after disciplinary action has been taken against ~~him~~them, and to continue to practice in a different jurisdiction but with the same hazards to the public.)
H-280.968	Do Not Hospitalize Orders	(1) acknowledges that do-not-hospitalize orders in the nursing home situation, when based on the resident's (or ~~his or her~~their family's) informed consent, provide an appropriate means of promoting patient autonomy and carrying out the expressed level of treatment goals and wishes of the resident; and
H-280.999	Physician Involvement in Long-Term Care	1. Our AMA will emphasize in its communications to the medical profession, medical educators, and other professional groups concerned with long-term care the importance of increased physician understanding, supervision of, and involvement in care of the chronically ill and disabled of all ages in all care settings. The AMA believes that physicians have a central role in assuring that all residents of nursing facilities receive thorough assessments and that medical plans of care are instituted or revised to enhance or maintain the resident's physical and psychosocial functioning. The AMA endorses the following "Guidelines for Physicians Attending Patients in Long-Term Care Facilities": D. Each attending physician should designate an alternate physician or should advise ~~his~~their physician exchange of who may be called to see ~~his~~their patients for regular or emergency care when the attending physician is not available. In the event that neither the attending physician nor the designated alternate physician is available to examine and treat a patient requiring immediate attention, the medical director shall have the authority to call another physician for appropriate treatment or treat the patient ~~himself~~themself. E. Prior to or upon admission of a patient, it would be desirable for the attending physician to perform a physical examination of ~~his~~their-patient and

		provide the facility with an admitting diagnosis, statement of patient's functional status, and orders for diet, medication and initial treatment. Other patient information required by the facility may be provided at the time of admission or as soon as practical thereafter and should include a family history, past medical history, report of current medical findings, and a statement of rehabilitation potential and prognosis. The physician should also make arrangements for furnishing the facility with appropriate laboratory, x-ray, and consultation reports. F. Each attending physician is responsible for planning the medical care of ~~his~~their patient. Upon admission of ~~his~~their patient, the physician should make a medical evaluation of ~~his~~their patient's immediate and long-term care needs. This should include information about medications, treatments, rehabilitative services, diets, precautions related to activities undertaken by the patient, and plans for continuing care and, when appropriate, discharge. In developing this plan, it may be necessary for the attending physician to consult with the patient and/or the patient's family. The attending physician should review this plan at least annually and make revisions when appropriate. The plan may be reviewed by the medical director so that he may ensure consistency with the facility's policies. G. The facility should inform each attending physician of the availability of social, psychological and other non-medical aspects of care for ~~his~~their patient so that he may assure ~~himself~~themself that such care is compatible with the medical condition of the patient. H. The attending physician should be aware of the need for the medical director, in fulfilling ~~his~~ required duties, to review the records of patients in the facility and, on occasion, actually contact the patient and/or family. K. The attending physician should visit ~~his~~their patient on a schedule determined by the patient's medical needs, and which is consistent with any state or federal regulations applicable, and this schedule should be documented in the patient's record. The attending physician may review ~~his~~their schedule of visits for each patient in conjunction with an annual reevaluation of the patient's health status. L. During each visit, the attending physician should see ~~his~~their patient, sign all written changes in orders and enter a progress note in the patient's record indicating that the patient has been visited. It should be the duty of the charge nurse to call the attention of the attending physician to orders requiring renewal. Except as specifically indicated below, treatment orders should not be permitted to expire without notification to the attending physician. M. The attending physician should give all orders for treatment in writing. An order may be considered in writing if it is dictated to a licensed nurse, signed and dated by the nurse, and countersigned by the physician at the time of ~~his~~their next visit to the facility or by other acceptable arrangements. Q. The attending physician should be aware that the pharmacist may review the drug regimen of each patient at least monthly and report ~~his~~their comments to the medical director and administrator. In those instances where the medical director and the pharmacist question the appropriateness of the drug regimen, the question should be brought to the attention of the attending physician.

H-285.910	The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community	In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise ~~his/her~~ independent professional judgment and be guided by ~~his/her~~ personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit Physician's right or ability to advocate on behalf of patients' interests or on behalf of good patient care, or to exercise ~~his/her~~**their** own medical judgment. Physician shall not be deemed in breach of this Agreement, nor may Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician's exercise of ~~his/her~~**their** rights under this paragraph.
H-285.952	Amendments to Managed Care Contracts	1. It is policy of our American Medical Association that: e. Our AMA opposes managed care plan mandating that physician to notify all ~~his/her~~**of their** patients. f. Our AMA opposes the preapproval of physician-developed notification letters by managed care plans required if a participating physician who is voluntarily leaving the plan chooses to inform ~~his/her~~**their** patient of the departure.
H-285.962	Anti-Psychiatry Practices of Certain Health Maintenance Organizations and Managed Care Organizations	Our AMA opposes managed care organization (MCO) requirements that a patient determined by ~~his or her~~**their** physician to be in need of specific treatment, including psychiatric treatment, be interviewed by an unqualified employee of the MCO prior to approval of the treatment.
H-285.991	Qualifications and Credentialing of Physicians Involved in Managed Care	1. AMA policy on selective contracting is as follows: (d) Prior to initiation of actions leading to termination or nonrenewal of a physician's participation contract for any reason the physician shall be given notice specifying the grounds for termination or nonrenewal, a defined process for appeal, and an opportunity to initiate and complete remedial activities except in cases where harm to patients is imminent or an action by a state medical board or other government agency effectively limits the physician's ability to practice medicine. Participation in a physician health program in and of itself shall not count as a limit on the ability to practice medicine. Our AMA supports the following appeals process for physicians whose health insurance contract is terminated or not renewed: (v) the physician or ~~his/her~~**their** representative should be able to appear in person at the hearing and present the physician's case;
H-285.998	Managed Care	5. Utilization Review The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payers should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed. Physician of the same specialty must be involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. All health plans conducting utilization management or utilization review should establish an appeals process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and decisions to deny coverage for services, and have the right to review of any coverage denial based on medical necessity by a physician independent of the health plan who is of the same specialty and has appropriate expertise and experience in the field. A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request. Any physician who makes judgments or recommendations regarding the necessity

		or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service and should be professionally and individually accountable for ~~his or her~~their decisions. All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the former. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to ~~his or her~~their patients. It is the responsibility of the patient and ~~his or her~~their health benefits plan to inform the treating physician of any coverage restrictions imposed by the plan. All health plans utilizing managed care techniques should be subject to legal action for any harm incurred by the patient resulting from application of such techniques. Such plans should also be subject to legal action for any harm to enrollees resulting from failure to disclose prior to enrollment any coverage provisions; review requirements; financial arrangements; or other restrictions that may limit services, referral, or treatment options, or negatively affect the physician's fiduciary responsibility to ~~his or her~~their patient. When inordinate amounts of time or effort are involved in providing case management services required by a third party payer which entail coordinating access to other health care services needed by the patient, or in complying with utilization review requirements, the physician may charge the payer or the patient for the reasonable cost incurred. "Inordinate" efforts are defined as those "more costly, complex and time-consuming than the completion of standard health insurance claim forms, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage." Any health plan or utilization management firm conducting a prior authorization program should act within two business days on any patient or physician request for prior authorization and respond within one business day to other questions regarding medical necessity of services. Any health plan requiring prior authorization for covered services should provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring prior authorization are recommended by the physicians. In the absence of consistent and scientifically established evidence that preadmission review is cost-saving or beneficial to patients, the AMA strongly opposes the use of this process.
H-290.985	Monitoring Medicaid Managed Care	8. In programs where more than one plan is available, beneficiary freedom to choose ~~his/her~~their plan, enforcement of standards for marketing/enrollment practices, and clear and comparable disclosure of plan benefits and limitations including financial incentives on providers.
H-295.861	Accommodating Lactating ~~Mothers~~Individuals Taking Medical Examinations	*Title change only; no policy change*

H-295.995	Recommendations for Future Directions for Medical Education	(30) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if ~~his or her~~ participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.
H-295.998	Due Process	(2) In addition, to clarify and protect the rights of medical students, the AMA recommends that: (b) These policies and procedures should define the responsible bodies and their function and membership, provide for timely progressive verbal and written notification to the student that ~~his/her~~**their** academic/nonacademic performance is in question, and provide an opportunity for the student to learn why it has been questioned. (c) These policies and procedures should also ensure that when a student has been notified of recommendations by the responsible committee for nonadvancement or dismissal, ~~he/she has~~**they have** adequate notice and the opportunity to appear before the decision-making body to respond to the data submitted and introduce ~~his/her~~**their** own data.
H-315.986	Confidentiality of Patient Records	Our AMA opposes the concept that filing a claim for medical insurance coverage constitutes a blanket waiver of a patient's right to confidentiality of ~~his/her~~**their** medical records for all purposes. The AMA will engage in a major initiative to educate patients about the implications and consequences of blanket medical records releases, and educate patients about the need for possible legislative modifications.
H-315.995	Hospital Face Sheet: Physician Responsibility	The AMA believes that it is the responsibility of the attending physician to specify all diagnoses and procedures in the hospital records, and that no alteration should be made without ~~his or her~~**their** consent.
H-320.954	Post-Partum Hospital Stay and Nurse Home Visits	The AMA: (1) opposes the imposition by third party payers of mandatory constraints on hospital stays for vaginal deliveries and cesarean sections as arbitrary and as detrimental to the health of the ~~mother~~**birthing patient** and of the newborn; and (2) urges that payers provide payment for appropriate follow-up care for the ~~mother~~**birthing patient** and newborn.
H-320.968	Approaches to Increase Payer Accountability	1. Disclosure Requirements. Our American Medical Association supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on: c. Plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to ~~his or her~~**their** patient.
H-320.985	Economic Discharge Order for Utilization Review Committee Denial	(1) reaffirms its policy that economic considerations should not conflict with a physician's primary responsibility to serve the best interests of ~~his or her~~**their** patient and that, if a third party payer or Medicare regulation results in urging of a physician to discharge a patient against the physician's medical judgment, the patient should be so informed and the physician should protest the limitation; and

H-335.996	Spurious Medical Necessity Denials	(2) Until such time as repeal of this provision is achieved, the AMA urges CMS and Medicare Part B carriers to make further changes in the implementation of this authority to correct problems being experienced, including: (f) opposing required wording in the patient waiver form (advance exculpatory notice) that suggests that the physician is about to provide medically unnecessary services to ~~his or her~~their patients.
H-340.907	Notification When Physician Specific Information is Exchanged	Our American Medical Association will petition CMS to require notification of a physician under focused review that ~~his or her~~their name is being exchanged between any carrier and the QIOs and to identify the reason for this exchange of information.
H-340.971	Medicare Program Due Process	The AMA supports legislative and regulatory changes, as necessary, to assure the provision of PRO review with due process protections before any physician is sanctioned under the Medicare Program. Such due process should include at a minimum the following specific protections that would entitle the physician to: (1) a written statement of the charges against ~~him or her~~them; (2) adequate notice of the right to a hearing, ~~his or her~~their rights in the hearing, and a reasonable opportunity to prepare for the hearing; (3) discover the evidence and witnesses against ~~him or her~~them sufficiently in advance of the hearing to enable preparation of the defense; (6) the opportunity to be present at the hearing and hear all of the evidence against ~~him or her~~them;
H-355.975	Opposition to the National Practitioner Data Bank	6. Our AMA opposes any legislative or administrative efforts to expand the Data Bank reporting requirements for physicians, such as the reporting of a physician who is dismissed from a malpractice suit without any payment made on ~~his or her~~their behalf, or to expand the entities permitted to query the Data Bank such as public and private third party payers for purposes of credentialing or reimbursement.
H-365.997	Corporation or Employer-Sponsored Examinations	Our American Medical Association encourages employers who provide or arrange for special or comprehensive medical examinations of employees to be responsible for assuring that these examinations are done by physicians competent to perform the type of examination required. Whenever practical, the employee should be referred to ~~his or her~~their personal physician for such professional services. In the many instances in which an employee does not have a personal physician, efforts should be made to assist ~~him or her~~them in obtaining one, with emphasis on continuity of care. This effort should be aided by the local medical society wherever possible.
H-365.998	Confidentiality of Occupational Medical Records	Our American Medical Association opposes the Department of Labor's rule requiring that, without the informed written consent of the patient-employee, ~~his~~their entire medical record shall be accessible to OSHA.
H-373.995	Government Interference in Patient Counseling	2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use ~~his or her~~their medical judgment as to the information or treatment that is in the best interest of their patients.

H-375.962	Legal Protections for Peer Review	Definitions Proceedings. Proceedings include all of the activities and information and records of a peer review committee. Proceedings are not subject to discovery and no person who was in attendance at a meeting of a peer review organization shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such organization or as to any findings, recommendations, evaluations, opinions, or other actions of such organization or any members thereof. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of a peer review organization, nor should any person who testifies before a peer review organization or who is a member of a peer review organization be prevented from testifying as to matters within ~~his/her~~their knowledge; but such witness cannot be asked about ~~his/her~~their testimony before a peer review organization or about opinions formed by ~~him/her~~them as a result of the peer review organization hearings.
H-375.969	Physician Access to Performance Profile Data	AMA policy is that every physician should be given a copy of ~~his/her~~their practice performance profile information at least annually by each organization retaining such physician information.
H-375.983	Appropriate Peer Review Procedures	(2) Peer review procedures and actions should, at a minimum, meet the Health Care Quality Improvement Act of 1986 standards for federal immunity: (a) In any situation where it appears that a disciplinary proceeding may be instigated against a physician that could result in the substantial loss or termination of the physician's medical staff membership and/or clinical privileges, the advice and guidance of legal counsel should be sought. The accused physician should have legal counsel separate from the health care organization or medical staff. The health care organization and the medical staff should each have separate legal counsel. The attorney of the body bringing the peer review action, be it the health care organization or the medical staff, should undertake the procedures needed to prepare for the hearing including the written notice of charges, the marshaling of evidence and the facts, and the selection of witnesses. This health care organization or medical staff attorney should be instructed that ~~his or her~~their role includes assuring that the proceedings are conducted fairly, bearing in mind the objectives of protecting consumers of health care and the physician involved against false or exaggerated charges. The attorney for the body which is not bringing the peer review action should work to ensure that proper peer review processes as outlined in the medical staff bylaws are followed. The role of the attorney for the accused physician is solely to defend ~~his or her~~their client. (h) Physicians serving on the hearing panel should receive information and training in the elements and essentials of peer review. Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible. Wherever feasible, data collection and analysis, or similar assessment instruments, and multiple reviewers should be used to increase reliability in evaluating whether peer review disciplinary proceedings are warranted. Where feasible, statistical analysis to compare with peers' performance must be used with appropriate case mix adjustments. (i) Physicians who are direct economic competitors of the physician involved may testify as witnesses, whether they are called by the physician or the hearing panel or the health care organization, but a physician should not be deprived of ~~his or her~~their privileges solely on the basis of medical testimony by economic competitors. In any proceedings that result in the

		termination of privileges, there should be testimony from one or more physicians who are not economic competitors or who do not stand to gain economically by an adverse action, but who are knowledgeable in the treatment, patient care management and areas of medical practice or judgment upon which the adverse action is based. (k) When investigation is underway and indicates that a disciplinary proceeding is warranted for the purpose of reducing, restricting, or terminating a physician's hospital privileges, ~~he or she~~they should be notified that resignation will result in a report to the National Practitioner Data Bank.
H-385.923	Definition of "Usual, Customary and Reasonable" (UCR)	1. Our American Medical Association adopts as policy the following definitions: a. "Usual; fee means that fee usually charged, for a given service, by an individual physician to ~~his~~their private patient (i.e., ~~his~~their own usual fee);
H-385.938	Most Favored Nation Clause within Insurance Contracts	Our AMA opposes the inclusion of "Most Favored Nation Clauses" into insurance contracts that require a physician or other health care provider to give a third-party payer ~~his~~their most discounted rate for medical services.
H-385.992	Reimbursement for CT scans and Other Procedures	(1) opposes denial of a physician's right to perform specific services or to be compensated for such services solely on the basis of ~~his~~their specialty designation;
H-390.877	Home Health Care Services	Our AMA urges the federal government to provide an "explanation of medical benefits" statement for post-acute and long-term care (i.e., post-hospital care for sub-acute and chronic illnesses in a variety of health care settings, such as home health agencies and skilled nursing facilities), to the responsible physician, upon ~~his or her~~their request, and to the recipient of such care when covered by Medicare; and urges the federal government to apply a beneficiary co-payment to all home health care services covered by Medicare.
H-390.888	Payment for Concurrent Care	(5) will communicate to CMS the importance of carrier understanding that more than one physician can be involved in a case and that the carrier or insurance company not expect a physician to manage a medical problem outside ~~his/her~~their area of expertise or specialty, and that both the primary care physician or other specialist be reimbursed for this care in accordance with their responsibilities; and
H-390.889	Medicare Reimbursement of Telephone Consultations	5. It is the policy of our AMA to seek enactment of legislation as needed to allow separate Medicare payment for those telephone calls that can be considered discrete and medically necessary services performed for the patient without ~~his/her~~their presence.
H-390.917	Consultation Follow-Up and Concurrent Care of Referral for Principal Care	(1) It is the policy of the AMA that: (a) the completion of a consultation may require multiple encounters after the initial consultative evaluation; and (b) after completion of the consultation, the consultant may be excused from responsibility of the care of the patient or may share with the primary care physician in concurrent care; ~~he/she~~they may also have the patient referred for care and thus become the principal care physician.
H-390.971	Hospitals Limited to Participating Physicians	3. Our AMA urges a return to the original intent of the Medicare Law (Title XVIII) as expressed in Sections 1801 and 1802 enacted in 1965 which read as follows: "Section 1801 [42 U.S.C. 1895] Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person." "Section 1802 [42 U.S.C. 1895a] Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or

		person qualified to participate under this title if such institution, agency, or person undertakes to provide ~~him~~ such services"
H-410.971	Clinical Algorithm Impact on Patient Care	1) Clinical algorithms are guidelines established to aid a physician in the diagnosis and treatment of patients. As such, they should be used by the physicians as guidelines, but recognizing that each patient is an individual and has unique needs and problems, the physician should use ~~his or her~~their best judgment in the use of the guidelines and should never be forced to specifically follow these guidelines rigidly.
H-420.947	Support for International Aid for Reproductive Health	1. Our American Medical Association opposes restrictions on U.S. funding to non-governmental organizations solely because they provide reproductive health care internationally, including but not limited to contraception and abortion care. 2. Our AMA supports funding for global humanitarian and non-governmental organizations for ~~maternal~~obstrectric care ~~healthcare~~ and comprehensive reproductive health services, including but not limited to contraception and abortion care.
H-420.953	Improving Mental Health Services ~~for~~During Pregnan~~t~~cy and Postpartum ~~Mothers~~	*Title change only; no policy change*
H-420.954	Truth and Transparency in Pregnancy Counseling Centers	4. Our AMA advocates that any entity licensed to provide medical or health services to pregnant ~~women~~people
H-420.957	Shackling of Pregnant ~~Women~~Patients in Labor	1. Our American Medical Association supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering ~~her~~a baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents: • An immediate and serious threat of harm to ~~herself~~themselves, staff or others. • A substantial flight risk and cannot be reasonably contained by other means." If an inmate who is in labor or who is delivering ~~her~~a baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used. 2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant ~~women~~people unless flight or safety concerns exist.
H-420.962	Perinatal Addiction - Issues in Care and Prevention	Our AMA: (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding ~~women~~people wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding ~~women~~people, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children

H-420.964	Fetal Alcohol Syndrome Educational Program	Our American Medical Association supports informing physicians about Fetal Alcohol Syndrome and the referral and treatment of alcohol abuse by pregnant ~~women~~patients or ~~women~~patients at risk of becoming pregnant.
H-420.968	Universal Hepatitis B Virus (HBV) Antigen Screening for Pregnant ~~Women~~People	It is the policy of our American Medical Association to communicate the available guidelines for testing all pregnant ~~women~~people for HBV infection.
H-420.969	Legal Interventions During Pregnancy	Court Ordered Medical Treatments And Legal Penalties For Potentially Harmful Behavior By Pregnant ~~Women~~Persons: (1) Judicial intervention is inappropriate when a ~~woman~~pregnant patient has made an informed refusal of a medical treatment designed to benefit ~~her~~their fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the ~~woman~~pregnant patient, entails a minimal invasion of ~~her~~their bodily integrity, and would clearly prevent substantial and irreversible harm to ~~her~~their fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases which do not present such exceptional circumstances. (2) The physician's duty is to provide appropriate information, such that the pregnant ~~woman~~patient may make an informed and thoughtful decision, not to dictate the ~~woman's~~patient's decision. (3) A physician should not be liable for honoring a pregnant ~~woman's~~patient's informed refusal of medical treatment designed to benefit the fetus. (4) Criminal sanctions or civil liability for harmful behavior by the pregnant ~~woman~~person toward ~~her~~their fetus are inappropriate.
H-420.972	Prenatal Services to Prevent Low Birthweight Infants	Our American Medical Association encourages all state medical associations and specialty societies to become involved in the promotion of public and private programs that provide education, outreach services, and funding directed at prenatal services for pregnant ~~women~~people, particularly ~~women~~those at risk for delivering low birthweight infants.
H-420.973	Adoption	(2) support and encourage the counseling of ~~women~~people with unintended pregnancies as to the option of adoption.
H-420.978	Access to Prenatal Care	1. Our American Medical Association supports development of legislation or other appropriate means to provide for access to prenatal care for all ~~women~~, with alternative methods of funding, including private payment, third party coverage, and/or
H-420.979	AMA Statement on Family, Medical, and Safe Leave	Our American Medical Association supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid: 1. Medical leave for the employee, including pregnancy, abortion, and stillbirth. 2. Maternity leave for the employee~~mother~~. 3. Leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children. 4. Leave for adoption or for foster care leading to adoption. 5. Safe leave provisions for those experiencing any instances of violence, including but not limited to intimate partner violence, sexual violence or coercion, and stalking.

H-420.998	Obstetrical Delivery in the Home or Outpatient Facility	(3) believes that obstetrical facilities and their staff should recognize the wishes of ~~women~~**patients** and their families within the bounds of sound obstetrical practice; and
H-435.951	Health Court Principles	AMA PRINCIPLES FOR HEALTH COURTS V. Experts Party Expert Witnesses - Health courts should only allow medical expert witnesses to testify if the expert witness is licensed as a doctor of medicine or osteopathy. - An expert witness should be trained and experienced in the same field as the defendant or has specialty expertise in the disease process or procedure performed in the case. - An expert witness should be certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association, or by a board with equivalent standards. - An expert witness should, within five years of the date of the alleged occurrence or omission giving rise to the claim, be in active medical practice in the same field as the defendant, or have devoted a substantial portion of ~~his~~**their**-time teaching at an accredited medical school, or in university-based research in relation to the medical care and type of treatment at issue. - A person who testifies as an expert witness in a health court should be deemed to have a temporary license to practice medicine in the state for the purpose of providing such testimony and should be subject to the jurisdiction of the state medical board.
H-435.973	Report of the Special Task Force on Professional Liability and the Advisory Panel on Professional Liability	(2) Implementation of the "Loser Pays" Rule in Medical Liability Litigation: Responsibility for a prevailing party's legal expenses, including attorney fees, should not be shifted to a losing party in medical liability litigation unless (c) the rule is adopted that no losing party will be required to pay expenses including legal fees that exceed ~~his or her~~**their** own bill for such goods or services; and
H-440.863	Restoring the Independence of the Office of the US Surgeon General	(2) calls for the Office of the United States Surgeon General to be free from the undue influence of politics, and be guided by science and the integrity of ~~his/her~~**their** role as a physician in fulfilling the highest calling to promote the health and welfare of all people.
H-440.898	Recommendations on Folic Acid Supplementation	2. Our AMA will continue to encourage broad-based public educational programs about the need for ~~women~~**people** of child-bearing potential to consume adequate folic acid through nutrition, food fortification, and vitamin supplementation to reduce the risk of NTD.
H-440.970	Nonmedical Exemptions from Immunizations	1. Our American Medical Association believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in ~~his or her~~**their** group and the community at large.
H-470.963	Boxing Safety	(1) Relevant regulatory bodies are encouraged to: (b) develop and enforce standard criteria for referees, ringside officials, and ringside physicians to halt sparring or boxing bouts when a boxer has experienced concussive or subconcussive blows that place ~~him or her~~**them** at imminent risk of more serious injury.
H-470.978	Blood Doping	The AMA believes that a physician who participates in blood doping is deviating from ~~his~~**their** professional responsibility and that blood doping must be considered in the category of unnecessary medical services.
H-470.984	Brain Injury in Boxing	(2) Recommend to all boxing jurisdictions that the ring physician should be authorized to stop any bout in progress, at any time, to examine a contestant and, when indicated, to terminate a bout that might, in ~~his~~**their** opinion, result in serious injury for either contestant.

H-475.997	Same-Day Admission for Elective Surgery	Our American Medical Association accepts the practice of same-day admission for elective surgery, unless this practice is determined to be detrimental to the patient's health by ~~his or her~~their physician. The determination of the advisability of same-day admission and/or outpatient surgery should be based on the judgment of the patient's physician and not solely on prescribed lists of procedures.
H-480.943	Integration of Mobile Health Applications and Devices into Practice	6. Our AMA encourages physicians to alert patients to the potential privacy and security risks of any mHealth apps that ~~he or she~~they prescribe~~s~~ or recommend~~s~~, and document the patient's understanding of such risks
H-485.991	Identification of Physicians by the Media	It is the policy of our AMA to communicate to the media that when a physician is interviewed or provides commentary ~~he or she~~they be specifically identified with the appropriate initials "MD" or "DO" after ~~his or her~~their name; and that others be identified with the appropriate degrees after their names.
H-515.965	Family and Intimate Partner Violence	(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before ~~he or she~~they leave~~s~~ the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course;
H-525.980	Expansion of AMA Policy on Female Genital Mutilation	Our AMA: (3) supports legislation to eliminate the performance of female genital mutilation in the United States and to protect young **girls** and **women** at risk of undergoing the procedure; (4) supports that physicians who are requested to perform genital mutilation on a patient provide culturally sensitive counseling to educate the patient and ~~her~~ family members about the negative health consequences of the procedure, and discourage them from having the procedure performed. Where possible, physicians should refer the patient to social support groups that can help them cope with societal mores;

Appendix B - Policies recommending being retained as written

Policy Number	Title	Policy Language
D-245.994	Infant Mortality	2. Our AMA will work with Congress and the Department of Health and Human Services to improve maternal outcomes through: (a) maternal/infant health research at the NIH to reduce the prevelance of premature births and to focus on obesity research, treatment and prevention; (b) maternal/infant health research and surveillance at the CDC to assist states in setting up maternal mortality reviews; modernize state birth and death records systems to the 2003-recommended guidelines; and improve the Safe Motherhood Program; (c) maternal/infant health programs at HRSA to improve the Maternal Child Health Block grant; (d) comparative effectiveness research into the interventions for preterm birth; (e) disparities research into maternal outcomes, preterm birth and pregnancy-related depression; and (f) the development, testing and implementation of quality improvement measures and initiatives.
H-20.903	HIV/AIDS and Substance Use	4. Our AMA urges development of educational, medical, and social support programs for persons who inject drugs and their sexual or needle-sharing partners to reduce risk of HIV infection, as well as risk of other bloodborne and sexually transmissible diseases. Such efforts must target a. pregnant people who inject drugs and those who may become pregnant to address the current and future health care needs of both mothers and newborns and
H-20.922	HIV/AIDS as a Global Public Health Priority	6. Our AMA, in coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods.
H-60.973	Provision of Health Care and Parenting Classes to Adolescent Parents	1. It is the policy of our American Medical Association: a. to encourage state medical and specialty societies to seek to increase the number of adolescent parenting programs within school settings which provide health care for infant and mother, and child development classes in addition to current high school courses; and
H-75.987	Reducing Unintended Pregnancy	Our AMA: (1) urges health care professionals to provide care for women of reproductive age, to assist them in planning for pregnancy and support age-appropriate education in esteem building, decision-making and family life in an effort to introduce the concept of planning for childbearing in the educational process;
H-245.982	AMA Support for Breastfeeding	1. Our AMA: (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places. 2. Our AMA: (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services;

		3. Our AMA: (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period. 5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines.
H-295.890	Medical Education and Training in Women's Health	1. Our American Medical Association encourages the coordination and synthesis of the knowledge, skills, and attitudinal objectives related to women's health/gender-based biology that have been developed for use in the medical school curriculum. Medical schools should include attention to women's health throughout the basic science and clinical phases of the curriculum. 2. Our AMA does not support the designation of women's health as a distinct new specialty. 3. Our AMA supports that each specialty should define objectives for residency training in women's health, based on the nature of practice and the characteristics of the patient population served. 4. Our AMA supports surveys of undergraduate and graduate medical education, conducted by the AMA and other groups, should periodically collect data on the inclusion of women's health in medical school and residency training. 5. Our AMA encourages the development of a curriculum inventory and database in women's health for use by medical schools and residency programs. 6. Our AMA encourages physicians to include continuing education in women's health/gender-based biology as part of their continuing professional development. 7. Our AMA encourages its representatives to the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education (ACGME), and the various ACGME Review Committees to promote attention to women's health in accreditation standards. 8. Our AMA will work with the ACGME to protect patient access to important reproductive health services by advocating for all family medicine residencies to provide comprehensive women's health, including training in contraceptive counseling, family planning, and counseling for unintended pregnancy. 9. Our AMA encourages the ACGME to ensure clarity when making revisions to the educational requirements and expectations of family medicine residents in comprehensive women's health topics.
H-420.970	Treatment Versus Criminalization - Physician Role in Drug Addiction During Pregnancy	(2) to forewarn the U.S. government and the public at large that there are extremely serious implications of drug addiction during pregnancy and there is a pressing need for adequate maternal drug treatment and family supportive child protective services; (3) to oppose legislation which criminalizes maternal drug addiction or requires physicians to function as agents of law enforcement - gathering evidence for prosecution rather than provider of treatment; and (4) to provide concentrated lobbying efforts to encourage legislature funding for maternal drug addiction treatment rather than prosecution, and to encourage state and specialty medical societies to do the same.

H-420.971	Infant Victims of Substance Abuse	It is the policy of the AMA: (1) to develop educational programs for physicians to enable them to recognize, evaluate and counsel women of childbearing age about the impact of substance use disorders on their children; and (2) to call for more funding for treatment and research of the long-term effects of maternal substance use disorders on children.
H-420.976	Alcohol and Other Substance Abuse During Pregnancy	(3) encourages intensified research into the physical and psychosocial aspects of maternal substance abuse as well as the development of efficacious prevention and treatment modalities.
H-420.995	Medical Care for Indigent and Culturally Displaced Obstetrical Patients and Their Newborns	Our AMA (1) reaffirms its long-standing position regarding the major importance of high-quality obstetrical and newborn care by qualified obstetricians, family physicians, and pediatricians and the need to make such care available to all women and newborns in the United States; (3) favors continuing discussion of means for improving maternal and child health services for the medically indigent and the culturally displaced.
H-425.976	Preconception Care	1. Our American Medical Association supports the 10 recommendations developed by the Centers for Disease Control and Prevention for improving preconception health care that state: 1. Individual responsibility across the lifespan--each woman, man, and couple should be encouraged to have a reproductive life plan. 2. Preventive visits--as a part of primary care visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes. 3. Interventions for identified risks--increase the proportion of women who receive interventions as follow-up to preconception risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact). 4. Inter-conception care--use the inter-conception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth). 5. Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and pre-conception and inter-conception care. 6. Public health programs and strategies--integrate components of pre-conception health into existing local public health and related programs, including emphasis on inter-conception interventions for women with previous adverse outcomes. 2. Our AMA supports the education of physicians and the public about the importance of preconception care as a vital component of a woman's reproductive health. 3. Our AMA supports the use of pregnancy intention screening and contraceptive screening in appropriate women and men as part of routine well-care and recommend it be appropriately documented in the medical record.
H-430.986	Health Care While Incarcerated	8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.

H-430.990	Bonding Programs for **Women** Prisoners and their Newborn Children	Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, Our American Medical Association supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. However, since there are established benefits of breast milk for infants and breast milk expression for mothers, the AMA advocates for policy and legislation that extends the right to breastfeed directly and/or privately pump and safely store breast milk to include incarcerated mothers. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of incarcerated females who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills and breastfeeding/breast pumping training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children.
H-525.991	Inclusion of Women in Clinical Trials	Our AMA: (1) encourages the inclusion of women, including pregnant women when appropriate, in all research on human subjects, except in those cases for which it would be scientifically irrational, in numbers sufficient to ensure that results of such research will benefit both men and women alike;