Informational Reports

BOT Report(s)

03 2021 Grants and Donations
05 Update on Corporate Relationships
06 Redefining AMA's Position on ACA and Healthcare Reform
07 AMA Performance, Activities and Status in 2021
08 Annual Update on Activities and Progress in Tobacco Control: March 2021 through February 2022
10 American Medical Association Center for Health Equity Annual Report
12 Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent
19 Demographic Report of the House of Delegates and AMA Membership

CEJA Opinion(s)

01 Amendment to E-1.1.6, Quality
02 Amendment to E-1.2.11, Ethical Innovation in Medical Practice
03 Amendment to E-11.1.2, Physician Stewardship of Health Care Resources
04 Amendment to E-11.2.1, Professionalism in Health Care Systems

CEJA Report(s)

05 Pandemic Ethics and the Duty of Care (D-130.960)
06 Judicial Function of the Council on Ethical and Judicial Affairs - Annual Report

Report of the Speakers

01 Recommendations for Policy Reconciliation

REPORT OF THE BOARD TRUSTEES

B of T Report 3-A-22

Subject: 2021 Grants and Donations

Presented by: Bobby Mukkamala, MD, Chair

This informational financial report details all grants or donations received by the American Medical Association during 2021.

American Medical Association
Grants & Donations Received by the AMA
For the Year Ended December 31, 2021
Amounts in thousands

Funding Institution	Project	Amount Received
Agency for Healthcare Research and Quality (subcontracted through RAND Corporation)	Health Insurance Expansion and Physician Distribution	$ 25
Centers for Disease Control and Prevention (subcontracted through American College of Preventive Medicine)	Building Healthcare Provider Capacity to Screen, Test, and Refer Disparate Populations with Prediabetes	227
Centers for Disease Control and Prevention (subcontracted through American College of Preventive Medicine)	Improving Minority Physician Capacity to Address COVID-19 Disparities	104
Centers for Disease Control and Prevention (subcontracted through National Association of Community Health Centers, Inc.)	Preventing Heart Attacks and Strokes in Primary Care	304
Centers for Disease Control and Prevention	Engaging Physicians to Strengthen the Public Health System and Improve the Nation's Public Health	100
Centers for Disease Control and Prevention	National Healthcare Workforce Infection Prevention and Control Training Initiative Healthcare Facilities	1,000
Centers for Disease Control and Prevention	Promoting HIV, Viral Hepatitis, STDs, and LTBI Screening in Hospitals, Health Systems, and Other Healthcare Settings	187
Health Resources and Services Administration (subcontracted through American Heart Association)	National Hypertension Control Initiative: Addressing Disparities Among Racial and Ethnic Minority Populations	38
Substance Abuse and Mental Health Services Administration (subcontracted through American Academy of Addiction Psychiatry)	Providers Clinical Support System Medicated Assisted Treatment	23
Government Funding		**2,008**
American Chemical Society	International Congress On Peer Review and Scientific Publication	20
American Heart Association, Inc.	Target: Blood Pressure Initiative	132
The Physicians Foundation, Inc.	American Conference on Physician Health	20
The Physicians Foundation, Inc.	Practice Transformation Initiative: Solutions to Increase Joy in Medicine	40
Nonprofit Contributors		**212**
Total Grants and Donations		**$ 2,220**

REPORT OF THE BOARD OF TRUSTEES

B of T Report 5-A-22

Subject: Update on Corporate Relationships

Presented by: Bobby Mukkamala, MD, Chair

PURPOSE

The purpose of this informational report is to update the House of Delegates (HOD) on the results of the Corporate Review process from January 1 through December 31, 2021. Corporate activities that associate the American Medical Association (AMA) name or logo with a company, non-Federation association or foundation, or include commercial support, currently undergo review and recommendations by the Corporate Review Team (CRT) (Appendix A).

BACKGROUND

At the 2002 Annual Meeting, the HOD approved revised principles to govern the American Medical Association's (AMA) corporate relationships, HOD Policy G-630.040 "Principles on Corporate Relationships." These guidelines for American Medical Association corporate relationships were incorporated into the corporate review process, are reviewed regularly, and were reaffirmed at the 2012 Annual Meeting. AMA managers are responsible for reviewing AMA projects to ensure they fit within these guidelines.

YEAR 2021 RESULTS

In 2021, 95 new activities were considered and approved through the Corporate Review process. Of the 95 projects recommended for approval, 52 were conferences or events, 13 were educational content or grants, 22 were collaborations or affiliations, six were member programs, one was an AMA Innovations, Inc. program, and one was an American Medical Association Foundation (AMAF) program. See Appendix B for details.

CONCLUSION

The Board of Trustees (BOT) continues to evaluate the CRT review process to balance risk assessment with the need for external collaborations that advance the AMA's strategic focus.

Appendix A

CORPORATE REVIEW PROCESS OVERVIEW

The Corporate Review Team (CRT) includes senior managers from the following areas: Strategy, Finance, Health Solutions Group (HSG), Advocacy, Federation Relations, Office of the General Counsel, Medical Education, Publishing, Ethics, Enterprise Communications (EC), Marketing and Member Experience (MMX), Center for Health Equity, and Health and Science.

The CRT evaluates each project submitted to determine fit or conflict with AMA Corporate Guidelines, covering:

- Type, purpose and duration of the activity;
- Audience;
- Company, association, foundation, or academic institution involved (due diligence reviewed);
- Source of external funding;
- Use of the AMA logo;
- Editorial control/copyright;
- Exclusive or non-exclusive nature of the arrangement;
- Status of single and multiple supporters; and
- Risk assessment for AMA.

The CRT reviews and makes recommendations regarding the following types of activities that utilize AMA name and logo:

- Industry-supported web, print, or conference projects directed to physicians or patients that do not adhere to Accreditation Council for Continuing Medical Education (ACCME) Standards and Essentials.

- AMA sponsorship of external events.

- Independent and company-sponsored foundation supported projects.

- AMA licensing and publishing programs. (These corporate arrangements involve licensing AMA products or information to corporate or non-profit entities in exchange for a royalty and involve the use of AMA's name, logo, and trademarks. This does not include database or Current Procedural Terminology (CPT ®) licensing.)

- Member programs such as new affinity or insurance programs and member benefits.

- Third-party relationships such as joint ventures, business partnerships, or co-branding programs directed to members.

- Non-profit association collaborations outside the Federation. The CRT reviews all non-profit association projects (Federation or non-Federation) that involve corporate sponsorship.

- Collaboration with academic institutions in cases where there is corporate sponsorship.

For the above specified activities, if the CRT recommends approval, the project proceeds.

In addition to CRT review, the Executive Committee of the Board must review and approve CRT recommendations for the following AMA activities:

- Any activity directed to the public with external funding.
- Single-sponsor activities that do not meet ACCME Standards and Essentials.
- Activities involving risk of substantial financial penalties for cancellation.
- Upon request of a dissenting member of the CRT.
- Any other activity upon request of the CRT.

All Corporate Review recommendations are summarized annually for information to the Board of Trustees (BOT). The BOT informs the HOD of all corporate arrangements at the Annual Meeting.

Appendix B

SUMMARY OF CORPORATE REVIEW
RECOMMENDATIONS FOR 2021

Project No.	Project Description	Corporations	Approval Date
CONFERENCES/EVENTS			
11126	**2021 Erie Neighborhood House Virtual Dinner –** Sponsorship with AMA name and logo.	Erie Neighborhood House Cigna John Burns Construction Company ComEd (Commonwealth Edison) Allstate Insurance Company Madigan Family Foundation Teamsters Local 708 VistaNational Insurance Group, Inc. Transportation and Logistics Advisors, LLC	1/13/2021
11137	**Minority Health Institute (MHI) Virtual Town Hall –** Sponsorship with AMA name and logo.	Minority Health Institute (MHI), Inc. UCLA (University of California Los Angeles) BRITE Center for Science	1/13/2021
15150	**AAPC HEALTHCON 2021 –** Repeat sponsorship with AMA name and logo.	AAPC (American Academy of Professional Coders) Health Conference	2/9/2021
15157	**March of Dimes Gala –** Sponsorship with AMA name and logo.	March of Dimes Samsung Electronics Co., Ltd NACDS (National Association of Chain Drug Stores) Foundation Chevron Corporation Comcast NBC (National Broadcast Company) Universal Southern Company Abbott Laboratories Aflac, Inc. Blue Cross Blue Shield Association GM (General Motors Company) National Restaurant Association Volkswagen BGR (Barbour, Griffith & Rogers) Group	2/24/2021
15190	**Black Men in White Coats –** Sponsorship of documentary screening with AMA name and logo.	Black Men in White Coats United States Navy United States Army Doximity Foundation	2/8/2021

		American Association of Colleges of Osteopathic Medicine DoctorDale Agency LLC DiverseMedicine Inc.	
15245	**Becker's Webinar –** Sponsorship and co-branding with AMA name and logo.	Becker's Hospital Review	3/2/2021
15299	**American Health Information Management Association (AHIMA) Middle East 2021 –** Sponsorship of virtual event with AMA name and logo.	American Health Information Management Association (AHIMA) SNOMED International Shearwater Health 3M (formerly Minnesota Mining and Manufacturing Company) Health AccuMed	2/16/2021
15394	**Life Sciences Intelligence (LSI) Emerging Medtech Summit 2021 –** Sponsorship of virtual event with AMA name and logo.	Life Sciences Intelligence, Inc. (LSI) BioQuest Alira Health Access Strategy Partners, Inc. Triple Ring Technologies PRIA Healthcare Miraki Innovation	3/5/2021
15419	**Women Business Leaders Foundation (WBL) Annual Summit 2021 –** Repeat sponsorship with AMA name and logo.	Women Business Leaders Foundation (WBL) Amgen, Inc. Anthem, Inc. McKesson Corporation Tivity Health, Inc. Epstein Becker Green, PC Medecision	2/26/2021
15638	**National Association of Black Journalists Convention (2021) –** Repeat sponsorship with AMA name and logo.	National Association of Black Journalists (NABJ) American Heart Association AARP (American Association of Retired Persons) The Commonwealth Fund Barstool Sports ETS (Educational Testing Service) / GRE (Graduate Record Examinations) Gannett Co., Inc. Amazon Prime Video/"The Boys" series (Amazon.com, Inc.) Spotify Walt Disney World Warner Brothers Entertainment Inc. Wells Fargo	3/19/2021

15787	**Digital Health Canada Webinar 2021 –** Participation with AMA name and logo.	Digital Health Canada	4/20/2021
15819	**Reckoning with Organized Medicine's History of Racism Webinar –** Sponsorship with AMA name and logo.	Robert Wood Johnson Foundation W.K. (Will Keith) Kellogg Foundation	4/14/2021
15822	**IAIABC Forum 2021 –** Sponsorship of virtual event with AMA name and logo.	International Association of Industrial Accident Boards and Commissions (IAIABC) Insurance Services Office, Inc. (ISO) National Council on Compensation Insurance (NCCI) The Black Car Fund Safety National	4/12/2021
15873	**UCSF Digital Health Equity Summit –** Sponsorship of virtual event with AMA name and logo.	UCSF (University of California, San Francisco) Digital Health Equity Summit Center for Care Innovations Health Tech 4 Medicaid Health Equity Ventures Social Innovation Ventures Health Net, LLC United States of Care	4/15/2021
15902	**TSMSS 44th Educational Conference and Exhibition –** Sponsorship of virtual event with AMA name and logo.	Texas Society for Medical Services Specialists (TSMSS) IntelliCentrics MD-Staff PreCheck	4/27/2021
15983	**CAMSS 50th Annual Educational Forum –** Sponsorship of virtual event with AMA name and logo.	CAMSS (California Association of Medical Staff Services)	5/7/2021
15998	**CPT/Arab Health 2021 Online Showcase –** Sponsorship of virtual event with AMA name and logo.	Arab Health Informa PLC Drager Turkish Healthcare B. Braun Medical Inc. Malaysia Rubber Council (MRC) Shinva Medical Instrument Co., LTD Purell GOJO Industries, Inc.	5/19/2021

16058	**Rush University Medical Center - 2021 Virtual Westside Walk for Wellness Initiative –** Sponsorship with AMA name and logo.	Rush University Medical Center	5/13/2021
16065	**Genetic Health Information Network Summit (GHINS) 2021 –** Repeat sponsorship with AMA name and logo.	Concert Genetics, Inc. Genome Medical, Inc. Genetic Health Information Network Summit	6/15/2021
16113	**ATA Annual Conference 2021 –** Repeat sponsorship of virtual event with AMA name and logo.	ATA (American Telemedicine Association) Amwell (American Well) Zoom Video Communications, Inc. Deloitte eVisit Ziegler (B.C. Ziegler and Company) Teledoc Health, Inc. TytoCare Cisco VMware, Inc. Doximity	5/21/2021
16278	**AMA Research Challenge 2021 –** AMA branded virtual event with Laurel Road sponsored prize.	Laurel Road	6/21/2021
16321	**Society for Human Resource Management Conference –** Event exhibit with AMA name and logo.	Society for Human Resource Management (SHRM)	6/14/2021
16353	**National Lesbian and Gay Journalists Association (NLGJA) Conference –** Repeat sponsorship of virtual event with AMA name and logo.	AARP (American Association of Retired Persons) The Points Guy, LLC WarnerMedia News & Sports The Coca-Cola Company JetBlue Airways Prudential Financial Inc. Knight Foundation (John S. and James L.) Meredith Corporation Craig Newmark Philanthropies PhRMA (Pharmaceutical Research and Manufacturers of America) FOX Walton Family Foundation Pulitzer Center Google News Lab SAG-AFTRA (Screen Actors Guild – American Federation of Television and Radio Artists)	6/22/2021

		TEGNA, Inc. McClatchy Amida Care	
16354	**Exhibit at Becker's Hospital Review 12th Annual CEO & CFO Roundtable –** Event exhibit with AMA name and logo.	Becker's Healthcare Becker's Hospital Review	7/28/2021
16355	**Becker's Hospital Review 12th Annual CEO & CFO Roundtable –** Sponsorship of virtual event with AMA name and logo.	Becker's Healthcare Becker's Hospital Review	7/28/2021
16401	**73rd Annual SAWCA Conference (2021) –** Sponsorship with AMA name and logo.	Southern Association of Workers' Compensation Administrators (SAWCA) ISO (Insurance Services Office)/Verisk Analytics, Inc. NCCI (National Council on Compensation Insurance) Holdings, Inc. Safety National Trean Corporation Sedgwick UBS Bank (Union Bank of Switzerland) Optum, Inc. ODG an MCG Health Company Akera Claims Solutions Brentwood Services, Inc. Rehabilitation Advisors Concentra, Inc.	6/28/2021
16575	**HIMSS 2021 "Lunch & Learn" Conference –** Repeat sponsorship with AMA name and logo.	HIMSS (Healthcare Information and Management Systems Society)	7/16/2021
16579	**SNOMED Virtual Clinical Terms (CT) Expo 2021 –** Repeat sponsorship of virtual event with AMA name and logo.	Systematized Nomenclature of Medicine (SNOMED) International SNOMED Clinical Terms (CT)	7/21/2021
16621	**Becker's 2021 Virtual Executive Roundtable –** Sponsorship of hybrid event with AMA name and logo.	Becker's Healthcare Change Healthcare Olive Cerner Grant Thornton LLP Altair Engineering, Inc. Caregility	7/29/2021

16795	**Reckoning with Racism Project – Social Determinants of Health Symposium –** Sponsorship of event with AMA name and logo.	Modern Healthcare W.K. (Will Keith) Kellogg Foundation Robert Wood Johnson Foundation American Academy of Pediatrics American Psychiatric Association (APA) Becker's Hospital Review	8/12/2021
16825	**Modern Healthcare's Virtual Briefing –** Sponsorship with AMA name and logo.	Modern Healthcare Podium Corp Inc. Ontrak, Inc. PwC (PricewaterhouseCoopers) Abbott Bristol Myers Squibb VirtualMed Staff LetsGetChecked	8/17/2021
16828	**Telehealth Awareness Week Immersion Program –** Hosting of virtual bootcamp with AMA name and logo.	American Telemedicine Association (ATA)	8/16/2021
16836	**Military Veterans in Journalism (MVJ) Convention –** Sponsorship of virtual event with AMA name and logo.	Military Veterans in Journalism Poynter Institute National Association of Hispanic Journalists (NAHJ) The National Press Club CNN (Cable News Network) With Honor DAV (Disabled American Veterans) Wyncote The Washington Post Verizon Media Knight Knight Stanford Fox News Facebook FourBlock Scripps	8/27/2021
16839	**Midwest LGBTQ Health Symposium –** Repeat sponsorship of virtual event with AMA name and logo.	Howard Brown Health	8/20/2021
16860	**Stanford Byers Center for Biodesign Webinar –** Sponsorship of virtual CPT event with AMA name and logo.	Stanford Byers Center for Biodesign Fogarty Innovation Wilson Sonsini Goodrich & Rosati Medical Device Manufacturers Association (MDMA) Silicon Valley Bank	8/25/2021

16861	**AHIMA 2021 Conference –** Repeat sponsorship of virtual event with AMA name and logo.	American Health Information Management Association (AHIMA) 3M (formerly Minnesota Mining and Manufacturing Company) Ciox Iodine	8/26/2021
16983	**Current Procedural Terminology (CPT) and Resource-Based Relative Value Scale (RBRVS) 2022 Annual Symposium –** Vendors and virtual exhibitors acknowledgement.	The Second City, Inc. The DJ Firm Grubhub AAPC (American Academy of Professional Coders) AHCAE (Association of Health Care Auditors and Educators) AHIMA (American Health Information Management Association) Find-a-Code Haugen Consulting Group Optum, Inc. Association of Health Care Auditors and Educators (AHCAE) American Health Information Management Association (AHIMA)	9/14/2021
17037	**AdvaMed MedTech Conference Sponsorship –** Sponsorship of hybrid event with AMA name and logo.	AdvaMed Abbott BD (Becton, Dickinson and Company) IQVIA Johnson & Johnson Services, Inc. Medtronic	9/15/2021
17068	**NAMSS 45th Annual Educational Virtual Conference and Exhibition (2021) –** Repeat sponsorship with AMA name and logo.	NAMSS (National Association Medical Staff Services) VerityStream PreCheck MD-Staff Symplr AOA Profiles Acorn Credentialing	9/17/2021
17080	**Securing Health in a Troubled Time: A National Conversation on Health Inequities - Forum –** Sponsorship with AMA name and logo.	The Hastings Center Association of American Medical Colleges United States Department of Veterans Affairs	9/27/2021
17095	**Pride South Side Festival 2021 –** Sponsorship with AMA name and logo.	Pride South Side (PSS) Public Health Institute of Metropolitan Chicago (PHIMC) Howard Brown Health Blue Cross Blue Shield	9/23/2021

		The Chicago Community Trust Chicago Department of Public Health Molson Coors Beverage Company Comcast Diageo Walgreens Co. Sidetrack Chicago (Side By Side, Inc.) AIDS Foundation Chicago (AFC) Equality Illinois The DuSable Museum of African American History, Inc.	
17101	**Health Equity "Basecamp" Leadership Program –** Co-branding workshop with AMA name and logo.	Groundwater Institute (GWI) Racial Equity Institute (REI) Impactive Consulting American Diabetes Association (ADA)	9/21/2021
17172	**2021 National Addiction Treatment Week (NATW) Campaign –** Repeat sponsorship with AMA name and logo.	American Society for Addiction Medicine Association of American Medical Colleges (AAMC) American College of Academic Addiction Medicine American Osteopathic Academy of Addiction Medicine American Society of Addiction Medicine (ASAM) Michigan Cares National Institute on Drug Abuse MED National Institute on Alcohol Abuse and Alcoholism University of California San Francisco (UCSF) Smoking Cessation Leadership Center	9/29/2021
17176	**AMA/AHIMA Outpatient Clinical Documentation Improvement Workshop –** Repeat virtual event with AMA name and logo.	AHIMA (American Health Information Management Association)	9/28/2021
17186	**NAHDO Annual Conference –** Sponsorship of hybrid event with AMA name and logo.	National Association of Health Data Organizations (NAHDO) California Health Care Foundation Milliman MedInsight BerryDunn (Berry, Dunn, McNeil & Parker, LLC) Comagine Health Peterson Center on Healthcare HCup (Healthcare Cost and Utilization Project) Mathematica	9/30/2021

		Mercer NORC at University of Chicago Symphony Care, LLC	
17246	**AMA Support for National Physician Suicide Awareness Day** – Sponsorship with AMA name and logo.	American Academy of Physical Medicine and Rehabilitation Accreditation Council for Graduate Medical Education Ada County Medical Society Akerman Med Alaska State Medical Association American Society of Suicidology American Medical Women's Association Association of Academy Physiatrists Creative Artists Agency California Academy of Family Physicians California Medical Association Carolina Urology Partners Connecticut State Medical Society Dr. Lorna Breen Heroes' Foundation Federation of State Physician Health Programs First Responders First Florida Medical Association Nebraska Medical Association Louisiana State Medical Society Medical Association of Georgia Chattanooga-Hamilton County Medical Society Medical Society of the District of Columbia Medical Society of New Jersey The Medical Society of Northern Virginia Medical Society of the State of New York Medical Society of Virginia The Memphis Medical Society Minnesota Medical Association MN Mental Health Advocates Montgomery County Medical Society National Capital Physicians Foundation Nebraska Health Network New Mexico Medical Society North Carolina Osteopathic Medical Association North Carolina Medical Society North Carolina Society of Osteopathic Family Physicians North Carolina Rheumatology Association Northwell Health NYC (New York City) Health + Hospitals	10/5/2021

		PBI (Professional Boundaries, Inc.) Education South Carolina Medical Association Society for Academic Emergency Medicine Strelcheck Healthcare Search Tennessee Medical Association Texas Medical Association Thalia's Medicine Thrive Global Vermont Medical Society Volunteers of America Washington State Medical Association Western Carolina Medical Society	
17349	**Lakeview Pantry Fighting Hunger, Feeding Hope Event –** Sponsorship with AMA name and logo.	Lakeview Pantry IMC (International Marketmaker's Combination) Kovitz Grubhub Huntington Bank Feinberg Foundation Purposeful Wealth Advisors Wintrust (Wintrust Financial Corp.) Kirkland & Ellis LLP CBRE CUBS/Cubs Charities CIBC (Canadian Imperial Bank of Commerce) TDS (Telephone and Data Systems) Advocate/IMMC (Illinois Masonic Medical Center) Asutra	10/7/2021
17469	**2021 Gulf Cooperation Council (GCC) eHealth Workforce Development Conference –** Sponsorship with AMA name and logo.	3M (formerly Minnesota Mining and Manufacturing Company) Think Research Elsevier Philips Healthcare InterSystems Orion Health HIMSS (Healthcare Information and Management Systems Society)	10/19/2021
17522	**Latino Policy Forum 2021 Virtual Luncheon –** Sponsorship with AMA name and logo.	Latino Policy Forums Virtual Policy Illinois Unidos Healthy Communities Foundation Walgreens Co. ADM (Archer Daniels Midland)	10/25/2021

		PNC Bank (Pittsburgh National Corporation/Provident National Corporation) Edwardson Family Foundation Allstate Insurance Company ComEd (Commonwealth Edison) JP Morgan Chase BMO Harris BCBS IL (Blue Cross and Blue Shield of Illinois) Erie Health Centers Peoples Gas FHL Bank (Federal Home Loan) Steams Family Foundation Pierce Family Foundation Rush University Medical Center ABC (American Broadcasting Company) State Farm Mutual Automobile Insurance Company Irving Harris	
17613	**Release the Pressure (RTP) with GirlTrek –** Collaboration for virtual event with AMA name and logo.	GirlTrek	11/3/2021
17856	**2022 International Conference on Physician Health (ICPH) –** Sponsorship with AMA name and logo.	British Medical Association Canadian Medical Association	11/22/2021
18209	**MedTech Color Collaborative –** Sponsorship with AMA name and logo for coalition addressing minority health issues and medical device research and development.	MedTech Color California Health Care Foundation Olympus Health+Commerce Ximedica ResMed Johnson & Johnson Services, Inc.	12/15/2021

EDUCATIONAL CONTENT OR GRANTS

4799	**Centering Equity in Emergency Response – A Guide for Healthcare Professionals and Organizations –** Updated organizations for co-branded content.	Planned Parenthood Federation of America (PPFA) American College of Preventive Medicine America's Essential Hospitals American Association of Public Health Physicians American Public Health Association National Birth Equity Collaborative East Boston Neighborhood Health Center	3/19/2021

11095	**Health System Science (HSS) Podcast Series –**Acknowledgement with AMA name and logo.	InsideTheBoards, LLC Ars Longa Media (The Ars Longa Group, LLC)	1/15/2021
11124	**Collaboration with HealthBegins, LLC –** Hosting of health equity educational activities on AMA Ed Hub.	HealthBegins, LLC Blue Shield of California	5/21/2021
13174	**AMA Return on Health Research –** Co-branded white papers on telehealth adoption.	Manatt Health (Manatt, Phelps & Phillips, LLP)	1/26/2021
15247	**Becker's Whitepaper –** AMA co-branding and sponsorship of Joy in Medicine whitepaper.	Becker's Healthcare Review	3/2/2021
15662	**COVID Black Educational Modules –** Co-branding with AMA name and logo.	COVID Black, LLC	4/1/2021
15686	**Edge-U-Cate 2021 Credentialing School Program –** Repeat sponsorship with AMA name and logo.	Edge-U-Cate, LLC ABMS Solutions/Certi-FACTS American Osteopathic Information Association (AOIA)	3/30/2021
16176	**AMA / AAMC Guide to Language, Narrative, and Concepts –** Co-branding of "Guide to Language, Narrative, and Concepts"	Association of American Medical Colleges (AAMC)	6/3/2021
16457	**THE CONTAGION NEXT TIME by Sandro Galea –** Book quote from Dr. Aletha Maybank.	The Contagion Next Time (Book)	7/7/2021
16489	**Alliance for Continuing Education in the Health Professions –** Participation in council with AMA name and logo.	Alliance for Continuing Education in the Health Professions Continuing Education for Health Professionals (CEHp) Partners' Council	7/8/2021
16532	**ASAM Opioid Use Disorder Educational Activity –** Sponsorship with AMA name and logo.	American Society Addiction Medicine (ASAM) Shatterproof	7/9/2021
17036	**AMA/CAQH Provider Directory White Paper –** Co-branded white paper with AMA name and logo.	CAQH (Council for Affordable Quality Healthcare)	9/15/2021

17792	**Health Begins/Patient Social Risk, Equity, & Coding –** Co-branded 2021 E/M Coding Guidelines Ed Hub module.	Health Begins, LLC	11/29/2021

COLLABORATIONS/AFFILIATIONS

15152	**"Principles for the Use of Funds from the Opioid Litigation" Policy Report –** Support and AMA name and logo use with Federation members, universities, and nonprofits.	Johns Hopkins Bloomberg School of Public Health American College of Academic Addiction Medicine American Society of Addiction Medicine American College of Emergency Physicians American Academy of Addiction Psychiatry International Society of Addiction Medicine Shatterproof Partnership to End Addiction Community Anti-Drug Coalitions of America Legal Action Center (LAC) Harm Reduction Coalition National Council for Behavioral Health Margolis Center for Health Policy--Duke University Doris Duke Charitable Foundation Columbia University Department of Epidemiology Columbia PHIOS (Policy and Health Initiatives on Opioids and Other Substances) Interdisciplinary Initiative Grayken Center for Addiction Medicine, Boston Medical Center Yale Department of Addiction Medicine Boston University School of Public Health University of Southern California Institute of Addiction Sciences	2/8/2021
15170	**Human Rights Campaign's Project THRIVE –** Collaboration for national LGBTQ equity campaign with AMA name and logo.	Human Rights Campaign (HRC)	6/1/2021
15212	**Chicago Area Public Affairs Group 2021 –** Repeat sponsorship with AMA name and logo.	Chicago Area Public Affairs Group (CAPAG) Conlon and Dunn Public Affairs Cozen O'Conner Public Strategies Electrical Contractors' Association Fooda, Inc. Strategia	2/3/2021

15473	**HL7 Benefactor 2021 –** Repeat membership in global healthcare standards organization with AMA name and logo use.	HL7 (Health Level Seven International)	3/3/2021
15691	**All In: Well-Being First For Healthcare Campaign –** Collaboration with professional well-being program with AMA name and logo.	American Hospital Association American Nurses Association Association of American Medical Colleges Schwartz Center for Compassionate Health Care Dr. Lorna Breen Heroes Foundation Thrive Global Foundation CAA (Creative Artists Agency) Foundation	4/6/2021
15732	**Made to Save Public Education Campaign –** Collaboration to promote COVID-19 vaccination with AMA name and logo.	Made to Save (Civic Nation)	4/1/2021
15856	**Improving Health Outcomes (IHO) Self-Measured Blood Pressure Pilot –** Collaboration to increase adoption of patient blood pressure self-monitoring with AMA name and logo.	Ascension Columbia St Mary's Hospital	5/5/2021
15863	**Improving Health Outcomes (IHO) Collaboration with Health Care Organizations (HCOs) (2021) –** AMA name and logo use alongside these HCOs for hypertension prevention strategies and quality improvement programs.	Mercy Northwest Arkansas, AR University of Colorado Health (Poudre Valley), CO UTMB (University of Texas Medical Branch) Health UT (University of Texas) Physicians Henry Ford Macomb, MI Wilson Value Drug, NC Young Men's Christian Association of Greater St. Petersburg Inc, FL Tampa Metropolitan Area Young Men’s Christian Association, Inc., FL Young Men's Christian Association of the Suncoast; Inc., Fl YMCA (Young Men’s Christian Association) of Delaware, DE Whatley Health Services, Inc., AL Medical University Hospital Authority, SC Long Island Community Hospital, NY Novant Health, NC Mission Health, NC Atrium - The Charlotte-Mecklenburg Hospital	4/22/2021

		Authority d/b/a Atrium Health, Charlotte, NC Wake Forest Baptist, NC Prisma Health	
16055	**Release the Pressure (RTP) Collaboration –** To support heart health and self-monitoring blood pressure (SMBP) in a virtual event with AMA.	Alpha Kappa Alpha Sorority	5/11/2021
16095	**Collaboration with AHA Foundation –** Hosting of health equity educational activities with AMA name and logo.	AHA (Ayaan Hirsi Ali) Foundation	5/25/2021
16831	**Joy in Medicine Program –** Organization achievement recognition of health care organizations (HCOs) with AMA name and logo.	Atrium Health Atrius Health Bassett Healthcare Network Bayhealth Medical Center BJC Medical Group Bozeman Health Centra Medical Group Children's Mercy Kansas City Children's Primary Care Medical Group ChristianaCare Christus Physician Group Confluence Health Kootenai Health LCMC (Louisiana Children's Medical Center) Health Massachusetts General Physicians Organization MedStar Health Mercy Medical Group Michigan Medicine, University of Michigan MidMichigan Health New Hanover Regional Medical Center Orlando Health Roswell Park Comprehensive Cancer Center Sanford Health South Georgia Medical Center Spectrum Health (Portand, ME) Spectrum Health (Rockford, MI) SUNY Upstate Medical University Thundermist Health Center UCHealth Southern Region UCHealth University of Colorado Hospital on the Anschutz Medical Campus	8/20/2021

		University of Utah Health	
16916	**Telehealth Academy Program –** Sponsorship with AMA name and logo of program for healthcare providers to integrate telehealth and virtual care into their delivery system.	Telehealth Academy The Nashville Entrepreneur Center Project Healthcare Sage Growth Partners The Disruption Lab	9/2/2021
17000	**Kids' Chance of America (KCA) –** Collaborative co-promotion with AMA Guides to the Evaluation of Permanent Impairment with AMA name and logo.	Kids' Chance of America	9/21/2021
17056	**Health Leaders Marketing Campaign –** Co-branding and promotion of white paper.	HealthLeaders/HCPro	9/17/2021
17200	**MAP (Measure, Act, Partner) Dashboards for Health Care Organizations (HCOs) –** The AMA MAP BP™ Dashboard is an evidence-based quality improvement (QI) program providing sustained improvements in blood pressure (BP) control through monthly reports, tracking data and outcome metrics.	Spectrum Health Lakeland USA Health Better Health Partnership Cedars-Sinai Health System ACCESS Community Health Lexington Health, Inc. Lexington Medical Center Network Rush University Medical Center Medical University Hospital Authority (MUHA) Carolina Family Care, Inc. University Medical Associates of the Medical University of South Carolina Carolina Primary Care Physicians, LLC Medical University of South Carolina (MUSC) Beth Israel Deaconess Medical Center, MA Harvard Medical Faculty Physicians, MA Emory University Hospital, GA	10/1/2021
17603	**Group Channel Partners for AMA MAP Program –** Collaboration with AMA name and logo.	Kansas Primary Care Association - Community Care Network of Kansas Azara Healthcare i2i Population Health Michigan Primary Care Association (MPCA) Health Catalyst, Inc.	11/16/2021

		Wisconsin Primary Health Care Association	
17772	**Telehealth Initiative Joint Communications Agreement –** Collaboration to support telehealth expansion in practices / health systems with AMA name and logo.	Physicians Foundation Iowa Medical Society (IMS) Montana Medical Society (MMS) Medical Society of the State of New York (MSSNY) Academy of Medicine of Cleveland & Northern Ohio (AMCNO) Massachusetts Medical Society (MMS) Texas Medical Association (TMA) Florida Medical Association (FMA)	11/19/2021
17958	**Principles for Equitable Health Innovation Initiative –** AMA name and logo association with collaborators supporting innovative health solutions for marginalized communities.	RockHealth.org i.c.stars (Inner-City Computer Stars Foundation) UCSF (University of California San Francisco) SOLVE Health Tech American Hospital Association HealthTech4Medicaid AdvaMed MedTech Color Telehealth Equity Coalition National Health IT Collaborative for the Underserved Center for Care Innovations Consumer Technology Association American Telehealth Association HLTH, LLC MassChallenge Health Tech MATTER West Coast Consortium for Technology & Innovation in Pediatrics HIMSS (Healthcare Information and Management Systems Society) Node.Health Digital Medicine Society Digital Therapeutics Alliance America's Health Insurance Plans Blue Cross Blue Shield Association Business Group on Health	12/9/2021
18005	**AMA Physician Innovation Network (PIN) Collaborators –** AMA Physician Innovation Network (PIN) collaboration agreements with limited AMA name and logo use.	Nursing Innovation Hub, Inc. (NIHUB) Radical Health	12/3/2021

18125	**Equity Campaign –** Collaboration announcement with AMA name.	Institute for Healthcare Improvement (IHI) American Hospital Association (AHA) Race Forward	12/3/2021
18231	**Current Procedural Terminology (CPT) Webinar –** Promotion of educational webinar with AMA name and logo**.**	Reichman University - Israel Anthem Innovation Israel, Ltd. 8400 – The Health Network Arkin Holdings	12/17/2021
	Glory Skincare – Release the Pressure (RTP) Campaign – Heart health promotion with AMA name.	Glory Skincare	2/2/2021

MEMBER PROGRAMS

15371	**Medline Industries Medical Supplies Affinity Program –** Licensing agreement with AMA name and logo.	Medline Industries, LP	3/12/2021
15696	**Laurel Road Bank Affinity Program –** Addition of two financial products to existing Laurel Road program.	Laurel Road Bank KeyBank (KeyCorp)	4/2/2021
15698	**Laurel Road Bank Membership Promotion –** AMA membership promotion on Laurel Road Bank customer platform with AMA name and logo.	Laurel Road Bank KeyBank (KeyCorp)	4/8/2021
16697	**U.S. Bank National Association Affinity Credit Card Program –** Co-branding with AMA name and logo.	U.S. Bank National Association	8/10/2021
16717	**Volvo Auto Affinity Program –** Licensing agreement with AMA name and logo.	Volvo Car USA, LLC	8/10/2021
	AMA Insurance Agency Supplemental Health Insurance Program with ArmadaCare LLC – Cobranding with AMA Insurance Agency name and logo.	ArmadaCare LLC ArmadaHealth ArmadaGlobal ArmadaCorp Capital Sirius International Insurance Group, Ltd.	2/22/2021

AMA INNOVATIONS INC

15228	**AMA Innovations Inc. License with mmHg, Inc. –** License for customized version of mmHg patient facing application to integrate with AMA Innovations Verifi Health technology platform.	mmHg, Inc.	2/2/2021

AMA FOUNDATION

	American Medical Association Foundation (AMAF) Corporate Donors 2021 – Corporate donors for 2021.	Anthem, Inc. AbbVie, Inc. Amgen, Inc. Bristol-Myers Squibb Eli Lilly Figs, Inc. Genentech GlaxoSmithKline, PLC Henry Schein Merck & Co., Inc. Novartis Pharmaceuticals (Novartis, AG) Pfizer, Inc. PhRMA (Pharmaceutical Research and Manufacturers of America) Sanofi Anthem Foundation	12/16/2021

REPORT OF THE BOARD OF TRUSTEES

B of T Report 6-A-22

Subject: Redefining AMA's Position on ACA and Healthcare Reform

Presented by: Bobby Mukkamala, MD, Chair

At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, "Redefining AMA's Position on ACA and Healthcare Reform," which called on our American Medical Association (AMA) to "develop a policy statement clearly outlining this organization's policies" on several specific issues related to the Affordable Care Act (ACA) as well as repealing the SGR and the Independent Payment Advisory Board (IPAB). The adopted policy went on to call for our AMA to report back at each meeting of the HOD. Board of Trustees Report 6-I-13, "Redefining AMA's Position on ACA and Healthcare Reform," accomplished the original intent of the policy. This report serves as an update on the issues and related developments occurring since the most recent meeting of the HOD.

IMPROVING THE AFFORDABLE CARE ACT

Our AMA continues to engage policymakers and advocate for meaningful, affordable health care for all Americans to improve the health of our nation. Our AMA remains committed to the goal of universal coverage, which includes protecting coverage for the 20 million Americans who acquired it through the ACA. Our AMA has been working to fix the current system by advancing solutions that make coverage more affordable and expanding the system's reach to Americans who fall within its gaps. Our AMA also remains committed to improving health care access so that patients receive timely, high-quality care, preventive services, medications, and other necessary treatments.

Our AMA continues to advocate for policies that would allow patients and physicians to be able to choose from a range of public and private coverage options with the goal of providing coverage to all Americans. Specifically, our AMA has been working with Congress, the Administration, and states to advance our plan to cover the uninsured and improve affordability as included in the "2021 and Beyond: AMA's Plan to Cover the Uninsured." The COVID-19 pandemic has led to many people losing their employer-based health insurance. This has only increased the need for significant improvements to the Affordable Care Act. We also continue to examine the pros and cons of a broad array of approaches to achieve universal coverage as the policy debate evolves.

Our AMA has been advocating for the following policy provisions:

Cover Uninsured Eligible for ACA's Premium Tax Credits

- Our AMA advocates for increasing the generosity of premium tax credits to improve premium affordability and incentivize tax credit eligible individuals to get covered. Currently, eligible individuals and families with incomes between 100 and 400 percent federal poverty level (FPL) (133 and 400 percent in Medicaid expansion states) are being provided with refundable and advanceable premium tax credits to purchase coverage on health insurance exchanges.
- Our AMA has been advocating for enhanced premium tax credits to young adults. In order to improve insurance take-up rates among young adults and help balance the individual health

insurance market risk pool, young adults ages 19 to 30 who are eligible for advance premium tax credits could be provided with "enhanced" premium tax credits—such as an additional $50 per month—while maintaining the current premium tax credit structure which is inversely related to income, as well as the current 3:1 age rating ratio.

- Our AMA also is advocating for an expansion of the eligibility for and increasing the size of cost-sharing reductions. Currently, individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which leads to lower deductibles, out-of-pocket maximums, copayments, and other cost-sharing amounts. Extending eligibility for cost-sharing reductions beyond 250 percent FPL, and increasing the size of cost-sharing reductions, would lessen the cost-sharing burdens many individuals face, which impact their ability to access and afford the care they need.

Cover Uninsured Eligible for Medicaid or Children's Health Insurance Program

Before the COVID-19 pandemic, in 2018, 6.7 million of the nonelderly uninsured were eligible for Medicaid or the Children's Health Insurance Program (CHIP). Reasons for this population remaining uninsured include lack of awareness of eligibility or assistance in enrollment.

- Our AMA has been advocating for increasing and improving Medicaid/CHIP outreach and enrollment, including auto enrollment.
- Our AMA has been opposing efforts to establish Medicaid work requirements. The AMA believes that Medicaid work requirements would negatively affect access to care and lead to significant negative consequences for individuals' health and well-being.

Make Coverage More Affordable for People Not Eligible for ACA's Premium Tax Credits

Before the COVID-19 pandemic, in 2018, 5.7 million of the nonelderly uninsured were ineligible for financial assistance under the ACA, either due to their income, or because they have an offer of "affordable" employer-sponsored health insurance coverage. Without the assistance provided by ACA's premium tax credits, this population can continue to face unaffordable premiums and remain uninsured.

- Our AMA advocates for eliminating the subsidy "cliff," thereby expanding eligibility for premium tax credits beyond 400 percent FPL.
- Our AMA has been advocating for the establishment of a permanent federal reinsurance program, and the use of Section 1332 waivers for state reinsurance programs. Reinsurance plays a role in stabilizing premiums by reducing the incentive for insurers to charge higher premiums across the board in anticipation of higher-risk people enrolling in coverage. Section 1332 waivers have also been approved to provide funding for state reinsurance programs.
- Our AMA also is advocating for lowering the threshold that determines whether an employee's premium contribution is "affordable," allowing more employees to become eligible for premium tax credits to purchase marketplace coverage.

EXPAND MEDICAID TO COVER MORE PEOPLE

Before the COVID-19 pandemic, in 2018, 2.3 million of the nonelderly uninsured found themselves in the coverage gap—not eligible for Medicaid, and not eligible for tax credits because

they reside in states that did not expand Medicaid. Without access to Medicaid, these individuals do not have a pathway to affordable coverage.

- Our AMA has been encouraging all states to expand Medicaid eligibility to 133 percent FPL.

New policy adopted by the AMA HOD during the November 2021 Special Meeting seeks to assist more than 2 million nonelderly uninsured individuals who fall into the "coverage gap" in states that have not expanded Medicaid—those with incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility. The new AMA policy maintains that coverage should be extended to these individuals at little or no cost, and further specifies that states that have already expanded Medicaid coverage should receive additional incentives to maintain that status going forward.

AMERICAN RESCUE PLAN OF 2021

On March 11, 2021, President Biden signed into law the American Rescue Plan (ARPA) of 2021. This legislation included the following ACA-related provisions that will:

- Provide a temporary (two-year) 5 percent increase in the Medicaid FMAP to states that enact the Affordable Care Act's Medicaid expansion and covers the new enrollment period per requirements of the ACA.
- Invest nearly $35 billion in premium subsidy increases for those who buy coverage on the ACA marketplace.
- Expand the availability of ACA advanced premium tax credits (APTCs) to individuals whose income is above 400 percent of the FPL for 2021 and 2022.
- Give an option for states to provide 12-month postpartum coverage under State Medicaid and CHIP.

ARPA represents the largest coverage expansion since the Affordable Care Act. Under the ACA, eligible individuals, and families with incomes between 100 and 400 percent of the FPL (between 133 and 400 percent FPL in Medicaid expansion states) have been provided with refundable and advanceable premium credits that are inversely related to income to purchase coverage on health insurance exchanges. However, consistent with Policy H-165.824, ARPA eliminated ACA's subsidy "cliff" for 2021 and 2022. As a result, individuals and families with incomes above 400 percent FPL ($51,040 for an individual and $104,800 for a family of four based on 2020 federal poverty guidelines) are eligible for premium tax credit assistance. Individuals eligible for premium tax credits include individuals who are offered an employer plan that does not have an actuarial value of at least 60 percent or if the employee share of the premium exceeds 9.83 percent of income in 2021.

Consistent with Policy H-165.824, ARPA also increased the generosity of premium tax credits for two years, lowering the cap on the percentage of income individuals are required to pay for premiums of the benchmark (second-lowest-cost silver) plan. Premiums of the second-lowest-cost silver plan for individuals with incomes at and above 400 percent FPL are capped at 8.5 percent of their income. Notably, resulting from the changes, eligible individuals and families with incomes between 100 and 150 percent of the federal poverty level (133 percent and 150 percent FPL in Medicaid expansion states) now qualify for zero-premium silver plans, effective until the end of 2022. In addition, individuals receiving unemployment compensation who qualify for exchange coverage are eligible for a zero-premium silver plan in 2021.

In addition, individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which reduces their deductibles, out-of-pocket maximums, copayments, and other cost-sharing amounts.

POSSIBLE LEGISLATIVE EXTENSION OF ARPA PROVISIONS

Within an election year and a challenging political environment, it is uncertain whether the Senate and House of Representatives will pass final legislation this year to allow funding for an extension of the aforementioned ACA subsidies included within the ARPA as well as provisions to close the Medicaid "coverage gap" in the States that have not chosen to expand.

ACA ENROLLMENT

According to the U.S. Department of Health and Human Services (HHS), 14.5 million Americans have signed up for or were automatically re-enrolled in the 2022 individual market health insurance coverage through the Marketplaces since the start of the 2022 Marketplace Open Enrollment Period (OEP) on November 1, 2021, through January 15, 2022. That record-high figure includes nearly 2 million new enrollees, many of whom qualified for reduced premiums granted under ARPA.

TEXAS VS. AZAR SUPREME COURT CASE

The Supreme Court agreed on March 2, 2020, to address the constitutionality of the ACA for the third time, granting the petitions for certiorari from Democratic Attorneys General and the House of Representatives. Oral arguments were presented on November 10, 2020, and a decision was expected before June 2021. The AMA filed an amicus brief in support of the Act and the petitioners in this case.

On February 10, 2021, the U.S. Department of Justice under the new Biden Administration submitted a letter to the Supreme Court arguing that the ACA's individual mandate remains valid, and, even if the court determines it is not, the rest of the law can remain intact.

This action reversed the Trump Administration's brief it filed with the Court asking the justices to overturn the ACA in its entirety. The Trump Administration had clarified that the Court could choose to leave some ACA provisions in place if they do not harm the plaintiffs, but as legal experts pointed out, the entire ACA would be struck down if the Court rules that the law is inseparable from the individual mandate—meaning that there would be no provisions left to selectively enforce.

On June 17, 2021, the Supreme Court in a 7-2 decision ruled that neither the states nor the individuals challenging the law have a legal standing to sue. The Court did not touch the larger issue in the case: whether the entirety of the ACA was rendered unconstitutional when Congress eliminated the penalty for failing to obtain health insurance.

With its legal status now affirmed by three Supreme Court decisions, and provisions such as coverage for preventive services and pre-existing conditions woven into the fabric of U.S. health care, the risk of future lawsuits succeeding in overturning the ACA is significantly diminished.

SGR REPEAL

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 repealing and replacing the SGR was signed into law by President Obama on April 16, 2015.

The AMA is now working on unrelated new Medicare payment reduction threats and is currently advocating for a sustainable, inflation-based, automatic positive update system for physicians.

INDEPENDENT PAYMENT ADVISORY BOARD REPEAL

The Bipartisan Budget Act of 2018 signed into law by President Trump on February 9, 2018, included provisions repealing IPAB. Currently, there are not any legislative efforts in Congress to replace the IPAB.

CONCLUSION

Our AMA will remain engaged in efforts to improve the health care system through policies outlined in Policy D-165.938 and other directives of the House of Delegates.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 7-A-22

Subject: AMA Performance, Activities, and Status in 2021

Presented by: Bobby Mukkamala, MD, Chair

Policy G-605.050, "Annual Reporting Responsibilities of the AMA Board of Trustees," calls for the Board of Trustees to submit a report at the American Medical Association (AMA) Annual Meeting each year summarizing AMA performance, activities, and status for the prior year.

INTRODUCTION

The AMA's mission is to promote the art and science of medicine and the betterment of public health. As the physician organization whose reach and depth extend across all physicians, as well as policymakers, medical schools, and health care leaders, the AMA uniquely can deliver results and initiatives that enable physicians to improve the health of the nation.

Representing physicians with a unified voice

AMA-led grassroots efforts resulted in 250,000 emails and more than 8,000 phone calls to Congress, pushing lawmakers to take urgent action in December to avert devastating Medicare physician payment cuts totaling nearly 10%. AMA actions helped secure temporary sequester relief, a Physician Fee Schedule increase, and a significant Medicare PAYGO cut for 2022.

The AMA lobbied successfully for several government interventions to help with the public health and practice-based issues resulting from the COVID-19 Public Health Emergency. The Administration doubled Medicare payment for administration of the COVID-19 vaccine to $40 per administration and pressed states to allocate vaccines for administration in physician offices.

The AMA elevated the voice of leadership on critical issues of public health during the pandemic, securing more than 94 billion media impressions representing nearly $870 million in estimated ad value. AMA's share of voice during COVID-19 continues to lead all other health care organizations.

The AMA worked closely with state medical associations to produce scope of practice legislation that yielded victories in more than 20 states, as well as important concessions to reduce the burden of prior authorization on patients and physicians.

The AMA worked with the Centers for Disease Control and Prevention (CDC) to provide innovative and highly effective infection control training for physicians and other frontline health care workers through Project Firstline.

The AMA successfully promoted use of the Defense Production Act to boost production of personal protective equipment for physicians and vaccines, as well as onshore production rapid COVID-19 tests. AMA advocacy also contributed to expanded testing and increased FDA Emergency Use Authorizations to speed the process and yield better-informed policy decisions.

The AMA responded to the urgent needs of physicians during COVID-19 as the Current Procedural Terminology (CPT®) Panel team worked closely with the CPT Editorial Panel and the CDC to quickly issue 19 new CPT vaccine and vaccine administration codes, along with guidance on their appropriate use.

The AMA was a tireless advocate for physicians in federal and state courts, and our legal arguments and medical expertise were instrumental in dismissing the latest attempts to undermine the Affordable Care Act and laws that would harm transgender youth, as well as informing key decisions on federal vaccine and testing mandates, access to COVID-19 vaccines for young people, protection from eviction during the pandemic, and provider liability for COVID-19-related care.

The AMA's friend of the court brief was cited favorably by the U.S. Supreme Court in its decision rejecting challenges to the CMS vaccine mandate. Additionally, through its role as a plaintiff in two separate lawsuits, the AMA helped achieve favorable government action involving both the regulation of menthol cigarettes and the Title X program, protecting the patient-physician relationship, and defending the freedom of communication between patients and their physicians.

Building support for improved mental health during a time of extreme stress, AMA Insurance partnered with ArmadaCare, a leading insurance program manager, to offer a new supplemental health insurance program for physician groups.

Removing obstacles that interfere with patient care

The AMA created a broad range of research and resources dedicated to professional well-being and physician practice viability, including authoring or co-authoring 21 peer-reviewed articles and a whitepaper that assessed the factors that create and sustain high-performing physician-owned practices. Additionally, more than 40 health systems were singled out during the first full year of the AMA Joy in Medicine™ Health System Recognition Program, which offers a roadmap to boosting physician satisfaction.

The AMA expanded its Behavioral Health Integration initiative to help physician practices better meet patients' mental and physical health needs with 10 new webinars, six podcasts, four practice how-to guides, and an updated BHI Compendium outlining the initial steps of integrated behavioral care delivery. Additional resources to support private practice physicians included on-demand webinars and a live educational session during the November Special Meeting.

The AMA launched five new resources for private practice physicians in 2021, including a live educational session at the November Special Meeting and three new on-demand webinars. The popular AMA STEPS Forward® online training program expanded with eight new and 17 updated toolkits, more than two dozen webinars, and 14 podcasts.

The AMA contributed to the Robert Wood Johnson Foundation's National Commission to Transform Public Health Data Systems, which promises to modernize data collection to better target interventions and resources.

Leading the charge to confront public health crises

The AMA built on its industry-leading work to stem the rise in chronic disease, particularly among historically marginalized communities, by co-authoring 14 publications on inequities in blood pressure control and providing direct support to patients, physicians, and health care teams nationwide.

The AMA became a leading voice nationally in advancing equity in medicine with the launch of its ambitious multi-year strategic plan to embed equity across the organization and in all of its actions.

A pandemic-inspired shift to virtual coaching helped more health care organizations implement AMA MAP BP™, our evidence-based quality improvement program targeting patients at risk of developing heart disease.

The AMA and West Side United collaborated to improve heart health on Chicago's West Side. AMA co-led efforts to distribute 1,000 validated BP measurement devices and accompanying SMBP training resources to residents.

Our national Release The Pressure initiative, designed to provide Black communities with the knowledge and resources to achieve optimal heart health, provided self-measured blood pressure training to more than 72,000 Black women.

Seeking to harness the power of health data through a common framework, AMA's Integrated Health Model Initiative published a national mandated standard for social determinants of health, positioning the AMA as a leader in this growing and increasingly important field.

Only in its third year, the AMA's Enterprise Social Responsibility (ESR) program continues to deliver an organized and thoughtful structure to engage AMA employees in public service work aligned with the organization's values and goals. The program has strategically integrated with the Center for Health Equity's strategic plan to support thriving, healthy, and equitable communities. Thirty-two percent of AMA employees, representing every business unit, supported nearly 100 organizations and donated $113,000 to community partners.

AMA's ESR program was recognized by Erie Neighborhood House with the Community Investment award. The Community Investment award reflects AMA's commitment to helping communities thrive and giving communities hope.

Driving the future of medicine

AMA's JAMA Network expanded its family of specialty journals with the launch of JAMA Health Forum, a peer-reviewed, open-access online journal that focuses on health policy and health care systems as well as global and public health.

Total sessions across the JAMA Network surpassed the 100-million mark for the second straight year, aided by the Coronavirus Resource Center which has proven to be an essential and trusted source of information for physicians, researchers, and patients.

The AMA created a cross-sector External Equity and Innovation Advisory Group, launched a series of equity-focused educational modules for CME credit on the AMA Ed Hub™ and partnered with the Association of American Medical Colleges to launch a language guide to help physicians better understand the role dominant narratives play in medicine.

The AMA built on its commitment to health equity, working to develop and implement a framework to embed equity across the organization.

The AMA Ed Hub™, an industry-leading online education platform, drew more than 6.4 million views and kept physicians informed on COVID-19, health equity, physician wellness,

telemedicine, diabetes prevention, and a host of other topics, while offering CME credits. AMA Ed Hub™'s content now includes research and insights from 24 outside organizations.

With nearly 4 million visits to its website in 2021 and a popular podcast, the *AMA Journal of Ethics*® provided expert ethics guidance to help physicians and medical students navigate complex medical decisions on topics ranging from advancing racial justice and equity in health care to addressing transgenerational trauma and diversity in medical school admissions.

The AMA launched the CPT Capstone series with six sessions to educate the innovator community on the CPT process and AMA's work in innovation and health equity. In addition, AMA launched a well-received series of CPT webinars addressing a broad range of topics attended by more than 20,000 participants.

We launched the AMA Intelligent Platform, a digital platform supporting a new and modern interface to the CPT Code Set and supporting data assets including a CPT API.

The AMA-convened Digital Medicine Payment Advisory Group launched an augmented intelligence taxonomy that provides structure and direction to this evolving area of organized medicine.

Since its launch in May, two dozen Federation partners have joined the AMA Telehealth Immersion Program, and thousands of physicians have improved their understanding and streamlined implementation of telehealth into their practices through the AMA's Telehealth Implementation and Remote Patient Monitoring Implementation playbooks, as well as the Telehealth Quick Guide and Telehealth Educators Playbook.

AMA's years-long effort to reinvent medical school education advanced with six Innovations in Medical Education webinars that engaged medical students in urgent health care topics, including a focus on the impact of structural racism in medicine that drew more than 1,300 participants. Additionally, AMA funded three grants to boost diversity and dismantle systemic racism in medical education as part of The Bright Ideas Showcase at its annual Change MedEd 2021 event.

The AMA published a supplement in *Medical Teacher* with a series of articles describing the work, and lessons from the work, of the consortium to deeply reform medical education by expanding the implementation of competency-based medical education; leveraging the power of information in delivering both care and education; viewing health systems science as a new form of professionalism in medicine; strengthening interdependence among educational programs, communities, and health systems; and aligning the development of the health care workforce with societal needs and enhanced diversity.

The rapid expansion of audio and video programming and other online content drew a record 27.3 million unique users to the AMA website in 2021, a 35% year-over-year increase. The AMA COVID-19 Resource Center recorded nearly twice as many users as the previous year, while podcast downloads and video watch times also rose sharply. Five informational webinars AMA hosted with experts from the FDA and CDC were viewed more than 20,000 times.

Membership

The myriad ways AMA supported physicians in 2021 contributed to another strong financial performance, the 11th consecutive year of membership growth, and the highest number of dues-paying members since 2001.

EVP Compensation

During 2021, pursuant to his employment agreement, total cash compensation paid to James L. Madara, MD, as AMA Executive Vice President was $1,223,228 in salary and $1,171,835 in incentive compensation, reduced by $4,598 in pre-tax deductions. Other taxable amounts per the contract are as follows: $23,484 imputed costs for life insurance, $24,720 imputed costs for executive life insurance, $3,360 paid for parking, and $3,500 paid for an executive physical. An $81,000 contribution to a deferred compensation account was also made by the AMA. This will not be taxable until vested and paid pursuant to provisions in the deferred compensation agreement.

For additional information about AMA activities and accomplishments, please see the "AMA 2021 Annual Report."

REPORT OF THE BOARD OF TRUSTEES

B of T Report 8-A-22

Subject: Annual Update on Activities and Progress in Tobacco Control: March 2021 through February 2022

Presented by: Bobby Mukkamala, MD, Chair

This report summarizes trends and news on tobacco usage, policy implications, and American Medical Association (AMA) tobacco control advocacy activities from March 2021 through February 2022. The report is written pursuant to AMA Policy D-490.983, "Annual Tobacco Report."

TOBACCO USE AND COVID-19

Since March 2020 COVID-19 and the resulting pandemic dominated the public health and health care landscape. The Centers for Disease Control and Prevention (CDC) began publishing an ongoing list of conditions likely to cause or may cause more severe outcomes in adults with COVID-19 based on available evidence. Health care providers could use this list to identify their patients at high risk of poor or fatal outcomes associated with contracting COVID-19. Smoking was included in CDC's higher risk category for severe COVID-19 outcomes. The CDC's analysis determined that this was true in former smokers as well. Smoking was not associated with higher risk of contracting COVID-19. According to an observational study in *Nicotine & Tobacco Research*, Impact of Tobacco Smoking on the Risk of COVID-19: A Large Scale Retrospective Cohort Study, smokers could be less susceptible to COVID-19. The authors stressed that this indicates the need for further research and not that smoking is considered a protection against contracting the virus.[1]

Uptick in Tobacco Use

The lockdowns associated with the pandemic resulted in an increased prevalence in unhealthy behaviors. These included poor dietary intake, decreased physical activity, and increased smoking.[2]

The rise in tobacco use was also demonstrated in the Federal Trade Commission's 2020 cigarette report, which showed an increase in cigarette sales for the first time in 20 years.[3] It is expected to see this continued upturn in the 2021 report. While the report does not indicate the pandemic and its subsequent lockdowns as the cause of the upsurge, Bloomberg reported that Altria's sales jumped because of what the company calls "pantry loading," which suggests smokers were stocking up on cigarettes. Altria Group is one the largest producers of cigarettes, tobacco, and nicotine products in the world.[4]

Pandemic Impacts Tobacco Cessation

"During the pandemic, smokers might have increased their smoking due to stress and boredom. On the other hand, the fear of catching COVID and risk for poor outcomes from COVID might have led them to cut down or quit smoking. In fact, we found that both happened," said Nancy Rigotti, MD, Director of Tobacco Research and Treatment Center at Massachusetts General Hospital.

Rigotti and colleagues analyzed data on current and former smokers who had been hospitalized before the pandemic and had previously participated in a smoking cessation clinical trial.[5]

Tobacco smoking is the leading cause of preventable death in the United States. The risks associated with poor COVID-19 outcomes for smokers was an opportunity for physicians to elevate conversations about quitting. It was also an opportunity for public health agencies to highlight the available cessation tools including online programs and state supported quit lines.

E-Cigarette Use by Youth Suggests Strong Nicotine Dependence

According to the 2021 National Youth Tobacco Survey (NYTS), more than 2 million middle and high school students use e-cigarettes. An analysis by the U.S. Food and Drug Administration (FDA) and CDC estimate that one in four use e-cigarettes daily.[6] The data also show a change in teen e-cigarette preferences.

For years, Juul was the most popular brand with its flash drive-like devices and pre-filled nicotine liquid cartridges, but the 2021 NYTS data shows that Puff Bar is the brand of choice. Puff Bar is a disposable e-cigarette in flavors such as Blue Razz and Watermelon.

The 2021 data cannot be compared to previous surveys due to changes made to how the survey was conducted during the pandemic. The NYTS was designed to provide national data on long-term, intermediate, and short-term indicators key to the design, implementation, and evaluation of comprehensive tobacco prevention and control programs.

Bipartisan Legislative Agreement Closes Loophole in FDA Authority

In response to the rising concern about the proliferation of e-cigarettes using synthetic nicotine, Congress introduced legislation to enable FDA to regulate synthetic nicotine products. The bipartisan agreement is included in the omnibus appropriations bill.

Current federal law (the 2009 Family Smoking Prevention and Tobacco Control Act) gives the FDA the authority to regulate tobacco products and defines a “tobacco product” as a product made or derived from tobacco. To evade FDA regulation, a growing number of e-cigarette manufacturers have switched to using synthetic nicotine–nicotine that is made in a lab rather than derived from tobacco–and are marketing these products with the kid-friendly flavors. In 2009 the FDA ordered Puff Bar, a leading e-cigarette manufacturer, to remove its flavored disposable products from the market. In 2021, it reentered the market as a synthetic nicotine e-cigarette.

TOBACCO AND HEALTH EQUITY

AMA Calls on FDA to Prioritize Its Enforcement as Authorized by Congress

In an August 9, 2021, letter to the FDA’s Center for Tobacco Products, the AMA called on the FDA to prioritize enforcement against two manufacturers for introducing new flavored tobacco products in defiance of the FDA review requirements. The AMA was one of 15 co-signers that included the American Academy of Pediatrics, National Medical Association, Black Women’s Health Imperative, The Center on Black Health & Equity, NAACP and others.

According to the NAACP the tobacco industry has successfully and intentionally marketed mentholated cigarettes to African Americans and particularly African American women and menthol smokers have a harder time quitting smoking.[7]

Reynolds American, Inc. introduced Newport Boost menthol cigarettes and Swedish Match introduced a "Limited Editions Chocolate and Vanilla Swirl." The Family Smoking Prevention and Tobacco Control Act (TCA) does not permit the introduction of new tobacco products (those introduced or modified after February 15, 2007), without rigorous premarket review by FDA and the issuance of premarket orders authorizing their sale. In April 2021, in part because of a lawsuit filed by the AMA and others, FDA announced it would advance two tobacco product standards: prohibiting menthol as a characterizing flavor in cigarettes; and prohibiting all characterizing flavors, including menthol, in cigars. Since then, the FDA has denied applications for 55,000 flavored e-cigarette products.

The letter also called on the FDA to expedite the issuance of proposed and final rules to establish menthol cigarette and flavored cigar product standards to eliminate these products from the marketplace.

OTHER EFFORTS TO ADDRESS TOBACCO CONTROL

USPSTF Expands Criteria for Lung Cancer Screening

The US Preventive Services Task Force has expanded the criteria for lung cancer screening. The updated final recommendations have lowered the age at which screening starts from 55 to 50 years and have reduced the criterion regarding smoking history from 30 to 20 pack-years. The updated final recommendations were published online on March 2021 in *JAMA*.[8]

According to the evidence review conducted by the Task Force, lung cancer is the second most common cancer and the leading cause of cancer death in the US. Smoking accounts for an estimated 90% of all lung cancer cases. Lung cancer has a generally poor prognosis, with an overall 5-year survival rate of 20.5%. However, early-stage lung cancer has a better prognosis and is more amenable to treatment.

Graphic Warning Labels Impact Perceptions About Smoking

Graphic warning labels on cigarette packages changes positive perceptions and increases awareness according to a study on JAMA Network Open.[9] Earlier studies have shown evidence of increased quit attempts when smokers have graphic warning labels affixed to the cigarette pack.[10] In 2009, graphic warning labels on cigarette packs were mandated by Congress. Despite attempts by the tobacco industry to delay implementation through lawsuits, the courts confirmed FDA's obligation to create and require graphic warning labels on cigarette packages. The AMA joined with other medical organizations and public health groups in filing amicus briefs in support of the FDA's mandated actions. It is estimated that more than 180,000 deaths could have been prevented over the past decades if graphic warning labels had been in place.[11]

The use of government imposed graphic labels has been a useful tool in other countries for more than 20 years. Today 120 counties mandate graphic warning labels.

REFERENCES

[1] Paleiron N, Mayet A, Marbac V, et al. Impact of Tobacco Smoking on the Risk of COVID-19: A Large Scale Retrospective Cohort Study. Nicotine Tob Res. 2021;23(8):1398-1404. doi:10.1093/ntr/ntab004
[2] F Chague, M Boulin, JC Eicher, F Bichat, M Saint-Jalmes, A Cransac-Miet, B Trojak, A Soudry, N Danchin, G Laurent, Y Cottin, M Zeller, Smoking and associated unhealthy lifestyle behaviours in patients with chronic cardiac diseases during COVID-19 related lockdown, European Journal of Preventive Cardiology, Volume 28, Issue Supplement_1, May 2021, zwab061.293, https://doi.org/10.1093/eurjpc/zwab061.293
[3] https://www.ftc.gov/system/files/documents/reports/federal-trade-commission-cigarette-report-2020-smokeless-tobacco-report-2020/p114508fy20cigarettereport.pdf. Accessed February 11, 2022
[4] https://www.bloomberg.com/news/articles/2020-04-30/despite-pandemic-stockpiling-boosts-altria-s-cigarette-brands
[5] Rigotti, N.A., Chang, Y., Regan, S. et al. Cigarette Smoking and Risk Perceptions During the COVID-19 Pandemic Reported by Recently Hospitalized Participants in a Smoking Cessation Trial. J GEN INTERN MED 36, 3786–3793 (2021). https://doi.org/10.1007/s11606-021-06913-3
[6] Park-Lee E, Ren C, Sawdey MD, et al. Notes from the Field: E-Cigarette Use Among Middle and High School Students — National Youth Tobacco Survey, United States, 2021. MMWR Morb Mortal Wkly Rep 2021;70:1387–1389. DOI: http://dx.doi.org/10.15585/mmwr.mm7039a4
[7] FDA eyes ban on Menthol Cigarettes. Insight News. https://www.insightnews.com/health/fda-eyes-ban-on-menthol-cigarettes/article_ec948ffe-ed1d-11e8-b8d3-afe5ad3dc807.html. Published November 20, 2018. Accessed March 16, 2022
[8] US Preventive Services Task Force. Screening for Lung Cancer: US Preventive Services Task Force Recommendation Statement. JAMA. 2021;325(10):962–970. doi:10.1001/jama.2021.1117
[9] Strong DR, Pierce JP, Pulvers K, et al. Effect of Graphic Warning Labels on Cigarette Packs on US Smokers' Cognitions and Smoking Behavior After 3 Months: A Randomized Clinical Trial. JAMA Netw Open. 2021;4(8):e2121387. doi:10.1001/jamanetworkopen.2021.21387
[10] Brewer NT, Hall MG, Noar SM, et al. Effect of pictorial cigarette pack warnings on changes in smoking behavior: a randomized clinical trial. JAMA Intern Med. 2016;176(7):905-912. doi:10.1001/jamainternmed.2016.2621
[11] Tam J, Jeon J, Thrasher JF, et al. Estimated Prevalence of Smoking and Smoking-Attributable Mortality Associated With Graphic Health Warnings on Cigarette Packages in the US From 2022 to 2100. JAMA Health Forum. 2021;2(9):e212852. doi:10.1001/jamahealthforum.2021.2852

REPORT 10 OF THE BOARD OF TRUSTEES (A-22)
American Medical Association Center for Health Equity Annual Report
(Center for Health Equity Annual Report)
(Informational)

EXECUTIVE SUMMARY

Background: At the 2018 Annual Meeting, the House of Delegates adopted the recommendations of Policy D-180.981 directing our AMA to "develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities" and instructing the "Board to provide an annual report to the House of Delegates regarding AMA's health equity activities and achievements." The HOD provided additional guidance via Policy H-180.944: "Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity." HOD policy was followed by creation of the AMA Center for Health Equity ("Center") in April 2019 and the AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity for 2021-2023 ("Plan") in May 2021.

Discussion: The AMA has steadfastly enhanced efforts over recent years to further embed equity in our work. The Plan serves as a guide for this work. This report outlines the activities conducted by our AMA during calendar year 2021, divided into five (5) strategic approaches detailed in the Plan: (1) Embed Equity; (2) Build Alliances and Share Power; (3) Ensure Equity in Innovation; (4) Push Upstream; and (5) Foster Truth, Reconciliation, and Racial Healing.

Conclusion: Despite challenges, including the ongoing COVID-19 pandemic, our AMA persevered in efforts to advance equity by continuously engaging in meaningful conversations, and finding innovative ways to connect, learn, and create. In 2021, it is estimated that our AMA mobilized at least 560 staff, collectively contributing more than 54,000 hours (or at least 30 full-time equivalents) to advance equity. The AMA continued to promote the art and science of medicine and the betterment of public health, advancing equity and embedding racial and social justice, making significant progress towards fulfilling the commitments outlined in the Plan during its first official year.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-A-22

Subject: American Medical Association Center for Health Equity Annual Report

Presented by: Bobby Mukkamala, MD, Chair

BACKGROUND

At the 2018 Annual Meeting, the House of Delegates adopted Policy D-180.981, directing our AMA to "develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities" and instructing the "Board to provide an annual report to the House of Delegates regarding AMA's health equity activities and achievements." The HOD provided additional guidance via Policy H-180.944: "Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity." HOD policy was followed by creation of the AMA Center for Health Equity ("Center") in April 2019 and the AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity for 2021-2023 ("Plan") in May 2021.

DISCUSSION

Our AMA has committed itself to advancing health equity, advocating for racial and social justice, and embedding equity across the organization and beyond. While achieving equity takes time, our AMA has raised the profile of health equity in medicine. This garners attention from all over the world. The creation of the Center is one of the most visible manifestations. Leadership and business units (BUs) across the AMA have steadfastly enhanced efforts over recent years to further embed equity in our work. The Plan, the latest major milestone since establishing the Center, serves as a guide for this work. This report outlines the activities conducted by our AMA during calendar year 2021, divided into five strategic approaches detailed in the Plan: (1) Embed Equity; (2) Build Alliances and Share Power; (3) Ensure Equity in Innovation; (4) Push Upstream; and (5) Foster Truth, Reconciliation, and Racial Healing.

Embed Equity

To ensure a lasting commitment to health equity by our AMA, it must be embedded using anti-racism, structural competency, and trauma-informed lenses as a foundation for transforming the AMA's staff and broader culture, systems, policies, and practices, including training, tools, recruitment and retention, contracts, budgeting, communications, publishing, and regular assessment of organizational change. The following are some of the relevant accomplishments during 2021:

- In May, the AMA released the Equity Strategic Plan to embed racial justice and advance health equity, a three-year enterprise-level roadmap to improving outcomes and care quality for historically marginalized groups. Dr. Madara, CEO, wrote to all employees, urging them to read the Plan and consider how individual roles and responsibilities can

contribute to these efforts. AMA employees were informed about adding equity goals to annual performance plans and reviews.

- Following the launch of the Plan, Dr. Madara, Chief Health Equity Officer Aletha Maybank, MD, MPH, and AMA President Gerald E. Harmon, MD, hosted a briefing for employees, including Q&A, with more than 900 employees attending.
- More than 65 percent of employees have participated in the two-day Racial Equity Institute trainings, which provide crucial foundational learning, encourage meaningful dialogue on the topics of equity and race, and promote a common language for health equity.
- Three cross-enterprise workgroups (Communications, Workforce Equity & Engagement, and Sourcing & Contracting) were established to create action plans that addressed the 2020 all-employee equity and engagement survey findings. These plans are being coordinated to aid development of the AMA Enterprise Equity Action Plan for 2022-2024.
- The Enterprise Equity Core Team, with leaders from the Center, Human Resources (HR) and other BUs, formed to support the cross-enterprise equity workgroups and BU equity action teams and monitor progress, succeeding a less formal team of volunteers.
- Every BU established an equity action team and drafted BU-specific action plans for embedding equity starting in 2022. All BU equity action teams field representatives on the enterprise-wide Health Equity Workgroup (HEW) that meets monthly to share best practices and troubleshoot challenges. Equity action teams also fostered leadership skills within units like JAMA Network who adopted a "grassroots" volunteer approach. The volunteers represented employees from a broad array of departments. Those with a spectrum of management skills and experience were put in a position to form teams, lead collaborative projects, and design learning experiences for all their colleagues.
- The Human Resources (HR) Diversity, Equity, and Inclusion (DEI) Office was established, leading efforts to positively impact organizational culture and shape the employee experience across the enterprise. The Office launched the HR DEI webpage on AMAtoday, the AMA's intranet portal, providing information on enterprise-wide DEI efforts including details on employee resource groups at the AMA.
- The Embedding Equity Hub was unveiled on AMAtoday, providing a collection of resources for AMA employees. The Embedding Equity community was launched on Yammer, the AMA's internal social media platform, as a place for employees to share the work that they're doing within their BUs and across the enterprise to embed equity at all levels.
- Through updates in talent acquisition practices including a new interview guide and methodology, and anonymizing of resumes, our AMA saw increases in people who identify with minoritized or marginalized groups of 12% among new hires (35% to 47%) and 3% among employees at the director level (15% to 18%). This included people who self-identified with one of the following categories: American Indian/Alaskan Native, Asian, Black or African American, Hispanic, Native Hawaiian/Pacific Islander, or two or more.
- New diversity, equity, and inclusion (DEI) editor appointments were completed in nine (9) of 13 JAMA Network journals, the JAMA Network manuscript submission system was updated with a core taxonomy term focused on DEI and 37 supporting terms, and 2 new policy guidelines for editorial staff and editors were developed to guide multimedia and social media publishing.
- The AMA Foundation's inaugural $750,000 National LGBTQ+ Fellowship Program grant was awarded to the University of Wisconsin-Madison School of Medicine and Public Health, out of 50 letters of intent, and 13 institutions asked to submit formal proposals.
- During November's Special Meeting of the House of Delegates (HOD), AMA hosted the virtual Health Equity Forum, beginning with a chat with Heather McGhee, MD, author of *The Sum of Us*, followed by a moderated conversation about the Equity Strategic Plan with

well-known, respected equity experts and scholars. HOD members had the opportunity to discuss the Equity Strategic Plan. The forum concluded with an opportunity for HOD members to engage directly with staff from the Center to hear more about their work.

- Produced a dismantling racism in medicine "Future Shock"[1] event for senior management group and other AMA leaders to explore organized healthcare roles and responsibilities.
- The AMA achieved the following reach with health equity content:
  - 8411 total placements and 22.7+ billion traditional and online media impressions through proactive and reactive media opportunities.
  - Published eight AMA Viewpoints focused on our work to address health inequities for marginalized communities.
  - Publication of 38 COVID-19 Update and Moving Medicine video episodes, including a strong focus on vaccine hesitancy and equitable distribution of vaccines.
  - Website traffic for health equity-related content increased 74% to 913,000 visits.
  - Prioritizing Equity series generated 146,000 views on YouTube, a 57% increase.
  - Leveraged over 300 Ambassadors to socialize the Equity Strategic Plan, yielding a social media reach potential of 61,000.
  - The Plan was the most downloaded AMA health equity document at 8,000.
  - Health equity content directly yielded 96 memberships, a 37% increase.
  - The AMA's equity content engagement via Ambassador Activation app (SMARP) yielded 344,000 social media reach potential, 591 clicks and 252 shares.

Build Alliances and Share Power

Building strategic alliances and partnerships and sharing power with historically marginalized and minoritized physicians and other stakeholders is essential to advancing health equity. This work centers previously excluded voices, builds advocacy coalitions, and establishes the foundation for true accountability. The following are some of the relevant accomplishments during 2021:

- With over 300 applicants from across the country, AMA and the Satcher Health Leadership Institute (SHLI) at Morehouse School of Medicine announced the inaugural cohort of 12 physicians for the AMA-SHLI Medical Justice in Advocacy Fellowship.
- The AMA, AMA Foundation, Association of Black Cardiologists (ABC), American Heart Association (AHA), Minority Health Institute (MHI) and National Medical Association (NMA) co-led the national Release the Pressure initiative to reach more than 300,000 Black women, with approximately 50,000 taking the 'Heart Health Pledge' and more than 72,000 watching the video on blood pressure self-measurement.
- Updated Guidance on Reporting Race and Ethnicity in Medical and Science Journals was developed and revised in consultation with 60 external experts and scholars, published in *JAMA* in August, with 56,000 views. JAMA Network is actively participating in Joint Commitment for Action on Inclusion and Diversity in Publishing with 52 organizations and 15,000 journals worldwide.
- Expanded equity focused offerings on AMA Ed Hub with education from the AMA and eight (8) external organizations leading to more than 300,000 views.
- Engaged 69 institutions and groups, securing and promoting virtual screening by at least 6,000 registrants and 1,679 discussion participants for short documentary videos produced by Black Men in White Coats, which seeks to increase the number of Black men in the field of medicine by exposure, inspiration, and mentoring.
- Partnered with the Association of American Medical Colleges (AAMC) and Accreditation Council for Graduate Medical Education (ACGME) to create the Physician Data

[1] Future shock is a concept popularized by sociologist Alvin Toffler of the pace of change exceeding human capacity to adapt: https://www.bbc.com/news/world-us-canada-36675260

Collaborative to explore the use of physician data to advance health equity. The Collaborative agreed on race and ethnicity standards, added the Middle Eastern/North African racial category to the work of the three organizations (see Board of Trustees Report 12-A-22 for more detail), and prioritized sexual orientation and gender identity (SOGI) as the next focus for reaching common standards and definitions.

Push Upstream

Pushing upstream requires looking beyond cultural, behavioral, or genetic reasons to understand structural and social drivers of health and inequities, dismantle systems of oppression, and build health equity into health care and broader society. The following are some of the relevant accomplishments during 2021:

- In February and March, a two-part theme issue on "racial and ethnic health equity in the US" was published in the *AMA Journal of Ethics*. During these 2 months, the journal received nearly 700,000 visits and 37,000 PDF downloads.
- Published an editorial on commitment to equity with a 14-point plan across JAMA Network journals (over 200,000 views). *JAMA* published a theme issue on racial and ethnic disparities and inequities in medicine and health care (over 159,000 views). Published 500 additional articles on DEI, health disparities, and health inequities in JAMA Network journals.
- The AMA partnered with HealthBegins on an educational module for physicians on the use of CPT Evaluation and Management codes in identifying social determinants and two open access Steps Forward toolkits, generating more than 15,000 pageviews: (1) Racial and Health Equity: Concrete STEPS for Smaller Practices and (2) Social Determinants of Health (SDOH). This partnership continued with creation of the AMA SDOH work group.
- To improve blood pressure control in communities on the west side of Chicago, AMA collaborated with West Side United and West Side Health Equity Collaborative providing training and education on self-measured blood pressure, and with health care organizations and health centers implementing the AMA MAP BP™ quality improvement program.
- The AMA partnered with the American College of Preventive Medicine and the Black Women's Health Imperative on a multi-year initiative to increase support for Black and Latinx women to enroll in an evidence-based Diabetes Prevention Program. The AMA worked with physicians to identify patients' social needs and remove barriers to participation.
- The AMA measured burnout in 27 Federally Qualified Health Centers (more than 1,000 physicians) and held 3 virtual workshops on reducing practice inefficiencies and burnout.
- The AMA, in partnership with the Association of American Medical Colleges (AAMC) Center for Health Justice, published the *Advancing Health Equity: A Guide to Language, Narrative and Concepts* provides guidance and promotes a deeper understanding of equity-focused, person-first language and why it matters.
- The AMA continued advocacy efforts around maternal and child health, particularly inequities in maternal morbidity and mortality.
    - Staff served as a guest speaker during a ReachMD radio podcast; participated on an AMA Advocacy Insights panel discussion; served on a panel discussion for the AMA's Women Physicians Section membership roundtable; and served as a guest speaker during the annual AMA Medical Student Advocacy Conference.
    - Staff developed and continue to update an AMA webpage devoted to amplifying the issue of maternal mortality and morbidity in the U.S. and the AMA's related work.
    - New AMA policy on "Reducing Inequities and Improving Access to Insurance for Maternal Health Care" (H-185.917) from Joint CMS-CSAPH Report N-21.

    - The AMA proactively engaged with the Administration, Congress, and state policymakers, including:
        - submitting an extensive statement for the record for a Congressional Hearing on the maternal health crisis;
        - supporting an American Rescue Plan Act of 2021 provision for temporary optional expansion of state Medicaid/CHIP coverage one year postpartum;
        - supporting the Mothers and Offspring Mortality and Morbidity Awareness (MOMMA) Act, which uses a six-pronged approach to address and reduce maternal deaths by: establishing national obstetric emergency protocols, ensuring coordination among maternal mortality review committees, standardizing data collection and reporting, improving access to culturally competent care, providing guidance and options for states paying for doula support services, and extending Medicaid coverage to one year postpartum;
        - supporting S. 796 and H.R. 958, the Protecting Moms Who Served Act, signed into law Nov. 30, 2021, requiring the Department of Veterans Affairs to implement the maternity care coordination program with community maternity care providers trained to address the unique needs of pregnant and postpartum veterans and requiring the U.S. Government Accountability Office to report on pregnant and postpartum veteran maternal mortality and severe maternal morbidity with a focus on veteran racial and ethnic disparities in maternal health outcomes; and
        - joining a sign-on letter urging CMS to approve pending Section 1115 demonstration projects extending the postpartum coverage period to a full year for individuals enrolled in Medicaid while pregnant. This advocacy led to CMS approving Illinois' Section 1115 waiver extending coverage.
- The AMA advocated around many policies to advance health equity including:
    - Joining joint letter to Congress in support of H.R. 3746, the Accountable Care in Rural America Act.
    - Submitting letters to Congress in support of: S. 937/H.R. 1843, the COVID-19 Hate Crimes Act; H.R. 955/S. 285, the Medicaid Reentry Act; and sustainable Medicaid funding for Puerto Rico and other U.S. territories.
    - Submitting letters to Departments of Justice, Labor, and Homeland Security (DHS) / Citizenship and Immigration Services (CIS) on: White House Immigration Regulatory Reviews, uninformed DHS public health determinations denying asylum, Alternatives to Detention, Haitian refugee health, Public Charge Rule, Procedures for Credible Fear Screening, and DACA.
    - Submitting letters supporting our IMG membership on: modifications to the H-1B petitions, the Healthcare Workforce Resilience Act, wage protections for H-1B and J-1 physicians, Barriers Across USCIS Benefits and Services, and the Conrad State 30 and Physician Access Reauthorization Act.
    - Submitting letter to FEMA urging equitable vaccine distribution.
- The AMA created additional new policies on anti-racism in medicine including:
    - Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions, H-65.951
    - Underrepresented Student Access to US Medical Schools, H-350.960

Ensure Equity in Innovation

The AMA is committed to ensuring equitable health innovation by internally and externally embedding equity in innovation, centering historically marginalized and minoritized people and communities in development and investment, and collaborating across sectors. The following are some of the relevant accomplishments during 2021:

- The AMA developed a health equity self-assessment tool for technology-based products or projects and used it on a current major AMA Innovations project, Verifi Health SMBP.
- As part of the DEI program for the Current Procedural Terminology (CPT) code set, AMA launched the Capstone course. In the Innovator Track, entrepreneurs, developers, and innovators learned about the CPT process and related DEI plans. The course has been provided to several external technology and innovation entities.
- As part of the AMA ChangeMedEd 2021 national conference, the AMA sponsored a Bright Ideas Showcase and solicited "blue sky" ideas to improve diversity and address structural racism across the medical education continuum. From 145 ideas received, 25 were selected to be presented, with attendees selecting three to each receive $20,000 AMA planning grants.
- Integrated Web Content Accessibility Guidelines (WCAG) standards, increasing accessibility for AMA education on AMA Ed Hub, impacting over 250 new activities.
- Nearly 300 activities evaluated for publication on the AMA Ed Hub according to newly created quality review rubric with an equity emphasis.
- In collaboration with the Gravity Project for Social Determinants of Health, AMA contributed to the publication through Health Level Seven® International (HL7®) a FHIR® implementation guide for the capture and use of SDOH data.

Foster Truth, Reconciliation & Racial Healing

The AMA recognizes the importance of acknowledging and rectifying past injustices in advancing health equity for the health and well-being of both physicians and patients. Truth, reconciliation, and racial healing is a process and an outcome, documenting past harms, amplifying and integrating narratives previously made invisible, and creating collaborative spaces, pathways, and plans. The following are some of the relevant accomplishments during 2021:

- The Prioritizing Equity series launched to illuminate how COVID-19 and other determinants of health uniquely impact marginalized communities, public health, and health equity. It has generated 146,916 views on YouTube.
- Five (5) AMA conference rooms (Washington, Lincoln, Rushmore, Mount Vernon, and Monticello) were previously named with presidential themes, mostly people or places connected to ownership of enslaved Africans. A team of five AMA staff collaborated on themes and options for renaming the rooms, landing on additional American landmarks: Rockies, Acadia, Rio Grande, Everglades, and Great Lakes.

Challenges and Opportunities

Commonly noted challenges included the ongoing COVID-19 pandemic, which created competing demands among staff and partners and required creativity in converting in-person activities to virtual alternatives that promoted robust engagement. Time needed for meaningful learning, relationship development, planning, and project implementation related to health equity were at times greater than anticipated, adding to existing work. Staff noted that uncomfortable conversations and uncertainty about next steps became easier as learning and collaboration continued.

Many staff were eager to learn more about the equity aspects of their work and to find new strategies to address and advance them. Externally-supported training and facilitated safe spaces for frank conversations among coworkers helped staff gain a new level of appreciation and understanding for one another and health equity. The Health Equity Workgroup (HEW), the Center, and external partners provided invaluable expertise in crafting and updating initiatives.

Commitments from leadership, clear policy on health equity, and building on existing relationships across the enterprise and with external partners supported progress.

CONCLUSION

AMA staff were asked for their most prominent equity-related accomplishments, and not everything submitted could be included in this report, so the above represents a fraction of the work completed in 2021. Based on submitted accomplishments AMA mobilized at least 560 staff, collectively contributing more than 54,000 hours (or at least 30 full-time equivalents) to advance equity. Overall, AMA has made significant progress towards fulfilling the commitments outlined in the Plan during its first official year.

APPENDIX

Table 1: Approaches, Commitments, Quarters, Staff, and Hours (Partial List)

Strategic Approach	Commitment	Quarter(s)				Staff	Hours
1. Embed racial and social justice throughout the AMA enterprise culture, systems, policies, and practices	a. Build the AMA's capacity to understand and operationalize anti-racism and equity strategies via training and tool development	1	2	3	4	383	12163
	b. Ensure equitable structures and processes and accountability with prioritization on the AMA's workforce, contracts/sourcing and communications	1	2	3	4	90	4018
	c. Integrate trauma—informed lens and approaches	1	2	3	4	69	670
	d. Assess organizational change (culture, policy, process) over time	1	2	3	4	146	1795
2. Build alliances and share power with historically marginalized minoritized physicians and other stake holders	a. Develop structures and processes to consistently center the experiences and ideas of historically marginalized (women, LGBTQ+, people with disabilities, International Medical Graduates) and minoritized (Black, Indigenous, Latinx, Asian) physicians	1	2	3	4	1	800
	b. Establish a national collaborative of multidisciplinary, multisectoral equity experts in health care and public health to collectively advocate for justice in health	1	2	3	4	15	3900
3. Push upstream to address all determinants of health and the root causes of health inequities	a. Strengthen physicians' understanding of public health and structural/social drivers of health and inequities	1	2	3	4	189	270
	b. Empower physicians and health systems to dismantle structural racism and intersecting systems of oppression						
	c. Equip physicians and health systems to improve services, technology, partnerships and payment models that advance public health and health equity	1		3	4	22	7070
4. Ensure equitable structures and opportunities in innovation	a. Embed equity within existing AMA health care innovation efforts		2	3	4	26	346
	b. Equip the health care innovation sector to advance equity			3	4	5	425
	c. Center and amplify historically marginalized and minoritized health care investors and innovators						
	d. Engage in cross-sector collaboration and advocacy efforts						
5. Foster truth and racial healing, reconciliation and transformation for the AMA's past	a. Amplify and integrate often "invisible-ized" narratives of historically marginalized physicians and patients in all that we do				4	4	240
	b. Quantify impacts of AMA's policy and process decisions that excluded, discriminated and harmed			3		8	160
	c. Repair and cultivate a healing journey for those who have been harmed	1		3	4	27	710

Table 2: External Partners

Accelerating Change in Medical Education (ACE) Consortium members	Accreditation Council for Graduate Medical Education (ACGME)	Ad Council
Adelante Healthcare	Albert Einstein College of Medicine	Alliance Chicago
American College of Preventive Medicine (ACPM)	American Heart Association	American Telemedicine Association (ATA) EDGE
Anytime Health	Arizona Alliance	Association of American Medical Colleges (AAMC)
Association of Black Cardiologists	Authority Health	Baylor College of Medicine
Black Men in White Coats	Black Women's Health Imperative	Boston Children's Hospital
Canyonlands Healthcare	Capital Region Medical Center	Center for Care Innovations
Centers for Disease Control and Prevention (CDC)	Chiricahua Community Health Centers, Inc.	Circle the City
Columbia University	Community Health Centers of Yavapai	Copper Queen Community Hospital
COVID Black	Creek Valley Health Clinic	Des Moines University
Desert Senita Community Health Center (CHC)	Diversity Lab (Mansfield Rule, Legal Department Edition)	Eastern Virginia Medical School
El Rio Health	Emory School of Medicine	Erie Family Health Centers
Florida International University	Gardeneers	Gartner
George Washington University Fitzhugh Mullan Institute for Health Workforce Equity	George Washington University School of Medicine	Gravity Project
Harvard Medical School / Massachusetts General Hospital (MGH) / Beth Israel Deaconess Medical Center (BIDMC)	Health Level Seven (HL7) International	HealthBegins
Heartland Health Centers	Highland Hospital	Horizon Health and Wellness
Howard Brown Health	Jacobs School of Medicine and Biomedical Sciences University at Buffalo	Johns Hopkins Medicine
Johns Hopkins University	Joint Commitment for Action on Inclusion and Diversity in Publishing	Kaiser Permanente Bernard J. Tyson School of Medicine
K'ept Health	Loma Linda University School of Medicine	Loyola University of Chicago
Mariposa Community Health Center	Mass Challenge Health Tech	MATTER
Mayfield	Mayo Clinic Alix School of Medicine	MedTech Color
MHC Healthcare	Minority Health Institute	Morehouse School of Medicine
Mountain Park Health Center	National Alliance on Mental Illness (NAMI)	National Digital Inclusion Alliance
National Medical Association	Native Americans for Community Action	Native Health
Neighborhood Outreach Access to Health	New York University (NYU) Grossman School of Medicine	North Country Healthcare
Northwestern University	Nursing Innovation Hub	Ohio State University
Per Scholas	Perelman School of Medicine at the University of Pennsylvania	Public Health Innovators

Raben Group Consulting	Racial Equity Institute (REI)	Radical Health
Rutgers New Jersey Medical School	Shasta Community Health Center Family Medicine Residency Program	Stanford University Byers Center for Biodesign
Stanford University School of Medicine	Sun Life Family Health Center	Sunset Community Health Center
TEKsystems	Telehealth Academy	Terros Health
Texas Medical Center (TMC) Innovation Health Tech Accelerator (formerly TMCx)	The Exeter Group	The Warren Alpert Medical School of Brown University
Thomas Jefferson University Hospital	Thomas Jefferson University, Sidney Kimmel Medical College	Together.Health
Tulane	United Community Health Center	University of Alabama at Birmingham
University of California (UC) Davis School of Medicine	University of California San Francisco (UCSF)	University of California San Francisco (UCSF) School of Medicine
University of Charleston	University of Connecticut School of Medicine	University of Illinois Chicago
University of Illinois Chicago College of Medicine	University of Illinois Chicago College of Nursing	University of Michigan Medical School
University of North Carolina School of Medicine	University of Southern California (USC)	University of Southern California (USC) Keck School of Medicine
University of Southern California (USC) Price School of Public Policy	University of Texas Health Science Center at Houston (UT Health Houston) McGovern Medical School	University of Texas Health Science Center at San Antonio (UT Health San Antonio)
University of Toledo College of Medicine and Life Sciences	University of Utah School of Medicine	University of Washington School of Medicine
Urban Alliance (High School Summer Internship Program)	Valle del Sol	Valleywise Health and District Medical Group
Wesley Health Center	West Side Health Equity Collaborative	West Side United
Willis Towers Watson (WTW)	Yale School of Medicine	

REPORT 12 OF THE BOARD OF TRUSTEES (A-22)
DISAGGREGATION OF DEMOGRAPHIC DATA FOR INDIVIDUALS OF MIDDLE EASTERN AND NORTH AFRICAN (MENA) DESCENT
(Informational)

EXECUTIVE SUMMARY

This informational report is put forth in response to Policy D-350.979 "Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent," which directs our AMA to "(1) add "Middle Eastern/North African (MENA)" as a separate racial category on all AMA demographics forms; (2) advocate for the use of "Middle Eastern/North African (MENA)" as a separate race category in all uses of demographic data including but not limited to medical records, government data collection and research, and within medical education; and (3) study methods to further improve disaggregation of data by race which most accurately represent the diversity of our patients."

This report lays out a historical overview of debates surrounding MENA as a separate category in race/ethnicity categorization and summarizes the current standing of these debates in the health equity research literature. Finally, this report outlines ways that our AMA can implement this directive, focusing on our initiatives to study data disaggregation by race/ethnicity.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-A-22

Subject: Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent

Presented by: Bobby Mukkamala, MD, Chair

BACKGROUND

Racial and ethnic categories are socially constructed, differ between countries and vary significantly over time.[1] Categories evolve as a result of political circumstances and social demands, and they are more fluid than most people perhaps recognize. For example, it was not until the 1980 U.S. Census that Hispanic/Latino was recognized as an ethnicity.[2] The process by which categories are officially recognized in the U.S. is complex; as Germine Awad et al note, the process reflects political motivations ranging from "remedying inequalities to advancing White supremacist values."[3] The former is done when categories are used to identify, measure, and track inequities; the latter has historically been used to define and uphold "whiteness" in political and social discourse.[1,4]

A group that has been omitted--and thus rendered invisible--in many medical and social data collection systems is the Middle Eastern and North African (MENA) population.[3,5-7] This invisibility perpetuates a cycle of largely unacknowledged health inequities affecting this diverse population.[7,8]

The current practice of the U.S Census Bureau is to include the MENA population in its definition of "white": "a person having origins in any of the original peoples of Europe, the Middle East, or North Africa." In this regard, the U.S. is alone among North American and European countries that collect population-level data on race and ethnicity in counting MENA individuals as "white."[9] * This has been the practice of the US Census Bureau since the early 20th century.[6] According to Sarah Jonny, "Fearing harsh limitations on immigration, Lebanese and Syrian immigrants wished to be omitted from the Asian Exclusion Act of 1924, which blocked Asian immigration to the United States and therefore lobbied Congress to be identified as Caucasian."[6]

Groups like the Arab American Institute have been advocating since the 1980s for changes to the U.S. Census. MENA activists have argued for the creation of a MENA identity category separate from the white category, based on the notion that including people of MENA descent within the white category erases and renders invisible the needs of this group.[7] Jonny observes: "…the white category became too restrictive and prevented MENA individuals from understanding their population's trauma."[6] And Neda Maghjbouleh et al point out: "In making their case, activists argued that MENA populations are not actually perceived by others in the United States as White. They have suggested that September 11, 2011 (9/11), the War on Terror, and increasingly divisive rhetoric in the United States political campaigns further differentiated this group from Whites,

* Throughout this report, we follow AP guidelines to lower case white, except when white was capitalized in a quoted source (see the AMA – AAMC Center for Health Justice's *Advancing Health Equity: A Guide to Language, Narrative and Concepts* for additional discussion).

leading to discriminatory experiences. …[This is an issue hampered by] the invisibility of this population in administrative data."[9] From this perspective, the lack of official data renders "invisible the unique challenges faced by Arab/MENA populations."[3] Some commentators have labelled this a form of structural violence.[8]

It was not until 2010 that the U.S. Census Bureau undertook a national study to investigate the need for a separate MENA category. After 67 focus groups with over 700 participants from across the U.S., the Bureau concluded that it was "inaccurate" to count the MENA population within the "white" category.[10] The Census Bureau further studied this issue in the 2015 National Content Test (NCT), which tested options for the inclusion of a MENA category.[1] By 2017 the U.S. Census Bureau concluded that it would be "optimal" to use a category dedicated to MENA, because fewer people would select "some other race" and would see their identity reflected in the questionnaire.[6] However, the Trump Administration rejected the Census Bureau's recommendation, called for more research on the issue, and as a result a MENA option was not added to the 2020 Census.[6] In 2018, the Bureau noted public feedback from "a large segment of the MENA" population who advocated for the category to be considered an ethnicity, rather than a race.[11] The Census Bureau continues to study the inclusion of MENA as an option for the 2030 Census.[12]

The MENA population in the U.S. is comprised of at least 19 different nationalities and 11 ethnicities, with varying histories of immigration and acculturation in the U.S.[9] Absent from official data collection systems, "the MENA population has been undercounted and disadvantaged in terms of acquiring services that could benefit this group."[1,13]

While the 2010 Census generated an estimate of 1.9 million Arab Americans living in the U.S., the Arab American institute suggests that this number is closer to 3.7 million, with many respondents indicating "some other race" rather than "white."[6,8] Indeed, in both the 2000 and the 2010 Census, "some other race" was the third largest "race" group.[1] Randa Kayyali notes: "like Hispanics, Arabic-speaking people relate to and can be identified racially from 'black' to 'white' or can be classified as Asian or African if accounted for according to continental origins."[13]

In 2016, the Association of American Medical Colleges (AAMC) took the position of advocating for the including of MENA as a separate category, distinct from "white," in federal data collection efforts. The AAMC noted: "Americans of Middle Eastern and North African descent, a group currently aggregated in the "White race alone" category, experience health and health care inequities. In order to maximize the documentation of disparities relevant to this population, AAMC fully supports creating a separate subcategory for Middle Eastern/ North African (MENA) respondents to more adequately reflect their self-identity."[14]

Our AMA now advocates for the inclusion of MENA as a separate racial category on all AMA demographics forms and the use of MENA as a separate race category in all uses of demographic data including but not limited to medical records, government data collection and research, and within medical education. In this way, AMA policy is now better aligned with the AAMC's position. Moreover, the AMA supports the study of methods to further improve disaggregation of data by race which most accurately represent the diversity of patients. This builds upon existing AMA policy supporting the disaggregation of demographic data for Asian-American and Pacific Islander (AAPI) populations.

Last, the federal government's Health Information Technology (health IT) Certification Program requires that all certified electronic health record (EHR) systems have the ability to collect an individual's race and ethnicity data based on the United States (U.S.) Centers for Disease Control and Prevention (CDC) coding system guidelines. Nearly all physicians and hospitals utilize

certified health IT and EHRs in their practice. The CDC's code set is based on current federal standards for classifying data on race and ethnicity, specifically the minimum race and ethnicity categories defined by the U.S. Office of Management and Budget (OMB) and a more detailed set of race and ethnicity categories maintained by the U.S. Bureau of the Census. The main purpose of the code set is to facilitate use of federal standards for classifying data on race and ethnicity when these data are exchanged, stored, retrieved, or analyzed in electronic form. There are over 900 specific codes representing race and ethnicity. *Middle Eastern or North African* is a recognized code concept within the CDC code system (e.g., Concept Code 2118-8).[15]

As part of the federal government's certification program, EHRs are required to be able to record multiple races or ethnicities reported by a patient. For reporting purposes, EHRs are also required to be able to consolidate an individual's chosen race and ethnicity data into one or more OMB categories.[†] Health IT certification requirements do not specify which race and ethnicity codes must be supported by default, only that the minimum OMB categories are enabled. For example, an EHR vendor may choose to make only the core OMB categories active by default when installing an EHR in a medical practice. However, to pass federal certification requirements, all EHRs must have the ability to capture any and all CDC and OMB category codes. Some EHR products may not automatically enable specific race and ethnicity codes, but each product must support the entire CDC code system upon customer request.

Considerations

Some researchers have expressed concern that adding MENA as a separate category may have negative unintended consequences, including increased surveillance and policing of the MENA population in the U.S.[1,16] Khaled Bedyodun, for example, warns that "the proposed MENA box will facilitate War on Terror policing… [and] will chill constitutionally protected activity and further curb the civil liberties of Arab Americans."[17] Yet while this concern is acknowledged in the literature by other commentators, more weight has been given to the benefits of overcoming data invisibility for the MENA population in the U.S.[3,8,13] As noted by Hephzibah Strmic-Pawl et al, "it is important to trace race in order to track racism"[1]--and without clear data, the needs of this community will never be fully understood or addressed.

Chandra Ford, a leading expert on critical race theory and public health data, has also written about the need to take this opportunity to not only refine racial/ethnic categories and bolster data collection systems, but to investigate and acknowledge the central concepts of white supremacy, whiteness, and white privilege in data collection and analysis.[16] Ford and her colleague Mienah Sharif note that this is an "opportunity to offer guidance to the NIMHD [National Institute on Minority Health and Health Disparities] about the types of data that are needed to distinguish data that enable antiracism research from those that may further marginalize these populations."[16] Such advice is also relevant to our AMA. Ford and Sharif also urge caution, noting that there exists the risk of unintended harms from any additional surveillance efforts.

There are also significant and ongoing debates about how to best include MENA as an option in demographic forms. Indeed, there are some suggestions that the term is not the most appropriate to use, given the colonial roots of the term "Middle East." Activists, including the SWANA Alliance

[†] The OMB standards have one category for ethnicity—Hispanic or Latino—and five minimum categories for data on race. This includes Ethnic Categories: Hispanic or Latino and Racial Categories: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White.

(https://swanaalliance.com) advocate for the use of SWANA – South West Asian/North African – as a decolonial term in place of Middle Eastern, Near Eastern, Arab World or more.

In the peer-reviewed literature, the latest and most authoritative piece from Awad et al outlines three options for the collection of MENA data (derived from the Census Bureau's NCT):

Option 1: A streamlined/combined question. Respondents would be instructed to mark all boxes that apply (allowing for multiple race/ethnicity combinations).

Option 2: Separation of ethnicity and race. This would treat MENA as an ethnicity, akin to Hispanic/Latino in many forms.

Option 3: Adding a separate MENA category. This option would enable data collection instruments that are restricted to OMB categories to collect additional data. The 2020 Michigan Behavioral Risk Factor Surveillance System included this option. [3]

These three options are depicted in figure 1:

Figure 1: Three options for collecting MENA data

Option 1:

What is the person's race or origin?

Mark all boxes that apply AND print origins in the spaces below. Note, you may report more than one group.

☐ **White** – Print, for example, German, Irish, English, Italian, Polish, French, etc.

_____

☐ **Hispanic, Latino, or Spanish origin** – Print, for example, Mexican or Mexican American, Puerto Rican, Cuban, Salvadoran, Dominican, Colombian, etc.

_____

☐ **Black or African Am.** – Print, for example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.

_____

☐ **Asian** – Print, for example, Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, etc.

_____

☐ **American Indian or Alaska Native** – Print, for example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, etc.

_____

☐ **Middle Eastern or North African**– Print, for example, Lebanese, Iranian, Egyptian, Syrian, Moroccan, Algerian, etc.

_____

☐ **Native Hawaiian or Other Pacific Islander** – Print, for example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese, etc.

_____

☐ **Some other race of origin** – Print race or origin.

_____

☐ **Multi-Racial** – Print race(s) or origin(s).

_____

Option 2:

Is the person of Hispanic, Latino, or Spanish origin?
*Mark one or more boxes **AND** print origins.*

☐ **No,** not of Hispanic, Latino or Spanish Origin
☐ **Yes,** Mexican, Mexican Am., Chicano
☐ **Yes,** Puerto Rican
☐ **Yes,** Cuban
☐ **Yes,** another Hispanic, Latino or Spanish origin – Print, for example, Salvadoran, Dominican, Colombian, Guatemalan, Spaniard, Ecuadorian, etc.
_____

Is the person of Middle Eastern or North African origin?
*Mark one box **AND** print origins.*

☐ **No,** not of Middle Eastern or North African Origin
☐ **Yes** – Print, for example, Lebanese, Iranian, Egyptian, Syrian, Moroccan, Algerian, etc.
_____

What is the person's race?
*Mark one or more boxes **AND** print origins.*
☐ **White** – Print, for example, German, Irish, English, Italian, Polish, French, etc.
_____

☐ **Black or African Am.** – Print, for example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.
_____

☐ **American Indian or Alaska Native** – Print, for example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, etc.
_____
☐ **Asian** – Print, for example, Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, etc.
_____

Option 3:

☐ **Middle Eastern or North African or Arab** – Print, for example, Lebanese, Iranian, Egyptian, Syrian, Moroccan, Algerian, etc.
_____

Source: Awad GH, Abuelezam NN, Ajrouch KJ, Stiffler MJ. Lack of Arab or Middle Eastern and North African Health Data Undermines Assessment of Health Disparities. *Am J Public Health*. 2022;112(2):209-212.

There is currently no consensus on which of these options is optimal, and context will always matter. But the basic goal of including an option for collecting data on MENA origin has gained a lot of momentum. Awad et al note that "Given that the reason for the lack of an Arab/MENA category is likely associated with politics as opposed to science [referring to the science of data collection, not race as a scientific category], it is imperative that researchers and practitioners take the initiative to include this group in data collection."[3] The absence of a MENA option will further perpetuate the invisibility of the needs of this diverse group.

IMPLEMENTATION

Our AMA is developing a collaboration with the AAMC to study the implications of adding MENA as a racial category in one of our most important data assets, the AMA Physician Masterfile ("the Masterfile"). Initially built in 1906, the Masterfile contains current and historical training and professional certification data for approximately 1.4 million physicians (MD and DO), residents, and medical students throughout the U.S. These records are maintained into perpetuity. Medical schools and other physician organizations, federal agencies, and research institutions rely on the Masterfile as a valid and reliable source of information about our nation's physician workforce and their competencies.

Until recently, the Masterfile did not provide a comprehensive demographic breakdown of our nation's physicians, the languages they speak, the patient communities to whom they deliver care, or other considerations from which entities can derive a cultural context that bears on the differential health needs of patients across diverse American communities. However, in the past two years, working in collaboration with the AAMC and the Accreditation Council for Graduate Medical Education (ACGME), our AMA has made strides to improve our collection of race and ethnicity data. Our collaboration with the AAMC and the ACGME includes a pilot test of the mechanisms and implications of adding MENA as a separate category of racial/ethnic identity in the Masterfile. The pilot test may need several years of data to generate meaningful results.

Our AMA routinely collects survey data from physicians, and these surveys differ in their approach to defining and collecting race/ethnicity data. The AMA Physician Benchmark Survey, for example, currently does not directly collect race/ethnicity; but individual-level records could be matched to the AMA Physician Masterfile, with valid data from the Masterfile merged into the Physician Benchmark Survey dataset. In 2020, our AMA initiated a cross-sectional Minoritized and Marginalized Physician Survey (MMPS). The MMPS did not include MENA as a racial or ethnic option, instead using the categories of American Indian or Alaska Native, Asian, Black or African-American, Latinx or Hispanic, Native Hawaiian or Pacific Islander, white, or two or more races.

Recognizing the need for clarity and consistency in categories used across AMA demographic data collection, our AMA will study methods for reviewing and standardizing racial/ethnic categories in all AMA demographic forms as part of an AMA-wide "Data for Equity" review described in our AMA Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity, to be completed in 2023.[18]

Moving forward, we propose several approaches for studying methods and strategies for disaggregation of data by race/ethnicity to most accurately represent the diversity of patients and the physician workforce.

1. The most critical, as discussed above, is a pilot test of the inclusion of a MENA category in the Masterfile. We will collaborate closely with the AAMC on this initiative, since they have already begun work on this, comparing data from the American Medical School Application Service (AMCAS), which uses the standard OMB categories, with data from the AAMC Matriculating Student Questionnaire (MSQ), given annually to all first-year medical students, and which now includes a MENA option. This pilot test will enable us to quantify the effects of adding a MENA option, and the implications it has for other racial/ethnic categories. This may have profound implications for our understanding of the diversity of the physician workforce.

2. A parallel area of research will involve a structured review of empirical studies in medical journals, focusing on quantifying the extent to which they report MENA as a disaggregated category and how this may change over the coming years as more data sources include a MENA option. It is important to do this, because if MENA data are collected but not published, the end result will be a continued invisibility for this diverse group. This would be supported by tracking developments with federal standards, post 2020 Census discussions and publications, as well as outreach to MENA advocates. Time is needed to see which of the three options (or others that may be developed) described above gain traction. This will be an opportunity to continue to listen to the MENA population and respond to its needs.

3. We will conduct outreach to EHR vendors and/or the EHR vendor trade association (e.g., EHRA) in order to better understand the process vendors use to enable or activate race and ethnicity data collection in accordance with federal health IT certification requirements. We will also encourage physicians to reach out to their EHR vendors and inquire about their vendor's ability to enable or activate CDC-level race and ethnicity data capture.

This work could inform AMA efforts to provide culturally sensitive/appropriate education to patients and clinicians about why this data collection is important. Our efforts will emphasize how the data should/should not be used, both internally and with respect to sharing with third parties in and outside of the healthcare system, and the importance of having policies and procedures in physician practices for how to collect the information and what to do if someone does not want to provide answers. These efforts would be further guided by our general stance on privacy and position that efforts by the government to collect such data must include assurances that the data will not be used against individuals (e.g., not shared with immigration/DHS/DOJ authorities for law enforcement purposes), will be appropriately secured, and will not be used to withhold benefits or social services.

CONCLUSION

There are substantial and ongoing debates pertaining to the inclusion of a MENA option in data collection systems. As of February 2022, there are at least three viable options being debated in the peer-reviewed literature for how to best operationalize the inclusion of MENA as a distinct category in demographic forms. The US Census Bureau continues to research this issue. Our AMA is actively collaborating with the AAMC on a pilot test of the inclusion of a MENA category for medical students and physicians, and our AMA is committed--through our Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity--to a "Data for Equity" review that could be tasked with advancing the study and implementation of best practices for the collection of MENA data.

REFERENCES

1. Strmic-Pawl H, Jackson BA, Garner S. Race counts: racial and ethnic data on the U.S. Cnesus and the implications for tracking inequality. *Sociology of Race and Ethnicity.* 2018;4(1):1-13.
2. Mora G. Cross-field effects and ethnic classification: the institutionalization of Hispanic panethnicity, 1965 to 1990. *American Sociological Review.* 2014;79(2):183-210.
3. Awad GH, Abuelezam NN, Ajrouch KJ, Stiffler MJ. Lack of Arab or Middle Eastern and North African Health Data Undermines Assessment of Health Disparities. *Am J Public Health.* 2022;112(2):209-212.
4. Robbin A. Classifying racial and ethnic group data in the United States: the politics of negotiation and accomodation. *J Gov Inf.* 2000;27(2):129-156.
5. Maghbouleh N. From white to what? MENA and Iranian American non-white reflected race. *Ethnic and Racial Studies.* 2020;43(4):613-631.
6. Jonny S. The erasure of Middle Eastern and North African immigrants from the American narrative: a case for adding a MENA category to the United States. *Georgetown Immigration Law Journal.* 2021;35:1009-1013.
7. Abuelezam NN, El-Sayed AM, Galea S. Arab American Health in a Racially Charged U.S. *Am J Prev Med.* 2017;52(6):810-812.
8. Abboud S, Chebli P, Rabelais E. The Contested Whiteness of Arab Identity in the United States: Implications for Health Disparities Research. *Am J Public Health.* 2019;109(11):1580-1583.
9. Maghbouleh N, Schachter A, Flores RD. Middle Eastern and North African Americans may not be perceived, nor perceive themselves, to be White. *Proc Natl Acad Sci U S A.* 2022;119(7).
10. Compton E, Bentley M, Ennis S, Rastogi S. *2010 Census Race and Hispanic Origin Alternative Questionnaire Experiment.* Washington, DC: U.S. Census Bureau; 2010.
11. Wang HL. The U.S. census sees Middle Eastern and North African people as white. Many don't. https://www.npr.org/2022/02/17/1079181478/us-census-middle-eastern-white-north-african-mena. Published 2022. Accessed March 4, 2022.
12. United States Census Bureau. Will the 2030 Census include a Middle Eastern or North African (MENA) category? https://www.census.gov/programs-surveys/decennial-census/decade/2020/planning-management/release/faqs-race-ethnicity.html. Published 2021. Accessed March 4, 2022.
13. Kayyali R. U.S. Census classifications and Arab Americans: contestations and definitions of identity markers. *Journal of Ethnic and Migration Studies.* 2013;39(8):1299-1318.
14. AAMC. AAMC Submits Letter to OMB on Presenting Federal Data on Race and Ethnicity. https://www.aamc.org/advocacy-policy/washington-highlights/aamc-submits-letter-omb-presenting-federal-data-race-and-ethnicity. Published 2016. Accessed February 22, 2022.
15. CDC. Public Health Information Network Vocabulary Access and Distribution System (PHIN VADS). https://phinvads.cdc.gov/vads/ViewCodeSystemConcept.action?oid=2.16.840.1.113883.6.238&code=2118-8. Published 2021. Accessed March 7, 2022.
16. Ford CL, Sharif MZ. Arabs, Whiteness, and Health Disparities: The Need for Critical Race Theory and Data. *Am J Public Health.* 2020;110(8):e2-e3.
17. Beydoun K. A demographic threat? proposed reclassification of Arab Americans on the 2020 Census. *Michigan Law Review First Impressions.* 2015(114):1-8.
18. American Medical Association. The AMA's strategic plan to embed racial justice and advance health equity. https://www.ama-assn.org/about/leadership/ama-s-strategic-plan-embed-racial-justice-and-advance-health-equity. Published 2021. Accessed May 25, 2021.

APPENDIX: RELEVANT AMA POLICY

AMA policy provides that AMA will: (1) add "Middle Eastern/North African (MENA)" as a separate racial category on all AMA demographics forms; (2) advocate for the use of "Middle Eastern/North African (MENA)" as a separate race category in all uses of demographic data including but not limited to medical records, government data collection and research, and within medical education; and (3) study methods to further improve disaggregation of data by race which most accurately represent the diversity of our patients. (Policy D-350.979, "Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent").

AMA will continue to work with the Association of American Medical Colleges to collect race/ethnicity information through the student matriculation file and the GME census including automating the integration of this information into the Masterfile. (Policy D-630.972, "AMA Race/Ethnicity Data").

AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology. AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice. AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category "race" can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities. AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease. (Policy H-65.953, "Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice").

AMA encourages the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race, ethnicity and preferred language. (Policy H-315.963, "Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities").

AMA supports the disaggregation of demographic data regarding: (a) Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and (b) ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine. AMA: (a) will advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; (b) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (c) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (d) will report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine. (Policy H-350.954, "Disaggregation of Demographic Data Within Ethnic Groups").

Last, AMA will develop a plan with input from the Minority Affairs Section and the Chief Health Equity Officer to improve consistency and reliability in the collection of racial and ethnic minority demographic information for physicians and medical students. (Policy D-350.982, "Racial and Ethnic Identity Demographic Collection by the AMA").

REPORT OF THE BOARD OF TRUSTEES

B of T Report 19-A-22

Subject: Demographic Report of the House of Delegates and AMA Membership

Presented by: Bobby Mukkamala, MD, Chair

INTRODUCTION

This informational report, "Demographic Report of the House of Delegates and AMA Membership," is prepared pursuant to Policy G-600.035, "House of Delegates Demographic Report," which states:

> A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.

In addition, this report includes information pursuant to Policy G-635.125, "AMA Membership Demographics," which states:

> Stratified demographics of our AMA membership will be reported annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.

This document compares the House of Delegates (HOD) with the entire American Medical Association (AMA) membership and with the overall United States physician and medical student population. Medical students are included in all references to the total physician population throughout this report to remain consistent with the biannual Council on Long Range Planning and Development report. In addition, residents and fellows endorsed by their states to serve as sectional delegates and alternate delegates are included in the appropriate comparisons for the state and specialty societies. For the purposes of this report, AMA-HOD includes both delegates and alternate delegates.

DATA SOURCES

Lists of delegates and alternate delegates are maintained in the Office of House of Delegates Affairs and are based on official rosters provided by the relevant society. The lists used in this report reflect 2021 year-end delegation rosters.

Data on individual demographic characteristics are taken from the AMA Physician Masterfile, which provides comprehensive demographic, medical education, and other information on all United States and international medical graduates (IMGs) who have undertaken residency training in the United States. Data on AMA membership and the total physician and medical student population are taken from the Masterfile and are based on 2021 year-end information.

Some key considerations must be kept in mind regarding the information captured in this report. Vacancies in delegation rosters mean that the total number of delegates is less than the 691 allotted

at the November 2021 Special Meeting, and the number of alternate delegates is nearly always less than the full allotment. As such, the total number of delegates and alternate delegates is 1,126 rather than the 1,382 allotted. Race and ethnicity information, which is provided directly by physicians, is missing for approximately 25% of AMA members and approximately 23% of the total United States physician and medical student population, limiting the ability to draw firm conclusions. Efforts to improve AMA data on race and ethnicity are part of Policy D-630.972. Improvements have been made in collecting data on race and ethnicity, resulting in a decline in reporting race/ethnicity as unknown in the HOD and the overall AMA membership.

CHARACTERISTICS OF AMA MEMBERSHIP AND DELEGATES

Table 1 presents basic demographic characteristics of AMA membership and delegates along with corresponding figures for the entire physician and medical student population.

Data on physicians' and students' current activities appear in Table 2. This includes life stage as well as present employment and self-designated specialty.

Table 1. Basic Demographic Characteristics of AMA Members & Delegates, December 2021

2021	AMA Members	All Physicians and Medical Students	AMA Delegates & Alternate Delegates 1,2
Total	277,823	1,419,190	1,126
Mean age (years)[3]	47	53	55
Age distribution (percent)			
Under age 40	50.03%	27.31%	18.56%
40-49 years	11.24%	17.95%	15.72%
50-59 years	9.86%	16.77%	18.65%
60-69 years	10.05%	16.67%	27.89%
70 or more	18.82%	21.30%	19.18%
Gender (percent)			
Male	60.60%	63.25%	64.56%
Female	38.55%	36.02%	35.35%
Unknown	0.85%	0.72%	0.09%
Race/ethnicity (percent)			
Asian	14.79%	15.39%	13.50%
Black or African American	4.89%	4.33%	5.15%
Hispanic, Latino, or Spanish Origin	5.94%	5.70%	3.46%
Native American	0.34%	0.27%	0.27%
Other	1.36%	1.43%	1.51%
Unknown	24.79%	23.46%	11.10%
White	47.89%	49.41%	65.01%
Education (percent)			
US or Canada	82.20%	77.67%	92.18%
IMG	17.80%	22.33%	7.82%

[1] There were 256 vacancies as of year's end, 18 of which were delegates and the remainder being unfilled alternate delegate slots.
[2] Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
[3] Age as of December 31. Mean age is the arithmetic average.
[4] Includes other self-reported racial and ethnic groups.

2021	AMA Members	All Physicians and Medical Students	AMA Delegates & Alternate Delegates 1,2
Life Stage (percent)			
Student[6]	20.10%	7.79%	6.66%
Resident[6]	25.66%	9.88%	6.75%
Young (under 40 or first 8 years in practice)	8.61%	13.71%	7.37%
Established (40-64)	21.78%	38.91%	44.23%
Senior (65+)	23.86%	29.71%	34.99%
Present Employment (percent)			
Self-employed solo practice	6.42%	7.94%	11.19%
Two physician practice	1.36%	1.77%	2.13%
Group practice	23.65%	39.55%	38.72%
HMO	0.24%	0.16%	0.89%
Medical school	0.94%	1.45%	3.20%
Non-government hospital	3.30%	4.84%	6.84%
State or local government hospital	3.79%	6.23%	10.39%
US government	0.87%	1.64%	3.29%
Locum Tenens	0.14%	0.19%	0.18%
Retired/Inactive	11.42%	12.42%	7.19%
Resident/Intern/Fellow	25.66%	9.88%	6.75%
Student	20.10%	7.79%	6.66%
Other/Unknown	2.12%	6.13%	2.58%
specialty (percent)			
Family Medicine	8.52%	11.34%	10.57%
Internal Medicine	19.49%	22.58%	20.78%
Surgery	13.18%	13.32%	19.72%
Pediatrics	5.09%	8.69%	4.09%
OB/GYN	4.83%	4.57%	6.84%
Radiology	3.32%	4.40%	5.33%
Psychiatry	4.19%	5.16%	4.26%
Anesthesiology	3.82%	4.93%	4.00%
Pathology	1.67%	2.19%	2.58%
Other specialty	15.78%	15.04%	15.19%
Students	20.10%	7.79%	6.66%

[5] See Appendix for a listing of specialty classifications.

[6] Students and residents are categorized without regard to age.

Appendix

Specialty classification using physician's self-designated specialties.

Major Specialty Classification	AMA Physician Masterfile Classification
Family Practice	General Practice, Family Practice
Internal Medicine	Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology
Surgery	General Surgery, Otolaryngology, Ophthalmology, Neurological Surgery, Orthopedic Surgery, Plastic Surgery, Colon and Rectal Surgery, Thoracic Surgery, Urological Surgery
Pediatrics	Pediatrics, Pediatric Allergy, Pediatric Cardiology
Obstetrics/Gynecology	Obstetrics and Gynecology
Radiology	Diagnostic Radiology, Radiology, Radiation Oncology
Psychiatry	Psychiatry, Child Psychiatry
Anesthesiology	Anesthesiology
Pathology	Forensic Pathology, Pathology
Other Specialty	Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 1-A-22

Subject: Amendment to E-1.1.6, "Quality"

Presented by: Alexander M. Rosenau, DO, Chair

INTRODUCTION

At the November 2021 Special Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-N-21, "Amendments to Opinions 1.2.11, 'Ethical Innovation in Medical Practice'; 11.1.2, 'Physician Stewardship of Health Care Resources'; 11.2.1, 'Professionalism in Health Care Systems'; and 1.1.6, 'Quality.'" The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-1.1.6, Quality

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

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

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

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

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

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

* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

(e) Demonstrating commitment to develop, implement, and disseminate appropriate, well-defined quality and performance improvement measures in their daily practice.

(f) Participating in educational, certification, and quality improvement activities that are well designed and consistent with the core values of the medical profession.

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 2-A-22

Subject: Amendment to E-1.2.11, "Ethical Innovation in Medical Practice"

Presented by: Alexander M. Rosenau, DO, Chair

INTRODUCTION

At the November 2021 Special Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-N-21, "Amendments to Opinions 1.2.11, 'Ethical Innovation in Medical Practice'; 11.1.2, 'Physician Stewardship of Health Care Resources'; 11.2.1, 'Professionalism in Health Care Systems'; and 1.1.6, 'Quality.'" The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-1.2.11, Ethically Sound Innovation in Clinical Practice

Innovation in medicine can span a wide range of activities. It encompasses not only improving an existing intervention, using an existing intervention in a novel way, or translating knowledge from one clinical context into another but also developing or implementing new technologies to enhance diagnosis, treatment, and health care operations. Innovation shares features with both research and patient care, but it is distinct from both.

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

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

(a) Innovate on the basis of sound scientific evidence and appropriate clinical expertise.

(b) Seek input from colleagues or other medical professionals in advance or as early as possible in the course of innovation.

* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

(c) Design innovations so as to minimize risks to individual patients and maximize the likelihood of application and benefit for populations of patients.

(d) Be sensitive to the cost implications of innovation.

(e) Be aware of influences that may drive the creation and adoption of innovative practices for reasons other than patient or public benefit.

When they offer existing innovative diagnostic or therapeutic services to individual patients, physicians must:

(f) Base recommendations on patients' medical needs.

(g) Refrain from offering such services until they have acquired appropriate knowledge and skills.

(h) Recognize that in this context informed decision making requires the physician to disclose:

(i) how a recommended diagnostic or therapeutic service differs from the standard therapeutic approach if one exists;

(ii) why the physician is recommending the innovative modality;

(iii) what the known or anticipated risks, benefits, and burdens of the recommended therapy and alternatives are;

(iv) what experience the professional community in general and the physician individually has had to date with the innovative therapy;

(v) what conflicts of interest the physician may have with respect to the recommended therapy.

(i) Discontinue any innovative therapies that are not benefiting the patient.

(j) Be transparent and share findings from their use of innovative therapies with peers in some manner. To promote patient safety and quality, physicians should share both immediate or delayed positive and negative outcomes.

To promote responsible innovation, health care institutions and the medical profession should:

(k) Ensure that innovative practices or technologies that are made available to physicians meet the highest standards for scientifically sound design and clinical value.

(l) Require that physicians who adopt innovations into their practice have relevant knowledge and skills.

(m) Provide meaningful professional oversight of innovation in patient care.

(n) Encourage physician-innovators to collect and share information about the resources needed to implement their innovations safely, effectively, and equitably.

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 3-A-22

Subject: Amendment to E-11.1.2, "Physician Stewardship of Health Care Resources"

Presented by: Alexander M. Rosenau, DO, Chair

INTRODUCTION

At the November 2021 Special Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-N-21, "Amendments to Opinions 1.2.11, 'Ethical Innovation in Medical Practice'; 11.1.2, 'Physician Stewardship of Health Care Resources'; 11.2.1, 'Professionalism in Health Care Systems'; and 1.1.6, 'Quality.'" The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-11.1.2, Physician Stewardship of Health Care Resources

Physicians' primary ethical obligation is to promote the well-being of individual patients. Physicians also have a long-recognized obligation to patients in general to promote public health and access to care. This obligation requires physicians to be prudent stewards of the shared societal resources with which they are entrusted. Managing health care resources responsibly for the benefit of all patients is compatible with physicians' primary obligation to serve the interests of individual patients.

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

(a) Base recommendations and decisions on patients' medical needs.

(b) Use scientifically grounded evidence to inform professional decisions when available.

(c) Help patients articulate their health care goals and help patients and their families form realistic expectations about whether a particular intervention is likely to achieve those goals.

(d) Endorse recommendations that offer reasonable likelihood of achieving the patient's health care goals.

* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

(e) Use technologies that have been demonstrated to meaningfully improve clinical outcomes to choose the course of action that requires fewer resources when alternative courses of action offer similar likelihood and degree of anticipated benefit compared to anticipated harm for the individual patient but require different levels of resources.

(f) Be transparent about alternatives, including disclosing when resource constraints play a role in decision making.

(g) Participate in efforts to resolve persistent disagreement about whether a costly intervention is worthwhile, which may include consulting other physicians, an ethics committee, or other appropriate resource.

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

(h) Encouraging health care administrators and organizations to make cost data transparent (including cost accounting methodologies) so that physicians can exercise well-informed stewardship.

(i) Advocating that health care organizations make available well-validated technologies to enhance diagnosis, treatment planning, and prognosis and support equitable, prudent use of health care resources.

(j) Ensuring that physicians have the training they need to be informed about health care costs and how their decisions affect resource utilization and overall health care spending.

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

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 4-A-22

Subject: Amendment to E-11.2.1, "Professionalism in Health Care Systems"

Presented by: Alexander M. Rosenau, DO, Chair

INTRODUCTION

At the November 2021 Special Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-N-21, "Amendments to Opinions 1.2.11, 'Ethical Innovation in Medical Practice'; 11.1.2, 'Physician Stewardship of Health Care Resources'; 11.2.1, 'Professionalism in Health Care Systems'; and 1.1.6, 'Quality.'" The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-11.2.1, Professionalism in Health Care Systems

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

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

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

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

Physicians in leadership positions within health care organizations and the profession should:

* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

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

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

(c) Ensure that all such tools:

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

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

b. Practice guidelines, formularies, and similar tools should be based on best available evidence and developed in keeping with ethics guidance.

c. Clinical prediction models, decision support tools, and similar tools such as those that rely on AI technology must rest on the highest-quality data and be independently validated in relevantly similar populations of patients and care settings.

(ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;

(iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;

(iv) mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.

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

(i) provide care for patients with difficult to manage medical conditions;

(ii) practice at their full capacity, but not beyond.

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

(f) Ensure that the use of financial incentives and other tools is routinely monitored to:

(i) identify and address adverse consequences;

(ii) identify and encourage dissemination of positive outcomes.

All physicians should:

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

(h) Advocate for changes in how the delivery of care is organized to promote access to high-quality care for all patients.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 5-A-22

Subject: Pandemic Ethics and the Duty of Care (D-130.960)

Presented by: Alexander M. Rosenau, DO, Chair

Policy D-130.960, "Pandemic Ethics and the Duty of Care," adopted by the American Medical Association (AMA) House of Delegates in June 2021, asks the Council on Ethical and Judicial Affairs to "reconsider its guidance on pandemics, disaster response and preparedness in terms of the limits of professional duty of individual physicians, especially in light of the unique dangers posed to physicians, their families and colleagues during the COVID-19 global pandemic."

A CONTESTED DUTY

As several scholars have noted, the idea that physicians have a professional duty to treat has waxed and waned historically, at least in the context of infectious disease [1,2,3]. Many physicians fled the Black Death; those who remained did so out of religious devotion, or because they were enticed by remuneration from civic leaders [1]. Even in the early years of the AIDS epidemic, physicians contested whether they had a responsibility to put themselves at risk for what was then a lethal and poorly understood disease [3]. Yet the inaugural edition of the AMA *Code of Medical Ethics* in 1847 codified a clear expectation that physicians would accept risk:

> When pestilence prevails, it is [physicians'] duty to face the danger, and to continue their labors for the alleviation of suffering, even at the jeopardy of their own lives [1847 Code, p. 105].

That same sensibility informs AMA's Declaration of Professional Responsibility when it calls on physicians to "apply our knowledge and skills when needed, though it may put us at risk." And it is embedded in current guidance in the *Code*. Based on physicians' commitment of fidelity to patients, Opinion 8.3, "Physicians' Responsibilities in Disaster Response and Preparedness," enjoins a duty to treat. This opinion provides that "individual physicians have an obligation to provide urgent medical care during disasters . . . . even in the face of greater than usual risks to physicians' own safety, health, or life." The *Code* is clear that this obligation isn't absolute, however. Opinion 8.3 qualifies the responsibility when it notes that "physicians also have an obligation to evaluate the risks of providing care to individual patients versus the need to be available to provide care in the future."

From the perspective of the *Code*, then, the question isn't whether physicians have a duty to treat but how to think about the relative strength of that duty in varying circumstances.

INTERPRETING ETHICS GUIDANCE

Over the course of the COVID-19 pandemic, AMA has drawn on the *Code* to explore this question in reflections posted to its COVID-19 Resource Center on whether physicians may decline to treat unvaccinated patients and under what conditions medical students may ethically be permitted to graduate early to join the physician workforce.

Drawing particularly on guidance in Opinion 1.1.2, "Prospective Patients," and—in keeping with Opinion 8.3, taking physicians' expertise and availability as itself a health care resource—Opinion 11.1.3, "Allocating Limited Health Care Resources," as well as Opinion 8.7, "Routine Universal Immunization of Physicians," these analyses offer key criteria for assessing the strength of the duty to treat:

- urgency of medical need
- risk to other patients or staff in a physician's practice
- risk to the physician
- likelihood of occurrence and magnitude of risk

To these criteria should be added likelihood of benefit—that is, physicians should not be obligated to put themselves at significant risk when patients are not likely to benefit from care [2]. Although the *Code* does not link the question specifically to situations of infectious disease or risk to physicians, it supports this position. Opinion 5.5, "Medically Ineffective Interventions," provides that physicians are not obligated to provide care that, in their considered professional judgment, will not provide the intended clinical benefit or achieve the patient's goals for care.

Similarly, to the extent that the *Code* articulates a general responsibility on the part of physicians to protect the well-being of patients and staff, it supports consideration of risk to others in assessing the relative strength of a duty to treat. Thus, while Opinion 1.1.2 explicitly prohibits physicians from declining a patient based solely on the individual's disease status, it permits them to decline to provide care to patients who threaten the well-being of other patients or staff. In the context of a serious, highly transmissible disease this responsibility to minimize risk to others in professional settings may constrain the presumption of a duty to treat.

Yet the *Code* is also silent on important matters that have been noted in the literature. For example, it doesn't address whether the duty to treat applies uniformly across all medical specialties. Some scholars argue that the obligation should be understood as conditioned by physicians' expertise, training, and role in the health care institution [4,5,6]. In essence, the argument is that the more relevant a physician's clinical expertise is to the needs of the moment, the more reasonable it is to expect physicians to accept greater personal risk than clinicians who don't have the same expertise. The point is well taken. Guidance that addresses the duty to treat "as if it were the exclusive province of any individual health profession" [2], risks undercutting its own value to offer insight into that duty.

Moreover, for the most part the *Code* restricts its analysis of physicians' responsibilities to the context of their professional lives, addressing their duties to patients, and to a lesser degree, to their immediate colleagues in health care settings. In this, guidance overlooks the implications of responsibilities physicians hold in their *nonprofessiona*l lives—as members of families, as friends, as participants in community outside the professional domain. Thus, it is argued, a physician whose household includes a particularly vulnerable individual—e.g., someone who has chronic underlying medical condition or is immune compromised and thus at high risk for severe disease—has a less stringent duty to treat than does a physician whose personal situation is different.

Although the *Code* acknowledges that physicians indeed have lives as moral agents outside medicine (Opinion 1.1.7, "Physician Exercise of Conscience"), it does not reflect as deeply as it might about the nature of competing personal obligations or how to balance the professional and the personal. In much the same way as understanding the duty to treat as the responsibility of a single profession, restricting analysis to a tension between altruism and physicians' individual self-

interest "fails to capture the real moral dilemmas faced by health care workers in an infectious epidemic" [7].

SUPPORTING THE HEALTH CARE WORKFORCE

As adopted in 1847, the *Code* addressed physicians' ethical obligations in the broader framework of reciprocal obligations among medical professionals, patients, and society. Over time, the *Code* came to focus primarily on physician conduct.

Pandemic disease doesn't respect conceptual boundaries between the professional and the personal, the individual and the institutional. Nor does it respect the borders of communities or catchment areas. In situations of pandemic disease, "the question is one of a social distribution of a biologically given risk within the workplace and society at large" [7].

Health Care Institutions

Under such conditions, it is argued, the duty to treat "is not to be borne solely by the altruism and heroism of individual health care workers" [7]. Moreover, as has been noted,

> … organizations, as well as individuals, can be virtuous. A virtuous organization encourages and nurtures the virtuous behavior of the individuals within it. At the very least, the virtuous institution avoids creating unnecessary barriers to the virtuous behavior of individuals [2].

The *Code* is not entirely insensitive to the ethics of health care institutions. It touches on institutions' responsibility to the communities they serve (Opinion 11.2.6, "Mergers between Secular and Religiously Affiliated Health Care Institutions"), and to the needs of physicians and other health care personnel who staff them (Opinions 11.1.2, "Physician Stewardship of Health Care Resources," and 11.2.1, "Professionalism in Health Care Systems). Health care facilities and institutions are the locus within which the practice of today's complex health care takes place. As such, institutions—notably nonprofit institutions—too have duties,

> … fidelity to patients, service to patients, ensuring that the care is high quality and provided "in an effective and ethically appropriate manner"; service to the community the hospital serves, deploying hospital resources "in ways that enhance the health and quality of life" of the community; and institutional stewardship [CEJA 2-A-18].

Analyses posted to the AMA's COVID-19 Resource Center look to this guidance to examine institutional obligations to protect health care personnel and to respect physicians who voice concern when institutional policies and practices impinge on clinicians' ability to fulfill their ethical duties as health care professionals.

Although existing guidance does not explicitly set out institutional responsibility to provide appropriate resources and strategies to mitigate risk for health care personnel, it does support such a duty. The obligation to be responsible stewards of resources falls on health care institutions as well as individuals. To the extent that health care professionals themselves are an essential and irreplaceable resource for meeting patient and community needs, institutions have an ethical duty to protect the workforce (independent of occupational health and safety regulation). On this view, institutions discharge their obligations to the workforce when, for example, they

- support robust patient safety and infection control practices
- make immunization readily available to health care personnel

- provide adequate supplies of appropriate personal protective equipment (PPE)
- ensure that staffing patterns take into account the toll that patient care can exact on frontline clinicians
- distribute burdens equitably among providers in situations when individual physicians or other health care personnel *should not* put themselves at risk
- have in place fair and transparent mechanisms for responding to individuals who decline to treat on the basis of risk. (Compare Opinion 8.7, "Routine Universal Immunization of Physicians.")

Equally, institutions support staff by gratefully acknowledging the contributions all personnel make to the operation of the institution and providing psychosocial support for staff.

Professional Organizations

So too physicians and other health care professionals should be able to rely on their professional organizations to advocate for appropriate support of the health care workforce, as in fact several organizations have done over the course of the COVID-19 pandemic. In March 2020, the American Medical Association, American Hospital Association, and American Nurses Association, for example, jointly argued vigorously for and helped secure use of the Defense Production Act (DPA) to provide PPE. The American College of Physicians similarly urged use of the DPA to address the shortage of PPE. Physicians for Human Rights led a coalition of organizations that called on the National Governors Association to urge governors to implement mandatory standards for protecting health workers during the pandemic.

The AMA further advocated for opening visa processing for international physicians to help address workforce issues, and secured financial support for physician practices under the Provider Relief Fund of the American Rescue Plan Act.

Public Policy

As noted, the *Code* originally delineated reciprocal obligations among physicians, patients, and society. Such obligations on the part of communities and public policymakers should be acknowledged as among the main factors that "contour the duty to treat" [1]. More specifically, it is argued,

> in preparation for epidemics communities should: 1) take all reasonable precautions to prevent illness among health care workers and their families; 2) provide for the care of those who do become ill; 3) reduce or eliminate malpractice threats for those working in high-risk emergency situations; and 4) provide reliable compensation for the families of those who die while fulfilling this duty [1].

In the face of the failure on the part of health care institutions and public agencies to ensure that essential resources have been in place to reduce risk and lessen the burdens for individuals of taking on the inevitable risk that remains, it is understandable that physicians and other health care professionals may resent the expectation that they will unhesitatingly put themselves at risk. At least one scholar has forcefully argued that, in the case of COVID-19, celebrations of medical heroism were overwhelmingly insensitive to the fact such heroism was the "direct, avoidable consequence" of institutional and public policy decisions that left the health care system unprepared and transferred the burden of responding to the pandemic to individual health care professionals [8].

ACKNOWLEDGING THE DUTY TO TREAT: SOLIDARITY

In the end, seeing the duty to treat as simply a matter of physicians' altruistic dedication to patients forecloses considerations that can rightly condition the duty in individual circumstances. As Opinion 8.3 observes, providing care for individual patients in immediate need is not physicians only obligation in a public health crisis. They equally have an obligation to be part of ensuring that care can be provided in the future. Equating duty to treat with altruism "makes invisible moral conflicts between the various parties to whom a person may owe care, and interferes with the need of healthcare professionals to understand that they must take all possible measures consistent with the social need for a functioning healthcare system to protect themselves in an epidemic" [7].

Further, such a view not only elides institutional and societal obligations but misrepresents how the duty actually plays out in contemporary health care settings. The risks posed by pandemic disease are distributed across the health care workforce, not uniquely borne by individuals, let alone by individual physicians. Ultimately, the risk refused by one will be borne by someone else, someone who is more often than not a colleague [2,7]. From this perspective, accepting the duty to treat is an obligation physicians owe to fellow health care personnel as much as to patients or to society.

AN ENDURING PROFESSIONAL RESPONSIBILITY

Taken together, the foregoing considerations argue that physicians indeed *should* recognize the duty to treat as a fundamental obligation of professional ethics. This is not to argue that the duty is absolute and unconditional. However, as the Preface to Opinions of the Council on Ethical and Judicial Affairs observes, recognizing when circumstances argue against adhering to the letter of one's ethical obligations

> … requires physicians to use skills of ethical discernment and reflection. Physicians are expected to have compelling reasons to deviate from guidance when, in their best judgment, they determine it is ethically appropriate or even necessary to do so.

Decisions to decline a duty to treat during a public health crisis carry consequences well beyond the immediate needs of individual patients. In exercising the required discernment and ethical reflection, physicians should take into account:

- the urgency of patients' medical need and likelihood of benefit
- the nature and magnitude of risks to the physician and others to whom the physician also owes duties of care
- the resources available or reasonably attainable to mitigate risk to patients, themselves and others
- other strategies that could reasonably be implemented to reduce risk, especially for those who are most vulnerable
- the burden declining to treat will impose on fellow health care workers

Physicians who themselves have underlying medical conditions that put them at high risk for severe disease that cannot reasonably be mitigated, or whose practices routinely treat patients at high risk, have a responsibility to protect themselves as well as their patients. But protecting oneself and one's patients carries with it a responsibility to identify and act on opportunities to support colleagues who take on the risk of providing frontline care.

Physicians and other health care workers *should* be able to rely on the institutions within which they work to uphold the organization's responsibility to promote conditions that enable caregivers

to meet the ethical requirements of their professions. So too, physicians and other health care workers *should* be able to trust that public policymakers will make and enforce well-considered decisions to support public health and the health care workforce. When those expectations are not met, physicians have a responsibility to advocate for change [Principles III, IX].

Yet, grounded as it is in physicians' commitment of fidelity to patients, the professional duty to treat ultimately overrides the failure of institutions or society.

REFERENCES

1 Huber SJ, Wynia MK.-When pestilence prevails … physician responsibilities in epidemics. *Am J Bioethics* 2004;4(1):w5-w11.
2 Brody H, Avery EN-Medicine's duty to treat pandemic illness: solidarity and vulnerability. Hast Center Report 2009;1:40-48.
3 Arras JD.-The fragile web of responsibility: AIDS and the duty to treat. *Hast Center Report* 1988;3:10-20.
4 McConnell D.-Balancing the duty to treat with the duty to family in the context of the COVID-19 pandemic. *J Med Ethics* 2020;46:360-363.
5 Bakewell F, Pauls MA, Migneault D.-Ethical considerations of the duty to care and physician safety in the COVID-19 pandemic. *CJEM* 2020;22(4):407-410.
6 Orentlicher D.-The physician's duty to treat during pandemics. *Am J Public Health* 2018;108(11):1459-1461.
7 Reid L.-Diminishing returns? risk and the duty to care in the SARS epidemic. *Bioethics* 2005;19(4):348-361.
8 Shuklenk U.-What health care professionals owe us: why their duty to treat during a pandemic is contingent on personal protective equipment (PPE). *J Med Ethics* 2020;46:432–435.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 6-A-22

Subject: Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report

Presented by: Alexander M. Rosenau, DO, Chair

At the 2003 Annual Meeting, the Council on Ethical and Judicial Affairs (CEJA) presented a detailed explanation of its judicial function. This undertaking was motivated in part by the considerable attention professionalism has received in many areas of medicine, including the concept of professional self-regulation.

CEJA has authority under the Bylaws of the American Medical Association (AMA) to disapprove a membership application or to take action against a member. The disciplinary process begins when a possible violation of the Principles of Medical Ethics or illegal or other unethical conduct by an applicant or member is reported to the AMA. This information most often comes from statements made in the membership application form, a report of disciplinary action taken by state licensing authorities or other membership organizations, or a report of action taken by a government tribunal.

The Council rarely re-examines determinations of liability or sanctions imposed by other entities. However, it also does not impose its own sanctions without first offering a hearing to the physician. CEJA can impose the following sanctions: applicants can be accepted into membership without any condition, placed under monitoring, or placed on probation. They also may be accepted, but be the object of an admonishment, a reprimand, or censure. In some cases, their application can be rejected. Existing members similarly may be placed under monitoring or on probation, and can be admonished, reprimanded or censured. Additionally, their membership may be suspended or they may be expelled. Updated rules for review of membership can be found at https://www.ama-assn.org/governing-rules.

Beginning with the 2003 report, the Council has provided an annual tabulation of its judicial activities to the House of Delegates. In the appendix to this report, a tabulation of CEJA's activities during the most recent reporting period is presented.

APPENDIX

CEJA
Judicial Function
Statistics

APRIL 1, 2021 – MARCH 31, 2022

Physicians Reviewed	SUMMARY OF CEJA ACTIVITIES
2	Determinations of no probable cause
27	Determinations following a plenary hearing
14	Determinations after a finding of probable cause, based only on the written record, after the physician waived the plenary hearing

Physicians Reviewed	FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS
4	No sanction or other type of action
2	Monitoring
11	Probation
5	Revocation
5	Suspension
0	Denied
0	Suspension lifted
1	Censure
7	Reprimand
8	Admonish

Physicians Reviewed	PROBATION/MONITORING STATUS
13	Members placed on Probation/Monitoring during reporting interval
10	Members placed on Probation without reporting to Data Bank
6	Probation/Monitoring concluded satisfactorily during reporting interval
0	Memberships suspended due to non-compliance with the terms of probation
8	Physicians on Probation/Monitoring at any time during reporting interval who paid their AMA membership dues
5	Physicians on Probation/Monitoring at any time during reporting interval who did not pay their AMA membership dues

REPORT OF THE SPEAKERS

Speakers' Report 01-A-22

Subject: Recommendations for Policy Reconciliation

Presented by: Bruce A. Scott, MD, Speaker; and Lisa Bohman Egbert, MD, Vice Speaker

---

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."

Your Speakers present this report to deal with policies, or portions of policies, that are no longer relevant or that were affected by actions taken at recent meetings of the House of Delegates. Suggestions on other policy statements that your Speakers might address should be sent to hod@ama-assn.org for possible action. Where changes to policy language will be made, additions are shown with underscore and deletions are shown with strikethrough, and where necessary, editorial corrections will also be made (e.g., numbering corrections).

RECOMMENDED RECONCILIATIONS

Policies to be rescinded in part

- H-65.952, "Racism as a Public Health Threat"
  1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
  2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
  ~~3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.~~
  4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
  5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
  6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

  Board of Trustees Report 6-N-21, "Mitigating the Effects of Racism in Health Care: 'Best Practices'," was prepared specifically in response to paragraph 3 of this policy and that part of

the policy will be rescinded. As additional reports are forthcoming pursuant to this policy and other related policies (D-350.981, "Racial Essentialism in Medicine;" H-65.952, "Racism as a Public Health Threat;" and H-65.953, "Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice"), this portion of the policy has been fulfilled, and the four policies will allow additional reports addressing the matter as best practices are identified.

- D-600.956, "Increasing the Effectiveness of Online Reference Committee Testimony"
  1. Our AMA will conduct a trial of two-years during which all reference committees, prior to the in-person reference committee hearing, produce a preliminary reference committee document based on the written online testimony.
  2. The preliminary reference committee document will be used to inform the discussion at the in-person reference committee.
  3. There be an evaluation to determine if this procedure should continue.
  ~~4. Our AMA will pursue any bylaw changes that might be necessary to allow this trial.~~
  5. The period for online testimony will be no longer than 14 days.

  Existing bylaws allow the House to direct such activities. See §2.13.1.5. This clause is therefore superfluous and will be rescinded.

Policies to have a change in title

- D-383.996 "Impact of the NLRB Ruling in the Boston Medical Center Case"
  Our AMA: (1) representatives to the ACGME be encouraged to ask the ACGME to review the Institutional Requirements and make recommendations for revisions to address issues related to the potential for resident physicians to be members of labor organizations. This is particularly important as it relates to the section on Resident Support, Benefits, and Conditions of Employment; and (2) through the Division of Graduate Medical Education, the Resident and Fellow Section, and the Private Sector Advocacy Group develop a system to inform resident physicians, housestaff organizations, and employers regarding best practices in labor organizations and negotiations.

  The title will be changed to "<u>AMA Resources, Advocacy, and Leadership Efforts to Secure Labor Protections for Physicians in Training</u>."

  This policy was reaffirmed at A-20, but the NLRB ruling is not descriptive of the policy, which has as its focus labor protections for physicians in training. In addition, AMA policy generally avoids reference to specific laws and regulations because they may change and no longer be relevant. This change was suggested by the Resident and Fellow Section.

Changes effected by the Speakers' Report do not reset the sunset clock for the items included in this report, and the changes are implemented upon filing of this report.

Fiscal Note: $50 to edit PolicyFinder